REGISTER OF DIRECTOR INTERESTS – 2017/2018 FROM MAY 2017

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
COLE, NIKKI	Chair	Non Executive Director of EKMS **(1)** Non Executive Director of NHS Providers **(1)**	11 May 2015 (First term)
COOKSON, WENDY	Non Executive Director	Managing Director of IdeasFourHealth Ltd, a consultancy for the healthcare industry **(2)** Sole Shareholder for IdeasFourHealth Ltd **(3)** Trustee of Bede House Charity, a local community charity in Bermondsey, London, from January 2017 **(4)**	6 January 2017 (First Term)
ADEUSI, SUNNY	Non Executive Director	None	1 November 2015 (First term)
ELY, JANE	Chief Operating Officer	None	Appointed January 2015
GERRARD, NICK	Director of Finance and Performance	Governor at Colchester Sixth Form College **(4)**	From 4 May 2015
KERSHAW, MATTHEW	Chief Executive	I am a special advisor (acting as inspection chair) for the CQC **(4)**	Appointed 8 January 2016
LE BLANC, SANDRA	Director of HR	Justice of Peace (East Kent) and I am a specialist advisor for the CQC **(4)**	1 September 2014
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd **(1) (2) (3)**	(First term) 1 July 2017

REGISTER OF DIRECTOR INTERESTS – 2017/2018 FROM MAY 2017

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
OLLIS, JANE	Non Executive Director	Quvium UK **(1)** The Heating Hub **(1)**	8 May 2017 (First term)
PALMER, KEITH	Non Executive Director	Managing Director of Silverfox Consultancy Ltd **(1)** Sole shareholder of Silverfox Consultancy Ltd **(3)**	1 January 2017 (First term)
SHUTLER, LIZ	Director of Strategic Development and Capital Planning	Nil	January 2004
SMITH, SALLY	Chief Nurse and Director of Quality	Advisory role for Independent Living Advisors **(4)**	Interim from 1 April 2015 Substantive from 28 July 2015
STEVENS, PAUL	Medical Director	CQC Adviser **(4)** NICE Chair, Chair of the Kidney Disease Guideline and Quality Standards Groups **(4)** Executive Member of Kidney Disease Improving Global Outcomes **(4)**	June 2013
TOMSON, COLIN	Non Executive Director	Nil	11 May 2015 (First term)
WILDING, BARRY	Senior Independent Director	Russet Homes Ltd **(1)**	11 May 2015 (First term)

REGISTER OF DIRECTOR INTERESTS – 2017/2018 FROM MAY 2017

Footnote: All members of the Board of Directors are Trustees of East Kent Hospitals Charity
Categories:

1 Directorships
2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
3 Majority or controlling shareholding
4 Position(s) of authority in a charity or voluntary body
5 Any connection with a voluntary or other body contracting for NHS services
6 Membership of a political party

UNCONFIRMED MINUTES OF THE SEVENTY-NINTH MEETING OF THE BOARD OF DIRECTORS FRIDAY 9 JUNE 2017 AT 9.30 AM BOARDROOM, KENT & CANTERBURY HOSPITAL

PRESENT:

Mrs N Cole	Chair	NC
Mr S Adeusi	Non-Executive Director	SA
Ms W Cookson	Non-Executive Director	WC
Mr N Gerrard	Director of Finance and Performance Management	NG
Ms J Ely	Chief Operating Officer	JE
Mr M Kershaw	Chief Executive	MK
Ms S Le Blanc	Director of Human Resources	SLB
Mr S Mathur	Non-Executive Director	SM
Ms J Ollis	Non-Executive Director	JO
Mr K Palmer	Non-Executive Director	KP
Ms L Shutler	Director of Strategic Development and Capital Planning	LS
Dr S Smith	Chief Nurse and Director of Quality	SSm
Dr P Stevens	Medical Director	PS
Mr C Tomson	Non-Executive Director	CT
Mr B Wilding	Senior Independent Director	BW

IN ATTENDANCE:

Andy Barker	IT Director (for minute numbers 49/17 and 57/17)	AB
Mrs A Brown	Senior A&E Sister, William Harvey Hospital (minute number 48/17)	ABr
Miss N	Patient's Sister (minute number 48/17)	Miss N
Sylvia Robson	Board Support Secretary (*Minutes*)	SR
Sarah Swindell	Assistant Trust Secretary	SS
Natalie Yost	Director of Communications	NY

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Chris Hudson	Divisional Director – Surgical Services Division	CH
Nigel Mansley	Non-Executive Director *(from 1 July 2017)*	NM
Lindsey Shorter	Senior Programme Manager	LS

4 members of the public
5 Governors

MINUTE NO.		ACTION
43/17	**CHAIRMAN'S WELCOME** The Chair opened the meeting and welcomed everyone present.	
44/17	**APOLOGIES FOR ABSENCE** There were no apologies for absence.	

45/17 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

46/17 **MINUTES OF THE PREVIOUS MEETING HELD ON 10 APRIL 2017**

WC highlighted that on page 2 'reflexively' should read 'reflectively'.

Subject to this amendment, the Board **APPROVED** the minutes of the previous meeting.

47/17 **MATTERS ARISING FROM THE MINUTES ON 10 APRIL 2017**

The Chair reported that all matters arising from the meeting on 10 April 2017 were closed.

48/17 **PATIENT EXPERIENCE STORY**

SSm welcomed Miss N and ABr to the meeting. Miss N and her family had asked to share their experience and gratitude. It was a positive story which illustrated the positive outcome and what could be achieved when all agencies, internal and external, worked together cohesively.

ABr echoed the remarks on the importance of working as a team. She was grateful for the learnings she had taken from Trust forums and for the protocols that were in place. She noted that many of the surgical staff had undergone extra training to enable the Trust to deliver life-saving damage control surgery and then transfer patients to other Trusts for tertiary care. Feedback from the patient's family had helped reinforce the positive experience the staff had had.

Miss N was very happy to have met the staff involved in the patient's care and emphasised the importance of giving emergency services the deserved recognition and gratitude.

JE questioned whether King's had fed back on the efficiency of the transfer and whether the family felt that King's had expected the patient. ABr responded that HEMS had airlifted the patient to King's under the understanding that the Trust had notified them. The call had been made whilst HEMS was in flight, which the Trust had since learned from. The Trust had also liaised with the Police once the patient had left, who had escorted the patient's family to the hospital. SM praised Dr Natasha Newton for her efforts.

MK highlighted the success of the Trust's liaising with other agencies, but emphasised that a further learning had been in relation to support for the patient's family.

The Board discussed and **NOTED** the Patient Experience Story, the themes of this story and the actions in place to make further improvements, and expressed their thanks to Miss N for attending the Board meeting and her family in sharing their experience.

49/17 **CYBER SECURITY**

The Chair commended the work of the IT department which had resulted in the Trust not being incapacitated during the recent ransomware attack on the NHS.

AB provided an update on Cyber Security and asked the Board to note the following.

The Trust had continued to invest in IT and had used external assessment frameworks to provide comfort. The Trust had survived the WannaCry ransomware attack unscathed. IT had learned lessons and excellent communications had gone been issued.

CT congratulated the IT team. He enquired how much it had cost to migrate from XP. AB responded that the work had been completed internally and within the regular annual investment, and had thus generated no additional cost.

Regarding the Sustainability and Transformation Plan (STP), KP questioned what impact the safety and security of other Trust's systems had on decisions made. AB explained that there was a clear risk in sharing information across organisations and maintaining security and control. The team were currently working towards the right balance.

PS praised AB, explaining that the changes he had made had benefitted both cyber security and clinical systems.

BW enquired whether the external partners' unwillingness to create changes had been addressed and why a small number of specialist work stations were still considered potentially vulnerable. Regarding the latter, AB responded that clinical devices were licensed for clinical use in certain configurations with certain software for patient safety, which contradicted the requirement to continuously upgrade. The NHS needed to understand how to progress the entire medical device licensing model. Nonetheless, the problem had been identified and measures taken to ameliorate the issue, and make the devices more secure.

Regarding the former question, discussions with the head of a significant contractor had revealed that they had been overwhelmed when the national situation had occurred. The contract currently did not allow the Trust to help the contractor in those circumstances. It was a work in progress.

MK enquired what message AB could offer the staff to assure them that the Trust protected themselves as much as possible. AB responded that social engineering was generally considered to be the weakest part of any defence. However, the fact that the education process had gone on for some time meant that staff were very careful with the way they handled e-mails. That education would continue and staff needed to continue to be sensitive to things that looked suspicious.

The Board discussed and **NOTED** the Cyber Security Report.

50/17 **CHAIR'S ACTIONS**

The Chair provided an update on Chair's Actions and asked the Board to note the following.

No actions had been taken between the last and current meeting. A joint meeting of the Quality Committee, Finance and Performance Committee (FPC) and the Integrated Audit and Governance Committee had taken place to approve the Trust's Annual Report and Annual Accounts, and submissions had then been made to NHS Improvement (NHSI). Additional submissions would follow on 22 June 2017.

The Chair had also met with the new Chairs of the neighbouring NHS organisations to build relationships and share challenges. They had recommitted to the STP and agreed to regular meetings going forward.

The Board **NOTED** the Chair's Actions Report.

51/17 **CHIEF EXECUTIVE'S REPORT**

MK outlined that in terms of Financial Special Measures (FSM), a second meeting had been held with NHSI where a positive discussion had taken place about month 1 and early signals around month 2. NHSI were happy with the Trust's progress and appreciated the challenge the Trust faced. That challenge would increase as the year progressed and NHSI would receive further updates.

MK noted that the report on strategic and annual priorities indicated that all partnership objectives had been achieved, but should state that three were fully met and those outstanding would be carried forward to 2017/18.

The Management Board had discussed, and was in support of, the Advanced Clinical Care Practitioner business case. The initiative would return to the Trust Board through the FPC for approval; however, work would meanwhile continue in order to avoid delays ahead of the Board discussion.

SA congratulated the team on achieving significant results with the Length of Stay (LoS) Project and reducing LoS, he questioned whether the project would be scaled across all sites. MK confirmed that it would.

SA congratulated MK on the Lord Carter Innovation Award for the Radio-Frequency Identification Device (RFID) tracking. He queried whether, whilst procurement was underway towards a new clinical Patient Administration System (PAS), whether RFID would be deployed in key areas in the Trust. MK confirmed that it would be.

ACTION: To identify the key areas in the Trust where RFID would be deployed. MK

BW highlighted the 15% improvement in performance that the Emergency Department (ED) at William Harvey Hospital (WHH) had seen. MK noted that this related to the four-hour A&E wait performance, which had been sustained at the improved level. However, there were still day-to-day challenges and more work to be done.

BW enquired whether the improvements in the ambulance handover time had been sustained. JE responded that the Trust had moved from bottom five to top five for the smallest number of ambulance handover delays. That was facilitated by weekly meetings and daily interactions to drive culture and behaviour.

The Board discussed and **NOTED** the Chief Executive's Report.

51.1/17 **EMERGENCY TRANSFER OF SERVICES**

MK outlined that the report regarding the decision of Health Education England (HEE) and the General Medical Council (GMC) to remove junior doctors in training from acute medicine at Kent and Canterbury Hospital. The Trust was currently working towards a changeover date of 19 June, to move services to the William Harvey Hospital (WHH) in Ashford and Queen Elizabeth the Queen Mother Hospital (QEQM) in Margate. It was a challenging issue and a significant process had been developed to support the work both internally and with partners.

The operation was a temporary move and an emergency response to the junior doctors change. The Trust had considered a range of proposals and felt that the solution proposed was the right approach. Other alternatives created other risks that were more difficult to mitigate, although that did not mean that the selected proposal was risk or challenge-free.

A significant amount of work had gone into creating capacity on the other two hospital sites, and mitigating risks, in preparation for 19 June. The Board had received the confidential risk assessment view from NHS England (NHSE), which made clear that there was a set of risks which needed to be managed, but also made clear that there had been significant progress around bed occupancy numbers and medical staffing support on the other sites to ensure that they were in the best possible position for 19 June.

The proposal was in hand and the set of risks were being managed. MK, in agreement with other stakeholders, recommended progressing with the planned changes on 19 June.

PS outlined that, from a clinical perspective, the difficulty prior to removing the trainees had predominantly been within the consultant workforce. 38 posts were affected and in terms of resident medical officer support, the Trust could not provide close to that number, but could put in a sufficient level of cover to be able to provide support to the others left on the site. In summary, the risk of not moving acute medical take from the site was greater than the risk of leaving it there.

After 19 June, patients in an emergency situation would go straight to the primary PCI unit in Ashford and receive treatment faster than they currently would. Descriptions of that type were important in helping people understand why the decision had been made.

SSm had worked on a similar change in the past. The change had depended on clear pathways, which JE's team had developed for the current situation. She was confident in the work underway and impressed with the external partners. There

was more to do, but there was a lot of governance in place which felt stronger than it had before. From a clinical perspective, the team was doing as much as they could and were seeing traction in preparation for 19 June.

From a staff perspective, engagement had improved. Every member of staff affected had been spoken to on a one to one basis and had been allocated to an area on the other sites. The staff were content, with some nervousness, but the process had been made as safe as possible. Significant support had also been received from external partners, who would keep the Trust on their toes in terms of sustainability.

JO was happy with how the Executive Team had worked to ensure patient safety and quality of care during the transfer, and was assured that the Trust had ensured a motivated and activated workforce. PS highlighted that Health Education Kent, Surrey and Sussex (HEKSS) and the GMC had assured themselves that the WHH and QEQM sites had capacity and capability.

KP requested comments on QEQM and South East Coast NHS Ambulance Trust (SECAmb). MK responded that he first wanted to congratulate JE and the team for their hard work and support. From a SECAmb perspective, the situation had significantly improved. Additional investment had been agreed for the short term, with a mechanism for extension if necessary. The work the teams had done in the Trust and the Ambulance Service to reduce ambulance delays had also improved the position and increased the level of assurance that the Trust was in a position to manage the additional workload that came through the ambulances to the other two sites.

MK explained that the QEQM situation was more challenging. The lack of availability of substantive medical staff in Margate drove a significant number of breaches, which would not be immediately ameliorated by the change on 19 June. However, having additional medical capacity and specialities would help. The contingency plan could need to be activated earlier for QEQM than at WHH based on the current situation, but other mechanisms could also be used towards how demand was split between Margate and Ashford, once live. Work continued and would continue until 19 June.

KP was concerned with the long term sustainability of QEQM and wondered what could be done. MK responded that a lot of work was currently underway. The success of the temporary changes would help in terms of further recruitment, which was currently underway.

SA supported the efforts that had been made in advance of 19 June. He urged the Trust not to under-cost the post-19 June 100-day plan.

BW enquired whether the metrics to achieve before 19 June had been achieved. MK responded that they were on track and the risk of not achieving them emphasised the importance of the contingency plan.

PS outlined that people needed to understand that the decision to remove trainees was beyond the Trust's control and there was currently no indication that the decision would change.

MK advised the Board not to underestimate the gravity of the situation for staff, patients and the public. Work would continue and the Board would receive regular progress updates.

The Board **APPROVED** to implement the temporary Emergency Transfer of Services on 19 June 2017.

52/17 **FULL CORPORATE RISK REGISTER/HIGHEST MITIGATED STRATEGIC RISKS**

SSm highlighted that the proposal around how to review the highest mitigated risks had been discussed at the Quality Committee. The Committee had looked favourably on the proposal. There were otherwise no significant changes to the corporate or strategic risk register.

BW noted that the Trust had seen a marked improvement in the risk management process over the past year. The core risk register was in a better state and the quality of discussion of risks had also drastically improved. The proposal was to review the full risk register once per quarter and to review monthly the highest risks in the new format. He noted that the risk register was still a work in progress.

The Chair requested an update on SRR 16. SLB reported that a paper had been distributed. LS outlined that in terms of the STP, a group was being convened to review outstanding issues, including the skills audit, for which a full analysis would be conducted into the current skill gaps, culminating in a proposal in July to meet those gaps.

The Board discussed and **NOTED** the Full Corporate Risk Register/Highest Mitigated Strategic Risks Report, and the sample report in Appendix 3 on the proposed risk reporting arrangements for the Quality Committee.

53/17 **BOARD COMMITTEE FEEDBACK**

53.1/17 **FINANCE AND PERFORMANCE COMMITTEE (FPC)**

SA reported that, with respect to Financial Special Measures (FSM), a first meeting had been held with the Deputy Chief Executive of NHSI and his team on 21 April and a second meeting on 2 June. The meetings had been positive and successful, and had allowed the Trust to demonstrate incremental progress on the Financial Recovery Plan (FRP) which underpinned the FSM. The meeting had given NHSI Executives confidence in progress. The Trust had taken away a number of actions and the next meeting was scheduled to be held in July.

Regarding Continuous Improvement Plans (CIPs), at the first meeting with NHSI the Trust had had a £32m stretching CIPs target for the financial year 2017/18. At 2 June, over 80% of the £32m CIPs were green and the team was working towards 100% green in the next few weeks.

For month 1 the Trust had over-performed on income, the expenditure run-rate, and CIPs delivery. Month 2 looked good and the FRP was on track.

However, a number of things could be done better. First, the Trust needed to invest the right amount of resource in patient flow. Second, the Trust needed to ensure they had a strong grip on the number of resources necessary to deliver the transformation programme and FRP, for which work needed to accelerate and return back to the Board with a high level of clarity.

WC questioned, on page 4, what 'pass through drugs' were. SA responded that they were high-cost drugs that did not have gain share. NG explained that it was a pass through of the cost.

WC enquired what the phrase, 'Diagnostic targets are being met' on page 5 referred to. MK responded that it referred to DMO1.

JO questioned whether there were indicators that patient flow would not be green by the end of June. SA responded that it would become an issue if the Trust did not invest enough resources, for which MK confirmed that work was underway.

The Board discussed and **NOTED** the FPC Report and **APPROVED** the capital plan for the 2017/18 financial year.

53.2/17 **QUALITY COMMITTEE**

BW had nothing further to add to the report.

KP questioned 'Harm Free Care' on page 1. BW explained that there was consensus that more could be done. SSm noted that the Trust's service was 99% harm free, which exceeded the national average.

The Board **NOTED** the Quality Committee Report.

53.3/17 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**

BW highlighted that the annual accounts had been finalised and signed off, and the process had gone well. The Quality Account had also been signed off; however, all three metrics they had looked at had been qualified. MK noted that the issue was under investigation; the measures would be comprehensively reviewed and specific action taken. BW added that their being qualified was the norm across the NHS, but the Trust could do better.

The Board **NOTED** the Integrated Audit and Governance Committee Report.

53.4/17 **STRATEGIC WORKFORCE COMMITTEE**

CT highlighted that although overall percentage of appraisals completed was moving well, Urgent Care was not, and was listed as a risk in the system. Progress was also unsatisfactory on the percentage of completed consultant job plans. A briefing paper had been requested to investigate next steps.

A staff turnover report had been requested from Picker. The Committee had also questioned whether reaching the top 20% of Trusts by 2019 was an achievable

ambition and a paper had been requested on a sensible target.

The Board **NOTED** the Strategic Workforce Committee Report.

53.5/17 **CHARITABLE FUNDS COMMITTEE (CFC)**

KP reported that funding for the refurbishments of St Augustine's Ward at QEQM had been approved and work was due to start shortly. The Charitable Funds Manager had retired and thanks were extended for her hard work and support over the 27 years she had worked for the Trust. Interviews for a replacement were being held and the Trust was confident that a suitable individual would be appointed.

The Board **NOTED** the CFC Report and the KPMG Audit Highlights Memorandum on the 2016/17 Charity Accounts, and **APPROVED** the £230,155 grant for the two endoscopic camera systems with blue light imaging, the 2016/17 Annual Report and Accounts, and the Charity Management Representation Letter for 2016/17.

53.6/17 **REMUNERATION COMMITTEE**

WC reported that a review was underway of the parity of pay for staff on the very senior managers pay scale.

The Board **NOTED** the Remuneration Committee Report.

53.7/17 **NOMINATIONS COMMITTEE**

WC reported that the skills assessment had revealed no major skill gaps and actions had been discussed to close the gaps identified.

An annual statement had been produced for Directors Fit and Proper Test. It was a legal requirement which the Trust would review annually.

NG had also resigned from his position of Director of Finance and Performance with the Trust and how to move forwards around recruiting a replacement had been considered. The Chair congratulated NG on his superb work and the value that he had added to the Board and the Trust.

The Board **NOTED** the Nominations Committee Report.

54/17 **OUR TRANSFORMATION JOURNEY**

MK provided an update on Our Transformation Journey and asked the Board to note the following.

Papers had been shared with the Board and discussions had subsequently been held with NHS England. The Trust then needed to activate the work.

The governance process underpinning the work was beginning to come together. Work was underway to close outstanding questions and get the work into day-to-day processes. The Chair understood the Board's desire to use their own skills and people wherever possible, and would endeavour to do so.

SA commented that the update demonstrated strong improvements since the last Board. He questioned whether the work would impact how the Trust progressed and defined the East Kent Way. MK responded that the East Kent Way was inherent to all conversations across the organisation. NY stated that it was about building on the work that had been done thus far around culture. The Chair noted that the values and behaviours that underpinned the East Kent Way had been defined and the challenge was a matter of embedding. PS highlighted that the East Kent Way received a positive response from individuals outside of the organisation. To further improve public perception of the Trust, the Board needed to continue to look forward.

BW requested the project plans and charts underpinning the work stream, to enable the Board to assess progress and delivery. MK responded that the documentation would be communicated when the timescales were confirmed. SA noted that the FPC had also requested one page summaries of the top 20 projects and schemes by value.

SM acknowledged the progress in terms of governance, planning and management and emphasised that focus then had to move to delivery. He advised the Trust not to assume that they knew it all, and encouraged them to use their people.

CT was concerned with whether the work would come together on time. The Board needed a way to get assurance on delivery. MK summarised that the balance between external support and internal enthusiasm and ability was important, but emphasised that ultimately the Trust's staff would be responsible for delivery.

The Board **NOTED** the update on Our Transformation Journey.

55/17 **INTEGRATED PERFORMANCE REPORT**

NG had nothing to add to the report.

BW stated that the impression of the Quality Committee on the report was that there had been some overall improvement. MK agreed that there were positive signs, but highlighted that there were also areas where that was not the case. The biggest concern was currently around the four-hour performance, closely followed by the cancer 62-day performance, both of which would see increasingly national interest.

BW commented that the Overall Domain Score weightings for the Effective Domain on page 12 did not total 100%. JE responded that the metrics were due to be reviewed.

ACTION: To review the metrics in the Overall Domain Score weightings for the Effective Domain and provide an update on the actions being undertaken to address and improve this to achieve a 100% total. JE

WC noted the productivity for theatres and outpatients on page 39 were not populated. NG responded that it would be populated when there was live data.

The Chair questioned what drove the increased staff turnover on page 32. SLB

responded that an exit interview process was currently in pilot to understand the drivers.

PS reported that a Stop Before You Block incident had occurred the day prior at QEQM theatres. The nerve stimulator had not had a Stop Before You Block notice. The anaesthetist had immediately self-reported the issue.

The Board discussed and **NOTED** the Integrated Performance Report.

56/17 **MENTAL HEALTH FIRST AID (MHFA) TRAINING FOR STAFF**

SLB reported that an annual report of MHFA training had been produced which was one of the many initiatives being implemented by the Trust as part of its health and wellbeing programme.

ACTION: To include in the Trust's generic job descriptions the need to identify senior staff representatives for staff health and wellbeing. SLB

The Board had no further questions on the report.

The Board **NOTED** the MHFA Training for Staff Report.

57/17 **MEDICAL DIRECTOR'S REPORT**

PS provided an update on the Medical Director's Report and the appended infection control action plan, and asked the Board to note the following.

An incident had been reported under infection prevention and control and a number of graphs had been included in the report related to the emergency care pathway, where a number of areas would need more attention in the future.

Given the importance of infection prevention and control, CT was pleased with the number of greens in the report. He noted that the action on page 6, related to training for catheter use, was red. PS noted that a number of items needed to be added to the action plan to explain why some items were red.

The Board **NOTED** the Medical Director's Report and the Infection Prevention and Control Action Plan.

58/17 **INFORMATION SHARING FOR KENT AND MEDWAY SUSTAINABILITY TRANSFORMATION PLAN (STP)**

AB outlined that the plan that was a critical enabler for the STP process. The Chair enquired whether it had been done elsewhere. AB responded that it had and that the Trust had taken learnings from other regions.

PS emphasised the importance of sufficient investment. AB noted that the organisation's current preference was to execute the plan using the Trust's internal resources.

KP questioned how the plan related to the electronic medical records project and

cyber security, what the costs were and what the timescale was. AB responded that the plan was intrinsically linked to the electronic medical records project. The Chair suggested that it was perhaps too early in the process to consider the cost.

JO enquired what the next steps were. The Chair explained that the business case would go to the Programme Board of the STP. Decisions would then be underwritten by each individual Trust that was party to them. CT highlighted that it was essential to the project to get the right level of collaboration on patient pathways across the system.

The Board had no further questions.

The Board **NOTED** the Information Sharing Kent and Medway STP Report.

59/17 **MEDICAL REVALIDATION: END OF YEAR REPORT**

PS outlined that the Medical Revalidation Report had to be regularly submitted to the Board. The returns were submitted to the south revalidation unit on a quarterly basis with the annual audit submitted annually.

WC enquired about the two non-engagements. PS outlined that the programme had slowly but strongly escalated. He explained the revalidation and appraisal policy, and GMC's role in such cases. SM questioned who was responsible for the appraisal. PS responded that there was a group of 160 individuals who underwent regular updates and training.

CT enquired whether there was a pattern behind the 12 conduct concerns related to doctor's practice on page 5. PS responded that conduct issues usually related to behaviour. CT requested the conduct behaviour policy.

ACTION: To share the conduct behaviour policy with CT. PS

The Board had no further questions.

The Board **NOTED** the Medical Revalidation: End of Year Report and formally recorded a thank you to Mr Richard Earland, who has been the Non-Executive Director supporting the Revalidation Working Group throughout its inception.

60/17 **ANY OTHER BUSINESS**

There were no further items of business.

61/17 **QUESTIONS FROM THE PUBLIC**

Mr Smith congratulated the Board for the award. He questioned whether the Trust's contract had been signed with the CCG and whether that would impact the plans. He also questioned whether the number of infection prevention and control cases was above target.

MK responded that contracts with the CCG were in place for the year and had been signed by the agreed deadline. Challenges still arose from the contract, which was

an ongoing discussion.

Regarding infection control and MRSA, PS stated that the desire was to have zero MRSA incidents.

Ms Laing highlighted that the map on page 3 of the paper on information sharing identified Buckland Hospital as a Kent Community Hospital.

ACTION: To ensure that it is made clear in future reports that Buckland Hospital is not a Community Hospital. LS

Ms Whorrell outlined that the Nursing and Midwifery Council (NMC) intended to reduce the pass mark for overseas nurses required to pass an English language test before working in the NHS. She wondered whether the Board agreed with lowering the standard. SLB responded that the pass mark had been raised to a seven and meetings were scheduled with the NMC for them to evidence why the pass mark had needed to changed.

Mr Cockney understood that the Trust had had a good infection control team over the years and asked whether that had changed. PS responded that the entire infection prevention and control team had been refreshed over the past few years. Good historic performance in those metrics had also contributed to complacency.

Mr Smith highlighted that the graphics provided in relation to infection prevention and control did not reflect data the way that it had in the past. The Chair responded that there was a trend line, which would be shared immediately after the meeting. PS noted that the graphic referred to had been requested for reintroduction.

The Chair closed the meeting at 12.42 pm.

Date of next meeting in public: Friday 11 August 2017 in the Board Room at William Harvey Hospital.

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 11 AUGUST 2017

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 9 JUNE 2017

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
		There were no outstanding actions.			
ACTIONS FROM THE LAST MEETING HELD					
51/17	09.06.17	**CHIEF EXECUTIVE'S REPORT** To identify the key areas in the Trust where Radio-Frequency Identification Device (RFID) would be deployed.	MK	August 2017	RFID use in the Trust. The Trust has a long track record of using bar codes to identify patients, locations, and orders for investigations. We are committed to the Scan4Safety initiative that is being led by NHS England. As part of this project we are reviewing all our tracking needs to determine whether we work in the best way. One area of improvement we have identified is to move from using bar codes to RFID. In fact we already use RFID tags across the Trust's sites in a number of areas. For example, medical devices are tagged which allows us to track their location which means that

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
					when equipment is required urgently for a patient, it can be located efficiently. However, there is more that can be done and the new Patient Administration System (PAS) that comes in later in 2017 will allow us to introduce a new national coding scheme to uniquely identify patients and this will then become the platform for further use of RFID in the future.
55/17	09.06.17	**INTEGRATED PERFORMANCE REPORT** To review the metrics in the Overall Domain Score weightings for the Effective Domain and provide an update on the actions being undertaken to address and improve this to achieve a 100% total.	JE	August 2017	This is still to be completed in August.
56/17	09.06.17	**MENTAL HEALTH FIRST AID (MHFA) TRAINING FOR STAFF** To include in the Trust's generic job descriptions the need to identify senior staff representatives for staff health and wellbeing.	SLB	August 2017	Draft generic statement produced on staff health and wellbeing. To be implemented by end of August 2017.
59/17	09.06.17	**MEDICAL REVALIDATION: END OF YEAR REPORT** To share the conduct behaviour policy with CT.	PS	August 2017	
61/17	09.06.17	**QUESTIONS FROM THE PUBLIC** To ensure that it is made clear in future reports that Buckland Hospital is not a Community Hospital.	LS	August 2017	

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**PATIENT EXPERIENCE STORY**
BOARD SPONSOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PAPER AUTHOR:	**CHIEF NURSE & DIRECTOR OF QUALITY** **TISSUE VIABILITY NURSE** **WARD MANAGER CHEERFUL SPARROWS FEMALE WARD**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Board of Directors have been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services. Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

This month's story relates to the experiences of a 96 year old lady who was admitted to Cheerful Sparrows ward following a fall. During her stay she developed an avoidable deep ulcer. Root cause analysis revealed a number of omissions in care. In response the team undertook the 'Teams Improving Patient Safety' programme which examined human factors, provided a framework to undertake improvement and addressed engagement and ward culture towards pressure ulcer prevention and care. The team designed a simple prompt card that staff used and implemented. Four months into the programme the ward has reported no avoidable pressure ulcers.

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	If we do not learn from the feedback from patients and their families there is a risk that we do not continue to make improvements to patient experience and outcomes.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR2 - Failure to maintain the quality and standards of patient care CRR 16 - Poor complaints management
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent recurrence.

Board of Directors
Patient Experience Story
August 2017

Introduction

This month's story relates to the experiences of an elderly lady who was admitted following a fall. During her stay on the ward she developed a deep pressure ulcer. There was a range of learning for the ward. Using the 'Teams Improving Patient Safety' (TIPS) programme the ward engaged their teams and made improvements to this aspect of care.

The Story

Mrs M is a 96 year old lady who lived independently at home. She was independently mobile and used one walking stick to help her walk. She had a history of heart disease, and there was a query whether she had suffered a stroke in the past. She was lucid and did not suffer from any memory loss or cognitive impairment.

On the 5 January 2017 Mrs M was brought to the Queen Elizabeth Queen Mother Hospital (QEQM) following a fall after tripping on the kerb on her way home from the shops. She was found in the road by her neighbours. It is unknown how long she had been there. She was transferred to Cheerful Sparrows Female ward that evening from the Emergency Department, and on the 8 January she was transferred to Cheerful Sparrows Male ward to a female bay. On admission to the ward her skin assessment was reported as 'skin intact'.

On 13 January an agency nurse caring for Mrs M identified a black area on her sacrum with two breaks, and as the tissue viability nurse was on the ward reviewing another patient, she was asked to see this lady. It was determined the patient had unstageable damage to her sacrum and a datix incident report was completed. This was later categorised as a category 3 pressure ulcer. A category 3 pressure ulcer is one where there is full thickness skin loss. Subcutaneous fat may be visible but bone, tendon and muscle are not exposed. All deep ulcers require a root cause analysis (RCA) to be undertaken. The following were the findings and omissions in care:

- There was no documentation indicating a body map was completed in the Emergency Department
- The 'Situation Background Assessment Recommendation' (SBAR) transfer tool did not have the "pressure sore" risk section completed
- There was no acknowledgement of the 10 hours spent either on the kerb post fall or on a trolley in the ambulance and Emergency Department
- The pressure ulcer risk assessment was not fully completed on the ward and incorrectly identified her as of "medium" risk of developing a pressure ulcer, when she was actually at high risk of developing pressure damage
- A body map was completed on admission to the ward indicating this lady's pressure areas were intact
- There was no change in risk assessment despite the fact that the patient had had surgery under spinal anaesthesia or the fact that there was deterioration in her mobility
- The 'SKIN[1]S' bundle was reviewed on a daily basis; however no changes were made to the original assessment despite new damage to her sacrum and heels being identified on 11 January 17
- No datix incident report was completed on this occasion
- The RCA review also pointed to the fact that on transfer to the male side they assessed this lady as bedbound, needing help with all activities of daily living and did not take into account that prior to discharge she was living independently.

[1] The SKINS bundle stands for S – support service (Is the mattress correct for the person?); K – keep moving; I – Incontinence (consider skin protection adjuncts and prevention strategies); N – nutrition (does the person require nutritional support?); S – skin assessment (full assessment).

In short the findings of the RCA were that there were missed opportunities to provide the correct level of pressure damage prevention strategies for this lady. Incorrect risk assessment on admission meant that appropriate actions were not taken and there was lack of reassessment following her surgery as well as evidence of a poor transfer between the two wards.

Evidence informs us that the cost of pressure ulcers to the NHS is around £1100 - £40,000 per person. We also know that 20% of patients in acute care have a pressure ulcer. The impact of this is that hospital-acquired pressure ulcers increase the length of stay by an average of 5–8 days per pressure ulcer. The cost of pressure ulcers to the patient includes pain, infection, an increased potential of sepsis and also increases the risk of increased morbidity and mortality rates.

Other areas for consideration for the ward when they underwent the RCA were around professional standards of nursing care and following policy. The Nursing & Midwifery Code (2015) states that when documenting care nurses must 'identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need…. Accurately assess signs of normal or worsening physical and mental health in the person receiving care.'

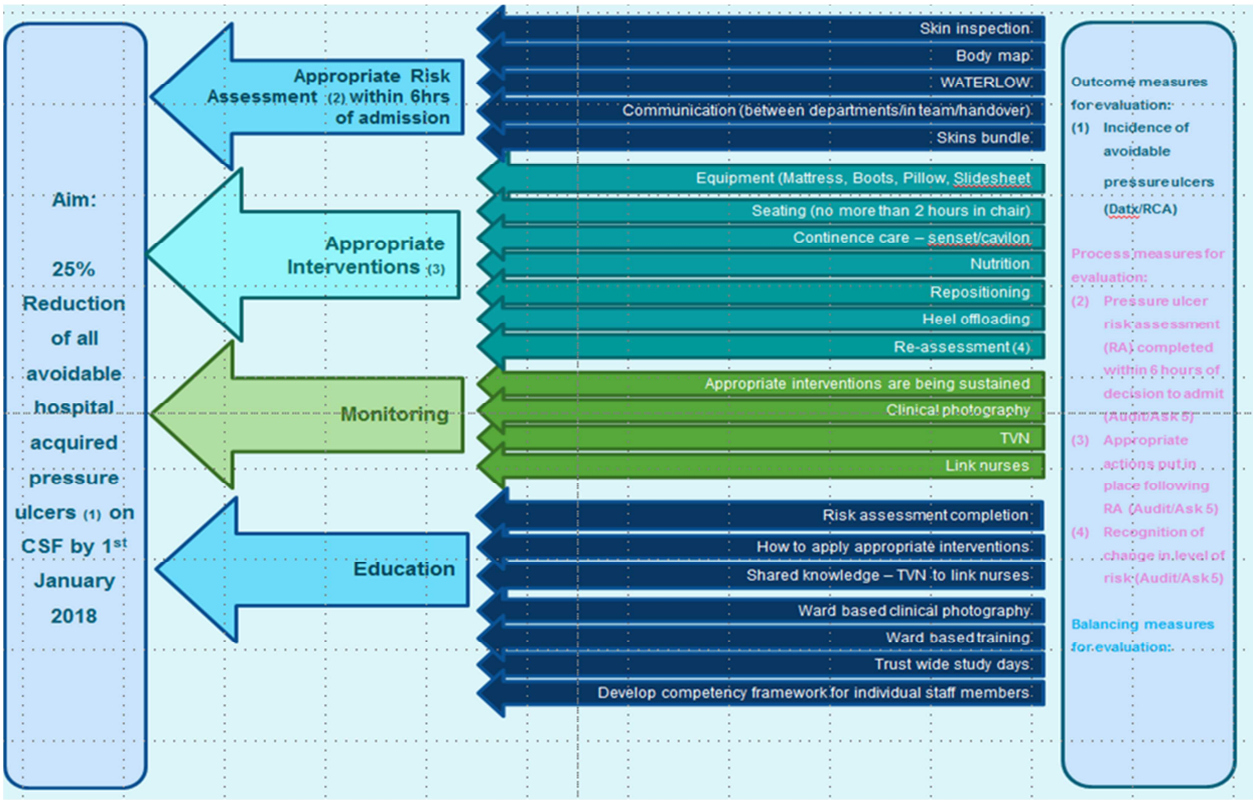
The Trust's policy for pressure ulcer prevention and care (2016) is that: 'All patients must be assessed for risk of pressure ulcers within six hours of admission.' Previous ward baseline audits indicated a 66% achievement of pressure ulcer risk assessment within 6 hours of admission. NICE guidance recommends that health care professionals should carry out and document an assessment of pressure ulcer risk for adults being admitted to secondary care - Clinical Guidance (CG179) April 2014.

Recognising the seriousness of the development of the deep ulcer, the team agreed take part in the Teams Improving Patient Safety (TIPS) programme and to transform the way they care for patients' pressure damage risk, prevention and treatment. Their project plan actions comprised:

- Formation of a Project group
- The Driver Diagram and measurements were developed (please see overleaf)
- Engagement of ward staff was key
- Baseline observations and data collection were undertaken
- Introduction of improvement measures were factored in
- Continued data collection in place
- Analysis.

Their high level aim was to achieve a 25% reduction of all avoidable hospital acquired pressure ulcers on Cheerful Sparrows Female by 1 January 2018.

Driver Diagram



Baseline Measures

The ward were planning on focusing on sacral and heel ulcers as they had been their most serious RCAs. However, on analysis of datix incident reports they realised that all body sites had been an issue so they agreed not to just focus on one particular body site as previous Trust wide tissue viability campaigns had done (Think Heels and Bottoms up). This was valuable local analysis and showed the importance of baseline measures. They then analysed the themes of avoidable hospital acquired pressure ulcers on the surgical floor at QEQM over an 18 month period. This showed that risk assessment was the largest issue. However they also found that if the risk assessment was incorrect then the correct interventions would not be carried out. By concentrating on risk assessment they hoped to have greater impact.

The team then analysed the human factors that impacted on this incident. They found that a number of human factors influenced pressure risk assessment on the ward. They found that the main issues were missed opportunities at the point of admission and that frequent moves between wards impacted on the continuity of care. They also found that personal factors had a big impact, for example one factor was when a staff member had a lack of understanding of how to complete the risk assessment and to ensure the correct interventions were put into place. At this time there were also pressures on the ward with high vacancies, new starters and the use of temporary staff who all required a greater level of support and supervision.

The Ward Manager started the programme by meeting with the Healthcare Assistants (HCAs) to gain their perspective and to understand what they felt would help with their day to day working. This also helped the Ward leaders to understand the HCAs' understanding of the patient pathway. To keep the project small the ward team engaged with the Tissue Viability link nurses and from this developed a new assessment care called the 'PROMPT' card (see below). This card was pocket size as well as laminated for staff to see and was a short guide which clearly stated the actions required following assessment.

PROMPT Card Actions

LOW RISK	DAILY SKIN INSPECTION CLEAR DOCUMENTATION (SKINS BUNDLE/NURSING NOTES)	REASSESS DAILY OR IF CHANGE IN CONDITION
MEDIUM RISK	DAILY SKIN INSPECTION CLEAR DOCUMENTATION (SKINS BUNDLE/NURSING NOTES) REPOSITIONING CHART (REPOSITION 4-6HRLY) OFFLOAD HEELS MAXIMUM 2HRS SITTING IN CHAIR EDUCATE PATIENT REGARDING RISK	REASSESS DAILY OR IF CHANGE IN CONDITION
HIGH RISK	DAILY SKIN INSPECTION CLEAR DOCUMENTATION (SKINS BUNDLE/NURSING NOTES) REP;OSITIONING CHART (REPOSITION 4-6HRLY) OFFLOAD HEELS MAXIMUM 2HRS SITTING IN CHAIR EDUCATE PATIENT REGARDING RISK	REASSESS DAILY OR IF CHANGE IN CONDITION LIAISE WITH TV TEAM FOR EQUIPMENT CHALLENGES
IF YOU ARE UNSURE PLEASE ASK		
IF YOU FIND PRESSURE TISSUE DAMAGE: COMPLETE DATIX, REFER TO TV TEAM IF ADVICE REQUIRED		

The team also set up a focus group with ward HCAs and student nurses as well as engaged key staff members to request feedback on the introduction of the PROMPT card. Using 'Plan Do Study Act' (PDSA) cycles they worked through their improvements. This enabled various changes in practice to help support their PROMPT and reduce avoidable pressure ulcers. These are summarised as:

- Appointing a HCA team leader to supervise other HCAs
- Introduced a safety briefing
- Removed the rounding tool as it was deemed to prevent staff prioritising SKINS assessment and was picked up elsewhere in the ward work
- Reintroduction of the daily recording of safety crosses to track progress
- Introduction of the PROMPT card
- Development of a flow chart to reinforce the PROMPT card
- Undertook focus groups to seek feedback and inform the PDSA cycles.

Evaluation

The ward worked really well as a team. In the beginning they had one strong leader and a couple of staff co-leading and they feel that they have really complemented each other's personalities. Staff engagement has been good despite pressures on the ward at the time. Staff changes on the ward posed some difficulty and finding time was a challenge given how busy everyone was. The junior ward sister moved jobs which meant she wasn't available to support the Ward Manager implementing the project. However, this was also an opportunity as the new role of this staff member will enable implementation to the wider site to include the Emergency Department.

The ward have seen an improvement in the risk assessment of using SKINS. Completion of the Body Map has improved. Since the implementation of the project at 4 months the ward have not reported any avoidable pressure ulcers.

Summary
A 96 year old lady was admitted to Cheerful Sparrows ward following a fall. During her stay she developed an avoidable deep ulcer. Root cause analysis revealed a number of omissions in care. In response the team undertook the 'Teams Improving Patient Safety' programme which examined human factors, provided a framework to undertake improvement and addressed engagement and ward culture towards pressure ulcer prevention and care. The team designed a simple prompt card that staff used and implemented. Four months into the programme the ward has reported no avoidable pressure ulcers.

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**CHAIR'S ACTIONS**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**Approval**
APPENDICES:	**APPENDIX 1: EKHUFT CONSTITUTION**

BACKGROUND AND EXECUTIVE SUMMARY

There have been no decisions taken by the Chair since the June 2017 Board of Directors meeting.

The Board of Directors have made the following decisions outside of the Board meeting cycle:

Dementia Village

Early implementation of a new model of care which we expect to revolutionise care for those with dementia.

The Board of Director's Finance and Performance Committee (FPC) undertook a detailed review of the Trust's business case to progress development of a Dementia Village in Dover. The FPC recommended to the Board for approval virtual (electronic) approval was received.

The approach of basing a dementia village on existing housing to providing nursing care for patients living with dementia is novel, it will closely integrate with acute and community care and provide benefits via access to the specialist skills that are available in healthcare of older people (HCOOP) within the Trust. The dementia village will also help in managing the flow of elderly patients through acute beds and therefore make a contribution to the capacity issues that the Trust faces. The model of care can be implemented more widely. As well as providing a better approach to care for the people who are residents at the dementia village, it will act as a source of clinical guidance for patients, carers and staff working in the community when issues arise.

The Board of Directors approved the option for an overseas cash grant from Interreg 2 Seas European fund to support the development. The funding gap would be met via a loan from Kent County Council (KCC).

NHS Improvement (NHSI) confirmed the project does not require formal NHSI approval and will be monitored through regional oversight processes. NHSI has asked for assurances through a self-certification process and this will be overseen by the Trust's FPC.

Constitution

The Joint meeting of the Council of Governors and Board of Directors meeting reviewed proposed changes to the Trust's Constitution at a meeting held on 9 June 2017.

The Constitution was formally taken through a Council of Governors public meeting held on 15 June 2017 and changes were approved.

The Board of Directors is asked to note the process and to formally endorse the proposed changes.

TO NOTE:

The Trust's Annual Report and Accounts 2016/17 were laid before Parliament in June 2017 and a copy is available on the Trust's website:

http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/annual-reports-and-business-plans/

WORKING WITH PARTNERS

A meeting of Chairs of Provider Trusts was held on 25 July 2017. Unfortunately, I was unable to attend and sent comments ahead of time. No decisions were made at the meeting and a further meeting will be convened shortly.

Council of Governors' Update

Joint meeting between Governors and Non-Executive Directors 9 June 2017
The meeting considered the outcome of the review of the Trust's Constitution and agreed to the proposed changes. The Governors also considered a number of practical questions arising from the changes made to their Committee framework following the meeting held on 31 March 2017. The meeting considered how the EKHUFT 'We Care' values could be applied to the work of the Council to make it more effective. An agreement was reached to have an introductory session to explore this further at the Council's development session on 21 July.

Full Council meeting 15 June 2017
There was an extended discussion about the introduction of the new Council Committee Framework, with concerns raised that due process had not been followed. This culminated in a vote to ratify the decisions taken on the basis of the notes from the meetings on the 31 March and 9 June 2017; there were fourteen votes in favour and two against. In his report to the Council, the Chief Executive provided an update with respect to the STP and the junior doctors move. As Chair, I reported on the governance arrangements relating to the STP process, FSM and the appointment of Nigel Mansley to the Non-Executive Director vacancy left by Satish Mathur. Reports were received from the CoG Membership Engagement and Communication Committee and the Nominations and Remuneration Committee. The Governors agreed to move the annual election of a Lead Governor to March, to coincide with the Governor elections, and to ask Michèle Lowe to extend her time in post until March 2018. The meeting also considered the Trust's objectives for 2017/18.

Development Session 21 July 2017
Jane Waters, Cultural Change Programme Lead, worked with the Governors to help them develop ground rules for effective meetings. This part of the cultural change programme has been very effective in improving the quality and outcomes from meetings across the Trust, so we wished to extend the opportunity to our Council. Philip Johnstone, Auditor KPMG, lead the second session providing training on reading accounts and presenting the outcome of the audit of the 2016/17 Accounts and Quality Accounts. The Council had the opportunity to ask questions and the issues covered included: data integrity; audit sample; cost improvement programmes; and the governor indicator.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Ensuring we stay close with our partners.

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

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

RECOMMENDATIONS AND ACTION REQUIRED:

To Note:

- The virtual approval of the Dementia Village Business Case.
- The submission of the Trust's Annual Report and Accounts 2016/17 to Parliament.
- Working with partners update

To Approve:

- Proposed changes to the Trust's Constitution and to note the process taken for review.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**CONSTITUTION REVIEW 2017**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**TRUST SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES	**APPENDIX 1: CONSTITUTION – TRACKED CHANGES**

BACKGROUND AND EXECUTIVE SUMMARY

It is best practice to review the Trust's Constitution at least every two years, the Trust last undertook this in October 2015 where a number of minor amendment including the addition of links to the Council of Governor policies and a definition of "Significant Transaction" (clause 49).

The Chairman and Trust Secretary have undertaken a detailed review to ensure the Constitution fully reflects and supports our operating environment.

The Constitution is provided at Appendix 1 and changes have been tracked for ease of reference. Where appropriate Monitor has been replaced with NHS Improvement but it should be noted that Monitor remains the legal regulator of NHS Foundation Trust's under the Health and Social Care Act 2012. The main changes are detailed below:

1. Constitution clause 10 – introduces automatic membership of the Trust for those signing up as volunteers.
2. Constitution clause 21 – the Panel set up by Monitor to answers questions from Governors on specific matters relating to the Constitution or the NHS Act 2006 was disbanded in January 2017, therefore this clause has been removed and will show as "not used" in the revised version.
3. Annex 4 Composition of the Council of Governors. As part of the facilitated discussion on the Governor Framework in March 2017, Governors had indicated their support for a smaller Council and this is now reflected for further discussion. If this change is approved the number of governors would be reduced from 26 to 19.
4. Annex 7 – Standing Orders for the Practice and Procedure of the Council of Governors: the addition of a paragraph at 3.12 provides for virtual voting where a decision is required ahead of the next scheduled full Council of Governors meeting.
5. Annex 7 – Standing Orders for the Practice and Procedure of the Council of Governors: paragraph 5.1, the paragraph on the appointment of governors to committees has been simplified.
6. Annex 7 – Standing Orders for the Practice and Procedure of the Council of Governors: paragraph 9, the period required to start the process to fill a non-executive / chairman vacancy has been increased from 6 months before the vacancy to 9 months.
7. Annex 7 – Standing Orders for the Practice and Procedure of the Council of Governors: paragraph 13.2 now require the Council of Governors Standing Orders to be reviewed at least every 2 years which is in line with the review period of the Constitution.
8. Annex 8 – Standing Orders for the Practice and Procedure of the Board of Directors', paragraph 3.1, deletion of requirement to post a notice as this is a duplication and the wording is better reflected in paragraph 3.3 – Notice of Meetings.
9. Annex 8 – Standing Orders for the Practice and Procedure of the Board of Directors', paragraph 3.20, clarifies that alternates / proxies can only vote at the Chairman's discretion.

10. Annex 8 – Standing Orders for the Practice and Procedure of the Board of Directors', paragraph 3.21 provides for virtual voting where a decision is required before the next scheduled Board of Directors' meeting.

In respect of clause 49, Mergers, Acquisitions and Significant Transactions, the definition was based on the Risk Assessment Framework (RAF) which has now been superseded by the Single Oversight Framework (SOF). At this point there has been no further guidance on how to define a significant transaction. However, the framework still provides clarity to the Board of Directors' and Council of Governors as to what constitutes a significant transaction. It is recommended that Diagram 1 of clause 49 is retained as the definition of significant transaction. If further guidance is issued a decision can be made as to whether clause 49 should be changed.

In order to effect the changes 50% or more the Council of Governors and 50% or more of the Board of Directors' must approve the changes. Once approved the changes take effect immediately. As no changes are being made to the powers or duties of the Council of Governors the Constitution will not need approval by the membership at the Annual Members' Meeting.

The constitutional changes were discussed at a joint meeting of the Council of Governors and Non-Executive Directors held on 9 June 2017. The Council of Governors ratified the amendments at a meeting held on 15 June 2017.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

PRIVACY IMPACT ASSESSMENT: No	**EQUALITY IMPACT ASSESSMENT:** No

RECOMMENDATIONS AND ACTION REQUIRED:

(a) Approve the changes made to the Trust's Constitution.
(b) Note the ratification of the changes by the Council of Governors:

The constitutional changes were discussed at a joint meeting of the Council of Governors and Non-Executive Directors held on 9 June 2017.

The Council of Governors ratified the amendments at a meeting held on 15 June 2017.

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

Constitution

OCTOBER 2015

CHAIR'S ACTIONS **BoD/57/17**

NHS Foundation Trust Model Core Constitution

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LIST OF ANNEXES

1. Interpretation and definitions

Unless otherwise stated, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

the 2006 Act is the National Health Service Act 2006.

The 2012 Act is the Health and Social Care Act 2012.

Annual Members Meeting is defined in paragraph 13 of the constitution.

constitution means this constitution and all annexes to it.

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

NHS Improvement is the umbrella organisation that has brought together a number of bodies including Monitor.

the **Accounting Officer** is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

2. Name

The name of the foundation trust is East Kent Hospitals University NHS Foundation Trust (the trust).

3. Principal purpose

3.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

3.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the trust are set out in the 2006 Act.

4.2 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

The trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency

5.2 a staff constituency

5.3 Not used

6. Application for membership

An individual who is eligible to become a member of the trust may do so on application to the trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the trust.

7.2 Those individuals who live in an area specified as an area for any public constituency are referred to collectively as the Public Constituency.

7.3 The minimum number of members in each area for the Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

8.1.1 he is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the trust under a contract of employment for at least 12 months.

8.2 Not used

8.3 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 Not used

8.5 The minimum number of members in the Staff Constituency is specified in Annex 2.

9. Automatic membership by default – staff

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency, and

9.1.2 invited by the trust to become a member of the Staff Constituency

shall become a member of the trust as a member of the Staff Constituency without an application being made, unless he informs the trust that he does not wish to do so.

10. Automatic membership by default – Volunteers

10.1 An individual who is:

10.1.1. eligible to become a member of the Public Constituency and have registered as a Volunteer the Trust; and

10.1.2 invited by the Trust to become a member of the Public Constituency

Shall become a member of the Trust as a member of the Public Constituency in which he resides without an application being made, unless he informs the Trust that he does not wish to do so.

11. Not used

12. Restriction on membership

12.1 An individual who is a member of a constituency, may not while membership of that constituency continues, be a member of any other constituency.

12.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

12.3 An individual must be at least 16 years old to become a member of the trust.

12.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 9 – Further Provisions.

13. Annual Members' Meeting

13.1 The trust shall hold an annual meeting of its members ('Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public.

13.2 Further provisions about the Annual Members' Meeting are set out in Annex 10 – Annual Members' Meeting.

14. Council of Governors – composition

14.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed governors.

14.2 The composition of the Council of Governors is specified in Annex 4.

14.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency. The number of governors to be elected by each constituency is specified in Annex 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.

15. Council of Governors – election of governors

15.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules.

15.2 The latest Model Election Rules are attached at Annex 5.

15.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 48 of the constitution (amendment of the constitution).

15.4 An election, if contested, shall be by secret ballot.

16. Council of Governors - tenure

16.1 An elected governor may hold office for a period of up to 3 years.

16.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency by which he was elected.

16.3 An elected governor shall be eligible for re-election at the end of his term, but for no more than two further terms making a maximum of nine years in total.

16.4 An appointed governor may hold office for a period of up to 3 years

16.5 An appointed governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him**.**

16.6 An appointed governor shall be eligible for reappointment at the end of his term, but for no more than two further terms making a maximum of nine years in total.

17. Council of Governors – disqualification and removal

17.1 The following may not become or continue as a member of the Council of Governors:

17.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

17.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

17.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

17.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

17.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 6.

17.4 NHS Improvement may remove one or all of the governors from the Council if this is necessary to deal with a situation where the trust is failing.

17.5 Governors will also be disqualified if they cease to meet the eligibility criteria, (mandatory or otherwise) for becoming governors, or if, through changing circumstances, they fall into the category of those who are excluded from becoming governors. Failure to meet the mandatory requirements under paragraph 17.1 will result in automatic termination. In circumstances where disqualification is under consideration for the non mandatory reasons set out in Annex 6, three weeks notice of the resolution must be given to the Council of Governors, and termination as a governor will require the approval of three quarters of those members of the Council of Governors present and voting at the meeting.

18. Council of Governors – duties of governors

18.1 The general duties of the Council of Governors are:

18.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

18.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

18.2 The trust must make steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

19. Council of Governors – meetings of governors

19.1 The Chairman of the trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 28.1 below) or, in his absence the Deputy Chairman (appointed in accordance with the provisions of paragraph 30 below) shall preside at meetings of the Council of Governors.

19.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons by resolution of the Council.

19.3 For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

20. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, are attached at Annex 7.

21. ~~Council of Governors – referral to the Panel~~Not used

~~**21.1** In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS Foundation Trust may refer a question as to whether the trust has failed or is failing:~~

~~**21.1.1** to act in accordance with its constitution, or~~

~~**21.1.2** to act in accordance with provision made by or under Chapter 5 of the 2006 Act.~~

~~**21.2** A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.~~

22. Council of Governors - conflicts of interest of governors

If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

23. Council of Governors – travel expenses

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust.

24. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 6.

25. Board of Directors – composition

25.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors. At least half the Board, excluding the chairman, shall be non executive directors.

25.2 The Board of Directors is to comprise:

25.2.1 a non-executive Chairman

25.2.2 a minimum of 5 and up to 7 other non-executive directors; and

25.2.3 a minimum of 4 and up to 7 executive directors.

25.3 One of the executive directors shall be the Chief Executive.

25.4 The Chief Executive shall be the Accounting Officer.

25.5 One of the executive directors shall be the finance director.

25.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

25.7 One of the executive directors is to be a registered nurse or a registered midwife.

26. Board of Directors – general duty

The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

27. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a non-executive director only if –

27.1 he is a member of a Public Constituency, and

27.2 Not used

27.3 Not used

27.4 he is not disqualified by virtue of paragraph 33 and/or paragraph 2.3 of Annex 9 below.

28. Board of Directors – appointment and removal of chairman and other non-executive directors

28.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chairman of the trust and the other non-executive directors.

28.2 Removal of the chairman or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

28.3 Non Executive Directors may in exceptional circumstances serve longer than six years, subject to annual re-appointment and to serving up to a maximum of a further three years (making nine years in total).

29. Not used

30. Board of Directors – appointment of deputy chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the non-executive directors as a deputy chairman of the Board of Directors following a recommendation by the Chairman.

31. Board of Directors - appointment and removal of the Chief Executive and other executive directors

31.1 The non-executive directors shall appoint or remove the Chief Executive.

31.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

31.3 Not used.

31.4 A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

32. Not used

33. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

33.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

33.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

33.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

33.4 A person who has been found, through due process, not to be fit and proper person on the grounds of a serious misconduct or incompetence.

33.5 a non executive director who ceases to comply with paragraph 27.

34. Board of Directors – meetings

34.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

34.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

35. Board of Directors – standing orders

CHAIR'S ACTIONS **BoD/57/17**

The standing orders for the practice and procedure of the Board of Directors, are attached at Annex 8.

36. Board of Directors - conflicts of interest of directors

36.1 The duties that a director of the trust has by virtue of being a director include in particular:

36.1.1 A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust.

36.1.2 A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

36.2 The duty referred to in paragraph 36.1.1 is not infringed if:

36.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

36.2.2 the matter has been authorised in accordance with the constitution.

36.3 The duty referred to in paragraph 36.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

36.4 In paragraph 36.1.2, "third party" means a person other than:

36.4.1 The trust, or

36.4.2 A person acting on its behalf.

36.5 If a director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the director must declare the nature and extent of that interest to the other directors.

36.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

36.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

36.8 This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

36.9 A director need not declare an interest:

36.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest;

36.9.2 If, or to the extent that, the directors are already aware of it;

36.9.3 If, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered;

36.9.3.1 By a meeting of the Board of Directors, or

36.9.3.2 By a committee of the directors appointed for the purpose under the Constitution.

36.10 The Standing Orders at Annex 8 specify the arrangements for excluding a Director from discussion or consideration of any contract or other matter in which he has declared an interest as appropriate.

37. Board of Directors – remuneration and terms of office

37.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other non-executive directors.

37.2 The trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

37.3 Pending the establishment of such a committee the Chairman of the trust may make alternative provision for these matters to be decided

38. Registers

The trust shall have:

38.1 a register of members showing, in respect of each member, the constituency to which he belongs

38.2 a register of members of the Council of Governors;

38.3 a register of interests of governors;

38.4 a register of directors; and

38.5 a register of interests of the directors.

39. Admission to and removal from the registers

In relation to 38.1 above, the registers of members of the trust will be validated annually.

40. Registers – inspection and copies

40.1 The trust shall make the registers specified in paragraph 38 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

40.2 Not used

40.3 The trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the trust, or their home, contact details or address, if the member so requests.

40.4 So far as the registers are required to be made available:

40.4.1 they are to be available for inspection free of charge at all reasonable times; and

40.4.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

40.5 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

41. Documents available for public inspection

41.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

41.1.1 a copy of the current constitution.

41.1.2 a copy of the latest annual accounts and of any report of the auditor on them, and

41.1.3 a copy of the latest annual report.

41.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times.

41.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

41.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006.

41.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

41.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

41.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

41.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65 KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

41.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

41.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act.

41.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

41.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

41.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

41.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

42. Auditor

42.1 The trust shall have an auditor.

42.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

43. Audit committee

The trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

44. Accounts

44.1 The trust must keep proper accounts and proper records in relation to the accounts.

44.2 ~~Monitor~~ NHS Improvement may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

44.3 The accounts are to be audited by the trust's auditor.

44.4 The trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

44.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

45. Annual report and forward plans and non-NHS work

45.1 The trust shall prepare an Annual Report and send it to ~~Monitor~~NHS Improvement.

45.2 The trust shall give information as to its forward planning in respect of each financial year to ~~Monitor~~NHS Improvement.

45.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

45.4 In preparing the document, the directors shall have regard to the views of the Council of Governors.

45.5 Each forward plan must include information about:

45.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

45.5.2 the income it expects to receive from doing so.

45.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in paragraph 45.5.1, the Council of Governors must:

45.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the trust of its principal purpose or the performance of its other functions, and

45.6.2 notify the directors of the trust of its determination.

45.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors of the trust voting approve its implementation.

46. Presentation of the annual accounts to the Governors and Members

46.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

46.1.1 the annual accounts

46.1.2 any report of the auditor on them

46.1.3 the annual report.

46.2 The documents shall also be presented to the members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

46.3 The trust may combine a meeting of the Council of Governors convened for the purposes of paragraph 46.1 with the Annual Members' Meeting.

47. Instruments

47.1 The trust shall have a seal.

47.2 The seal shall not be affixed except under the authority of the Board of Directors.

48. Amendment of the constitution

48.1 The trust may make amendments of its constitution only if:

48.1.1 more than half of the members of the Council of Governors of the trust voting approve the amendments, and

48.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

48.2 Amendments made under paragraph 48.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

48.3 Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

48.3.1 At least one member of the Council of Governors must attend the next Annual Members' meeting and present the amendment, and

48.3.2 the trust must give the members an opportunity to vote on whether they approve the amendment.

48.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

48.5 Amendments by the trust of its constitution are to be notified to ~~Monitor~~ NHS Improvement. For the avoidance of doubt, ~~Monitor's~~ NHS Improvement's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

49. Mergers etc and significant transactions

49.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

49.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

49.3 A significant transaction is determined ~~where Monitor has classified any transaction requiring a detailed review in accordance to whether it meets one of the criteria in the sub-clauses below:~~

~~**49.3.1** A relative size of greater than 40% in any of the tests as set out in Diagram 18 of Monitor's Risk Assessment Framework (see below) will always lead to a detailed review.~~

~~**49.3.2** A relative size of between 25% and 40% of the tests as set out in Diagram 18 of Monitor's Risk Assessment Framework (see below) will lead to a detailed review where an additional risk factor has been identified by Monitor and is considered relevant.~~

~~**49.3.2** A relative size of between 10% and 25% of the tests as set out in Diagram 18 of Monitor's Risk Assessment Framework (see below) will lead to a detailed review where, in Monitor's view, one or more major risk or more than one other risk has been identified by us and is considered relevant.~~ using the framework below

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Diagram 1~~8~~: ~~Monitor reporting requirements~~
~~If a potential transaction meets any one of the criteria below, the NHS foundation trust should report it to Monitor:~~**Significant Transaction Framework**

Ratio	Description	Reporting requirements: Non-healthcare/ International	Reporting requirements: UK Healthcare
Assets	The gross assets* subject to the Transaction, divided by the gross assets of the foundation trust	> 5%	> 10%
Income	The income attributable to: • the assets; or • the contract associated with the Transaction, divided by the income of the foundation trust	> 5%	> 10%
Consideration to total foundation trust capital	The gross capital** or consideration associated with the Transaction divided by the total capital*** of the foundation trust following completion, or the effects on the total capital of the foundation trust resulting from a Transaction	> 5%	> 10%

* Gross assets is the total of fixed assets and current assets
** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets
*** Total capital of the foundation trust equals taxpayers' equity

49.4 A significant transaction does not include:

49.4.1 a transaction in the ordinary course of business (including the renewal, extension or entering into an agreement in respect of healthcare services carried out by the trust);

49.4.2 any agreement or changes to healthcare services carried out by the trust following a reconfiguration of services led by the commissioners of such services; and

49.4.3 any grant of public dividend capital or the entering into of a working capital facility or other loan, which does not involve the acquisition or disposal of any fixed asset of the trust.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

The areas specified as areas for public constituencies are the six local authority areas described in the table below. In addition there is a rest of England and Wales public constituency. The table sets out the minimum numbers of members required in each area.

Constituency	**Minimum number of members**
Ashford Borough Council	100
Canterbury City Council	100
Dover District Council	100
Shepway District Council	100
Swale Borough Council	100
Thanet District Council	100
Rest of England and Wales	25

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraph 8.5)

There are no classes within the Staff Constituency. The minimum number of members required in the Staff Constituency is 500

ANNEX 3 – THE PATIENTS' CONSTITUENCY

There is no Patients' Constituency.

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 14.2 and 14.3)

The Council of Governors will consist of a Chairman and ~~26~~ 19 governors as follows:

Type of Governor	Number of Governors
Elected Governors	
Public constituencies – residents of the following constituency areas	
Ashford Borough Council	~~3~~2
Canterbury City Council	~~3~~2
Dover District Council	~~3~~2
Shepway District Council	~~3~~2
Swale Borough Council	2
Thanet District Council	~~3~~2
Rest of England and Wales	1
Staff Constituency	~~4~~3
Appointed Governors	
Statutory	
Appointed jointly by: Ashford Borough Council Canterbury City Council Dover District Council Shepway District Council Swale Borough Council Thanet District Council	1
From partnership organisations*	
Appointed jointly by Canterbury Christ Church University University of Kent	1
South East Coast Ambulance Service NHS Foundation Trust	~~1~~0
Nominated by the following League of Friends to represent the interests of the League of Friends and other volunteers working with the Trust: ▪ The League of Friends of the Kent & Canterbury Hospital ▪ The League of Friends of the William Harvey Hospital ▪ League of Friends, Queen Elizabeth the Queen Mother Hospital ▪ League of Friends, Royal Victoria Hospital, Folkestone ▪ The League of Friends of Dover Hospitals	1

* Specified for the purposes of paragraph 9 (7) of Schedule 7 to the 2006 Act.

ANNEX 5 – MODEL ELECTION RULES
(Paragraph 15)

PART 1 - INTEPRETATION

1 Interpretation

1.1 In these rules, unless the context otherwise requires:

"2006 Act" means the National Health Service Act 2006;

"corporation" means the public benefit corporation subject to this constitution;

"council of governors" means the council of governors of the corporation;

"declaration of identity" has the meaning set out in rule 21.1;

"election" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"e-voting" means voting using either the internet, telephone or text message;

"e-voting information" has the meaning set out in rule 24.2;

"ID declaration form" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"internet voting system" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"lead governor" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"list of eligible voters" means the list referred to in rule 22.1, containing the information in rule 22.2;

"method of polling" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"Monitor" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

NHS Improvement is the umbrella organisation that brought together a number of bodies including Monitor.

"numerical voting code" has the meaning set out in rule 64.2(b)

"polling website" has the meaning set out in rule 26.1;

"postal voting information" has the meaning set out in rule 24.1;

"telephone short code" means a short telephone number used for the purposes of submitting a vote by text message;

"telephone voting facility" has the meaning set out in rule 26.2;

"telephone voting record" has the meaning set out in rule 26.5 (d);

"text message voting facility" has the meaning set out in rule 26.3;
"text voting record" has the meaning set out in rule 26.6 (d);

"the telephone voting system" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"the text message voting system" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"voter ID number" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"voting information" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2 – TIMETABLE FOR ELECTIONS

2 Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3 Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3 – RETURNING OFFICER

4 Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5 Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6 Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7 Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4 – STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8 Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9 Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation, but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10 Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11 Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if the candidate has no such interests, the paper must include a statement to that effect.

12 Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13 Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14 Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15 Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16 Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17 Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18 Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5 – CONTESTED ELECTIONS

19 Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and
(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20 The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21 The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or
(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22 List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23 Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24 Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available

on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25 Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26 E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,
(ii) the constituency, or class within a constituency, for which the election is being held,
(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
(v) instructions on how to vote and how to make a declaration of identity,
(vi) the date and time of the close of the poll, and
(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter’s voter ID number;
(ii) the voter’s declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter’s vote,

(e) if the voter’s vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;
(ii) the voter's declaration of identity (where required);
(iii) the candidate or candidates for whom the voter has voted; and
(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and
(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;
(iii) the voter's declaration of identity (where required);
(iv) the candidate or candidates for whom the voter has voted; and
(v) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27 Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28 Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29 Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30 Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31 Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32 ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33 Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34 Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35 Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36 Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37 Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received

by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
(c) place the document or documents in a separate packet.

38 Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(b) place the ID declaration form in a separate packet.

39 De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40 Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6 – COUNTING THE VOTES

STV41 Interpretation of Part 6

STV41.1 In Part 6 of these rules:
"ballot document" means a ballot paper, internet voting record, telephone voting record or text voting record.

"continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X",

"non-transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"preference" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule STV46,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"stage of the count" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"transferable vote" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42 Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and
(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43 The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44 Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44 Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty, and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked

does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45 First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46 The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be

deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47 Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48 Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49 Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or
(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50 Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51 Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51 Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7 – FINAL PRCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52 Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53 Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8 – DISPOSAL OF DOCUMENTS

54 Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55 Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57 Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58 Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and
(ii) that ~~Monitor~~NHS Improvement has declared that the vote was invalid.

PART 9 – DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59 Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the

records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59 Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other

candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10 – ELECTION EXPENSES AND PUBLICITY

Election expenses

60 Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to ~~Monitor~~NHS Improvement under Part 11 of these rules.

61 Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62 Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63 Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64 Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(d) a photograph of the candidate.

65 Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11 – QUESTIONNING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66 Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to ~~Monitor~~NHS Improvement.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to ~~Monitor~~NHS Improvement by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as ~~Monitor~~NHS Improvement may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If ~~Monitor~~NHS Improvement requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 ~~Monitor~~NHS Improvement shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 ~~Monitor~~NHS Improvement may prescribe rules of procedure for the determination of an application including costs.

67 Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68 Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69 Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70 Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and

ANNEX 6 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraph ~~14.~~17.3 ~~and Note 21~~)

1.0 **Disqualification.**

With reference to Section ~~14~~ 17 and paragraphs ~~14~~17.3 and ~~14~~17.4 the following additional provisions are made as to the circumstances in which an individual may not become or continue as a member of the Council of Governors :-

1.1 In respect of elected governors, he or she is disqualified from being a public, or staff member of the relevant constituency

1.2 He or she is an executive or non-executive director of the Trust or, in respect of elected governors, a governor, non-executive director, chairman, or chief executive of another NHS Foundation Trust

1.3 He or she is incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs

1.4 In respect of elected governors, he or she ceases to be a member of the trust

1.5 He or she has had their name placed on registers of Schedule 1 offenders pursuant to the Sex Offenders Act 1977 and/or the Children and Young Person Act 1933

1.6 He or she has failed to attend at least half of the meetings of the Council of Governors in any financial year without a reason acceptable to the Council

1.7 He or she has failed to attend three consecutive meetings without a reason acceptable to the Council

1.8 He or she has failed to declare a significant conflict of interest

1.9 He or she has a conflict of interest making membership of the Council untenable

1.10 He or she is guilty of conduct or actions prejudicial to the Council or the Trust

In all cases where disqualification is being considered for the above reasons, three weeks notice of the resolution must be given to the Council, and termination as a governor will require the approval of three quarters of those members of the Council of Governors present and voting at the meeting in accordance with paragraph ~~14~~17.4

For the avoidance of doubt, an individual may not at the same time be both an elected and an appointed governor.

2.0 **Terms of office of Council members.**

2.1 In order to avoid the periods of office of members of the Council of Governors all ending at the same time, arrangements to stagger the initial terms of office on the establishment of the Council will be made.

2.2 As with elected governors, appointed governors may hold office for a period of up to three years and may serve for no more than three successive terms, making a total of nine years.

3.0 Performance evaluation

3.1 Led by the Chairman, the Council of Governors should periodically assess their collective performance. The Council of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 16)

CONTENTS

INTERPRETATION

1. Save as otherwise permitted by law and subject to the Constitution, at any meeting the Chairman shall be the final authority on the interpretation of the Standing Orders, with a right of appeal to a committee of the Council of Governors convened for that purpose, whose decision shall be final and binding except in case of manifest error.

2. Any expression to which a meaning is given in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (and other Acts relating to the National Health Service or in the Financial Regulations made under the Act or regulations made under it) shall have the same meaning in this interpretation and in addition.

Council of Governors and (unless the context requires otherwise) "Council"	The Council of Governors of the Trust as constituted by the Constitution
Board of Directors	Chairman, Executive and Non-Executive Directors of the Trust collectively as a body
Chairman of the Council or Chairman of the Trust	Person appointed by the Council of Governors to lead the Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman of the Trust if the Chairman is absent from the meeting or otherwise unavailable
Chief Executive	Chief Executive Officer of the Trust
Committee	A Committee of the Council of Governors
Constitution	The Constitution of the Trust
Committee members	Chairman of the committee and the governors (and other

	people by invitation) formally appointed by the Council of Governors to sit on or to Chairman specific committees
Executive Director	A member of the Board of Directors holding an executive office of the Trust
Member of the Council	A Governor of the Trust. (Member of the Council in relation to the Council of Governors does not include the Chairman)
Non-Executive Director	A member of the Board of Directors who does not hold an executive office of the Trust
SOs	Refers to the Standing Orders of the Council of Governors
Trust Secretary	A person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Council and the Chairman and ~~monitor~~NHS Improvement the Trust's compliance with the Statutory Framework and these Standing Orders
Deputy Chairman	The Non-Executive Director appointed from amongst the Non-Executive Directors as Deputy Chairman by the Board of Governors in accordance with the constitution to take on the Chairman's duties if the Chairman is absent for any reason

1. INTRODUCTION

1.1 Statutory Framework

The East Kent Hospitals University NHS Foundation Trust is a statutory body which became a public benefit corporation on 1 March 2009 following its approval as an NHS Foundation Trust by Monitor, pursuant to the National Health Service Act 2006.

The statutory functions conferred on the Trust are set out in:

- The National Service Act 2006;
- The Health and Social Care Act 2012;

The trust is also required to comply with the licence granted to it by Monitor
.
All business of the Council of Governors will be conducted in the name of the Trust.

The Constitution, paragraph 20, requires the Council of Governors to adopt its own Standing Orders for its practice and procedure.

2. THE COUNCIL OF GOVERNORS

2.1 Composition of the Council

The composition of the Council of Governors is set out in the constitution.

One of the Governors shall be elected by the Council of Governors as the Lead Governor. The position of Lead Governor shall be determined by election annually on the basis of a secret ballot.

If a Governor resigns from office as Lead Governor then the Council of Governors shall thereupon elect another Governor as the Lead Governor without delay. Any such Governor shall serve as the Lead Governor for one year from the date at which he/she is elected by the Council of Governors.

The Lead Governor may preside at meetings of the Council of Governors in the following circumstances:

2.1.3 where matters relating to the Non-Executive Directors are being considered and, as a result, a conflict of interest exists relating to the Chairman and the Deputy Chairman.

2.2 Role of the Chairman

The Chairman is not a member of the Council of Governors. Under the Statutory Framework, the Chairman presides at meetings of the Council of Governors and has a casting vote.

Where the Chairman ceases to hold office, or where s/he has been unable to perform his/her duties as Chairman owing to illness or any other cause, the Deputy Chairman (a Non-Executive Director appointed by the Council of Governors) shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his/her duties, as the case may be. References to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his/her duties, be taken to include references to the Deputy Chairman.

3. MEETINGS OF THE COUNCIL

3.1 Calling meetings

Ordinary meetings of the Council of Governors shall be held at such times and places as the Chairman may determine. Not less than 3 meetings will be held each year. One such meeting shall be combined with the Annual Members' Meeting. Meetings will normally be held in public. However the Council may resolve to exclude the public where it wishes to discuss particular issues in private session. The Council of Governors may also meet on an informal basis for development days (away days). For the avoidance of doubt, where a meeting of the Council of Governors is combined with the Annual Members' meeting, the meeting of the Council of Governors must be open to members of the public.

The Chairman may call meetings of the Council of Governors. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of governors including at least two elected and two appointed governors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within 14 days after such requisition has been presented to him/her, at the Trust's Headquarters, such one third or more governors may forthwith call a meeting of the Board.

3.2 Notice of meetings

Before each meeting of the Council of Governors, a notice of the meeting signed by the Chairman or by an officer of the Trust authorised by the Chairman to sign on his/her behalf shall be delivered to every member of the Council, or sent by post to the usual place of residence of such governor, no less than six clear days in advance of the meeting

3.3 Notice of business to be transacted

Before each meeting of the Council of Governors, an agenda setting out the business of the meeting, signed by the Chairman or by an officer of the Trust authorised by the Chairman to sign on his/her behalf shall be delivered to every member of the Council of Governors, or sent by post to the usual place of residence of such governor specifying the business proposed to be transacted at it so as to be available to the governor at least six clear days before the meeting, including weekends. Supporting papers, whenever possible, shall accompany the agenda, but will be dispatched no later than three clear days before the meeting save in an emergency.

Lack of service of the notice on any governor shall not affect the validity of a meeting.

In the case of a meeting called by the governors in default of the Chairman, the notice shall be signed by those respective governors and no business shall be transacted at the meeting other than that specified in the notice

A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of post or otherwise on the day following electronic or facsimile transmission.

3.4 Setting the agenda

The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an appendix to the Standing Orders.)

A governor desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 clear days including weekends before the respective meeting. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

For the purposes of obtaining information about the trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

3.5 Attendance and questions from the public

The public shall be welcome at all meetings of the Council of Governors unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chairman may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

Up to 15 minutes will be set aside at the end of each ordinary meeting to enable members of the public or other interested parties to ask questions of the Council. Questions on any matter that has been discussed at the meeting can be raised at this point. Questions on general matters related to the business of the Trust should be sent in writing to the Chairman at least 10 days prior to the meeting.

Nothing in these standing orders shall require the Trust to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chairman.

3.6 Chairman of meeting

At any meeting of the Council, the Chairman of the Council, if present, shall preside. If the Chairman is absent from the meeting, or absent temporarily on the grounds of a declared conflict of interest, the Deputy Chairman, if there is one, and s/he is present, shall preside. If the Chairman and Deputy Chairman are absent, such Non-Executive Director as the Non-Executive Directors present shall choose, shall preside. Where the Chairman, Deputy Chairman, and other Non-Executive Directors are all absent or have a conflict of interest, the Lead Governor/Vice Chair of Governors (to be appointed from amongst the Council of Governors) shall preside at the meeting and shall have a casting vote

3.7 Notices of motion

A governor of the Trust desiring to move or amend a motion shall send a written notice thereof signed by at least one other Governor at least 15 days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting without notice, on any business mentioned on the agenda

Emergency Motions:- Subject to the agreement of the Chairman, a Governor may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Council at the commencement of the business of the meeting as an additional

item included in the agenda. The Chairman's decision to include or exclude the item shall be final

3.8 Motions: Procedure at and during a meeting

i) **Who may propose**

A motion may be proposed by the Chairman of the meeting or any Governor present. It must also be seconded by another member.

ii) **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;
- consideration of any item of business before the Council;
- the accuracy of minutes;
- that the Council proceed to next business
- that the Council adjourn;
- that the question be now put.

iii) **Motion once under debate**

When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business. (*)
- the motion be now put. (*)
- that a Governor be not further heard;
- a motion resolving to exclude the public, including the press

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Governor who has not previously taken part in the debate.

iv) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Council. The Chairman's decision on this will be final

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

v) **Rights of reply to motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive / original motion

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9 Withdrawal of motion or amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and consent of the Chairman.

3.10 Motion to rescind a resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the governor who gives it and also the signature of 4 other governors. When any such motion has been disposed of by the Council, it shall not be competent for any governor other than the Chairman to propose a motion to the same effect within 6 months, however the Chairman may do so if he/she considers it appropriate.

If a Governor persistently disregards the ruling of the Chairman by behaving improperly or offensively or deliberately obstructs business, the Chairman may move that the Governor be not heard further. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chairman may move that either the Governor leaves the meeting room or that the meeting is adjourned for a specified period. If seconded, the motion will be voted on without discussion.

3.11 Chairman's ruling

Statements of governors made at meetings of the Trust shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.12 Virtual Voting

In the event that a decision is required ahead of the next Council of Governors meeting a virtual vote will be proposed. The vote will be passed if 65% of Governors vote for the motion and at least 50% of the elected and appointed Governors has voted. The decision will be ratified at the next public Council of Governors meeting.

~~3.12~~3.13 ~~3.12~~ Voting

Every question at a meeting shall be determined by a majority of the votes of the Chairman of the meeting and the governors present and voting on the question and, in the case of any equality of votes, the Chairman or person presiding shall have a second or casting vote.

All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the governors present so request

If at least one third of the governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor present voted or abstained

If a governor so requests his/her vote shall be recorded by name upon any vote (other than by paper ballot).

In no circumstances may an absent governor vote by proxy. Absence is defined as being absent at the time of the vote.

~~3.13~~3.14 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next meeting where they will be signed by the Chairman or person presiding

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting

Minutes shall be circulated in accordance with the Council's wishes. Where providing a record of a public meeting the minutes shall be made available to the public

3.15 Waiver of standing orders

These standing orders shall not be waived except:

3.15.1 where urgent action is required and the Chairman considers it to be in the interests of the Trust to waive one or more of the Standing Orders, s/he may do so, subject to such action being reported to and ratified by the next meeting of the Council

3.15.2 upon a notice of motion under Standing Order 3.7

3.15.3 at least half of the total number of governors, including not less than one third public governors, not less than one third staff governors and not less than one third appointed governors are present at the meeting

A decision to waive Standing Orders shall be recorded in the minutes of the next meeting of the Council of Governors

All waivers of Standing Orders shall be reported to the Board of Directors' Integrated Audit and Governance Committee. The Committee shall review every decision to waive the Standing Orders

3.16 Amendment of standing orders

These Standing Orders shall only be amended in accordance with paragraph 48 of the Constitution.

3.17 Record of attendance

The names of the Chairman and governors, and any invited attendees present at the meeting shall be recorded in the minutes

3.18 Quorum

No business shall be transacted at a meeting of the Council of Governors unless there is a quorum present consisting as follows:

3.17.1 One third of the governors are present with the majority having been elected by one of the public constituencies

If insufficient members to constitute a quorum are in attendance within 30 minutes of the time fixed for a meeting, the meeting will stand adjourned for 7 days and at the reconvened meeting those present will constitute a quorum.

If a governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution because of the declaration of a conflict of interest he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business

4. DELEGATION OF FUNCTIONS AND STATUS OF STANDING ORDERS

4.1 Delegation of powers to committees

The Council may not delegate any of its functions or powers to any sub-committees or committees of the Council.

4.2 Non-Compliance with Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council for action or ratification. All members of the Council have a duty to disclose any non-compliance with these Standing Orders to the Trust Secretary as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the constitution and the Statutory Framework , the Council of Governors may appoint committees of the Council of Governors consisting of a sub-set of Governors. ~~wholly or partly of members of the Trust (whether or not they include governors of the Trust) or wholly of persons who are not members of the Trust (whether or not they include governors of the Trust).~~ The Council of Governors may not delegate any of its powers to a committee but committees may act in an advisory capacity to assist the Council of Governors in carrying out its functions.

~~A committee appointed under Standing Order 5.1 may, subject to any restrictions imposed by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include governors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include governors of the Trust). No powers may be~~

~~delegated to sub-committees. They exist to advise and assist the committee/Council of Governors.~~

The Committee can be substantive (for example Nominations and Remunerations Committee) or set up for the purposes of a task and will only exist until the task is deemed complete by the Council of Governors

The standing orders of the Council of Governors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Council of Governors. The minimum quorum for any committee shall be four.

Each such committee ~~or sub-committee~~ shall have such terms of reference and be subject to such conditions (as to reporting to the Council) as the Council shall decide and shall be in accordance with the Statutory Framework and any direction or guidance issued by ~~Monitor~~NHS Improvement. Such terms of reference shall have effect as if incorporated into the standing orders.

The Council of Governors shall approve the appointments to each of the committees which it has formally constituted, and their chairs. ~~Where the Council determines that persons who are neither governors nor officers shall be appointed to a committee, the terms of such appointment shall be determined by the Council.~~ The Council of Governors may request that external advisers assist them or any committee they appoint in carrying out its duties.

Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Statutory Framework, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Statutory Framework.

The committees ~~and sub-committees~~ established by the Council shall be such committees as are required to assist the Council in discharging its responsibilities.

5.2 Nominations and Remuneration Committee

The council shall appoint a Nominations and Remuneration Committee to be responsible for the identification and nomination of non executive directors, including the Chairman, and to make recommendations to the Council.

The Committee will also recommend to the Council the remuneration and terms of appointments of the Chairman and NEDs

The Nominations and Remuneration Committee will operate in accordance with guidance set out in the NHS Foundation Trust Code of Governance issued by

~~Monitor~~NHS Improvement, or as shall from time to time be further issued by ~~Monitor~~NHS Improvement.

5.3 Confidentiality

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council or shall otherwise have concluded on that matter.

A governor of the Trust ~~or a member of a committee~~ shall not disclose any matter reported to the Council or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council or committee shall resolve that it is confidential.

A governor of the Trust ~~or a member of a committee~~ shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the meeting which ~~make~~ may take place on such reports or papers.

6. DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of Interests

Council members are required to declare interests which are relevant and material to the Council. Interests should be declared on appointment and updated to the Trust Secretary as circumstances change, and at least annually.

Interests which should be regarded as 'relevant and material' are set out in paragraph 22 of the Trust's constitution:

At the time Council members' interests are declared, they should be recorded in the Council's minutes. Any changes notified to the Trust Secretary in between meetings should be declared at the next Council meeting following the change occurring.

Council members' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Council's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a meeting, if a conflict of interest is established, the member of the Council concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

There is no requirement for the interests of Council members' spouses or partners to be declared. However, if the Council members' spouses or partners, if

living together, have any pecuniary interest, direct or indirect, in contracts or proposed contracts with the Trust, this is regarded as relevant and should be disclosed.

If ~~Board~~ Governors ~~members~~ have any doubt about the relevance of an interest this should be discussed with the Chairman or the Trust Secretary.

6.2 Register of Interests

The Trust Secretary shall maintain a register of members' interests. This will include details of all directorships and other relevant and material interests which have been declared by Council members as defined in Standing Order 6.1.

The register will be subject to regular review by the Trust Secretary at each meeting or as required by the Statutory Framework. The register will be updated as and when members' declare an interest/revise a declaration. Any such changes made will be declared and noted at the next meeting of the Council of Governors.

The register will be available to the public and the Chairman will take reasonable steps to bring the existence of the register of the attention of the local population and to publicise arrangements for viewing it.

In establishing, maintaining, updating and publicising the register, the Trust will comply with all requirements as laid out in the Statutory Framework.

7. DISPUTE RESOLUTION PROCEDURES

Provisions for the resolution of disputes about the constitution or its interpretation, whether raised by the Board of Directors or Council of Governors, will be established. For the avoidance of doubt, these procedures will apply to disputes about the constitution or its interpretation between the Board of Directors and the Council of Governors.

Disputes shall be referred in the first instance to the Chairman of the Council of Governors.

If appropriate the Chairman may refer the dispute to a committee of the Council of Governors to advise the full Council of Governors.

Any unresolved dispute is to be submitted to an arbitrator agreed by the parties or nominated in default of agreement by decision of the Council and Board of Directors. The arbitrator's decision will be binding and conclusive on all parties.

8. PROCESS FOR THE APPOINTMENT OF NON-EXECUTIVE DIRECTORS

When a vacancy arises or is scheduled to arise within ~~6~~ 9 months, a Nominations Committee shall be convened with clear terms of reference to advise the Council of Governors on the appointment of Non-Executive Directors.

9. PROCESS FOR THE APPOINTMENT OF THE CHAIRMAN

Subject to the provisions within the constitution in relation to the appointment and removal of the Chairman, the Chairman shall be appointed in accordance with the process of open competition.

When a vacancy arises or is scheduled to arise within ~~6~~9 months, a Nominations Committee shall be convened with clear terms of reference to advise the Council of Governors on the appointment of the Chairman

10. PROCESS FOR THE APPOINTMENT OF AUDITORS

The Council will appoint external auditors following a recommendation from the Integrated Audit and Governance Committee to which will be delegated the tendering and selection arrangements. The recommendation will set out the reasons for the proposed choice of external auditor.

11. STANDARDS OF BUSINESS CONDUCT

11.1 Duty of compliance

Governors should comply with the Trust's values, the Trust's code of conduct, Trust's policy on Standards of Business Conduct, the requirements of the Statutory Framework as referred to in standing order 1.1 and any relevant guidance issued by ~~Monitor~~NHS Improvement.

11.2 Canvassing of and recommendations by, members of the Council in relation to appointments

Canvassing of directors or governors of the Trust or of any committee of the Trust directly or indirectly for any appointment with the Trust shall disqualify the candidate for such appointment. This clause of the Standing Orders shall be brought to the attention of candidates.

A member of the Council shall not solicit for any person any appointment with the Trust or recommend any person for such appointment. This clause of the Standing Orders shall not preclude a member of the Council from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointments panels or committees, whether solicited or unsolicited should be declared to the panel or the committee.

12. DECLARATION OF ELIGIBILITY

At their first meeting, all governors shall be required to sign declarations of their right to represent their constituency and to vote at Council of Governors' meetings. These declarations shall be valid for the duration of their term of office. Declaration forms are attached .

13. MISCELLANEOUS

13.1 Standing Orders to be given to members of the Council

It is the duty of the Trust Secretary to ensure that existing and new members of the Council are notified and understand their responsibilities within the constitution and these standing orders.

13.2 Review of Standing Orders

These Standing Orders shall be reviewed ~~annually~~every two years in line with the Constitution

GOVERNORS' DECLARATION

PART 1

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST (the "Trust")

I, ….....(insert name)

Of …..... (insert address)

Hereby declare that I am entitled to stand for election to the Council of Governors as a Governor elected by *one of the public constituencies / the staff constituency** because I am a member of one of the *public constituencies staff / constituency* * and that I am not prevented from being a member of the Council of Governors of the Trust by paragraph 8 of Schedule 7 of the National Health Service Act 2006 or under the constitution of the Trust.

Signed ….....

Print
Name…….....

Date of Declaration ….....

*delete as appropriate

PART 2

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST (the "Trust")

I, ….....(insert name)

Of …..... (insert address)

Hereby declare that I am entitled to vote at meetings of the Council of Governors as a Governor elected by *one of the public constituencies / the staff constituency** or because *I have been appointed as a Partner Governor* and that I am not prevented from being a member of the Council of Governors of the Trust by paragraph 8 of Schedule 7 of the National Health Service Act 2006 or under the constitution of the Trust.

Signed…….....

Print…….....
Name

Date of Declaration ….....

*delete as appropriate

APPENDIX 1 TO COUNCIL OF GOVERNORS STANDING ORDERS

List of internal and external documents relevant to Governors

1 Index of internal Trust documents relevant to the Council of Governors

- EKHUFT Constitution
- EKHUFT Governor Roles Document
- EKHUFT Code of Conduct for Governors
- EKHUFT Dispute Resolution Procedure (Board of Directors and Council of Governors)
- Guide to the Appointment of the Trust Chairman and Non-Executive Directors of the Board
- EKHUFT Chairman's Appraisal Process
- EKHUFT Non-Executive Director Appraisal Process

2 Index of External documents relevant to the Council of Governors

- NHS Improvement's "Your Statutory Duties" publication
- NHS Improvement's Code of Governance
- NHS Improvement's Risk Assessment Framework
- NHS Improvement's "NHS Foundation Trust Governors: Representing the Interests of Members and the Public" publication

All documents are held by the Trust Secretariat.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 25 and 36)

CONTENTS

INTRODUCTION

Statutory Framework

East Kent Hospitals University NHS Foundation Trust (the Trust) is a body corporate which became a public benefit corporation on 1 March 2009 following its approval as an NHS Foundation Trust by Monitor, pursuant to the National Health Service Act 2006 (the 2006 Act).
The Trust Offices are at Kent & Canterbury Hospital, Ethelbert road, Canterbury, CT1 3NG.
NHS Foundation Trusts are governed by Acts of Parliament, mainly the 2006 Act (as amended by the Health and Social Care Act 2012), by their constitutions and by the terms of their licence granted by Monitor (the Statutory Framework).
The functions of the Corporation are conferred by the Statutory Framework.
As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

Reservation and Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit.
Delegated Powers are covered in a separate document (Standing Financial Instructions incorporating Reservation of Powers to the Board of Directors and Detailed Scheme of Delegation.

1 INTERPRETATION

1.1 Save as permitted by law and subject to the Constitution, at any meeting the Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive or Trust Secretary).

1.2 Any expression to which a meaning is given in the 2006 Act or in the Regulations or Orders made under the 2006 Act shall have the same meaning in this interpretation and where there is a conflict between the 2006 Act and another legislative provision the 2006 Act interpretation shall prevail (unless, in either case, the context otherwise requires) and in addition:

"Accounting Officer" shall be the Officer responsible and accountable for funds entrusted to the Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets and performing the

functions delegated to him by the Constitution in relation to the Trust's accounts. For this Trust it shall be the Chief Executive.
"Trust" means East Kent Hospitals University NHS Foundation Trust.
"Board of Directors" and (unless the context otherwise requires)
"Board" shall mean the Chairman and other non-executive directors, and the executive directors appointed by the relevant committee of the Trust.
"Council of Governors" means the Council of Governors of the Trust.
"Budget" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;
"Chairman" is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall be deemed to include the Deputy Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.
"Chief Executive" shall mean the Chief Executive Officer of the Trust.
"Committee" shall mean a committee of the Board of Directors.
"Committee Members" shall be the directors formally appointed by the Trust to sit on or to chair specific committees.
"Constitution" means the constitution of the Trust.
"Contract" shall include any proposed contract or other course of dealing.
"Deputy Chairman" means the non-executive director appointed by the Council of Governors to take on the Chairman's duties if the Chairman is absent for any reason.
"Director" shall mean a person appointed as a director in accordance with the Constitution and includes the Chairman.
"Finance Director" shall mean the chief finance officer of the Trust.
"Funds held on trust" shall mean those funds which the Trust holds on trust at its date of authorisation as an NHS Foundation Trust or chooses subsequently to accept. Such funds may or may not be charitable.
"Motion" means a formal proposition to be discussed and voted on during the course of a meeting.
"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing orders (SOs) and Standing financial Instructions (SFIs).
"Officer" means an employee of the Trust.
"SFIs" means Standing Financial Instructions.
"SOs" means Standing Orders.
"Spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
"Trust Secretary" means a person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the Statutory Framework and these standing orders

2. THE TRUST

2.1 Preamble

All business shall be conducted in the name of the Trust.

2.2 The Trust has the functions conferred on it by the Statutory Framework.

2.3 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees~~.~~, ~~Accountability~~ accountability for charitable funds held on trust is to the Charity Commission.

2.5 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board. These powers and decisions and those delegated by the Board to officers and other bodies are set out in the Reservation of Powers to the Board of Directors.

2.6 Composition of the Board

In accordance with, but always subject to, the provisions of the Constitution, the composition of the Board shall be:

- The Chairman of the Trust
- A minimum of 5 and up to 7 other Non executive directors excluding the Chairman
- A minimum of 4 and up to 7 Executive directors including:
  - The Chief Executive (and Accounting Officer)
  - The Director of Finance
  - A medical or dental practitioner
  - A registered nurse or registered midwife.

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2.7 Appointment of the Chairman and other Non-Executive Directors

The Chairman and the other Non-Executive Directors are appointed by the Council of Governors.

2.8 Appointment of the Executive Directors

The Chief Executive is appointed by the Chairman and other Non-Executive Directors, subject to the approval of the Council of Governors.

The other Executive Directors are appointed by the Nominations Committee that the Board shall appoint from time to time for that purpose.

2.9 **Terms of Office of the Chairman and other Non-Executive Directors**

The regulations setting out the period of tenure of office of the Chairman and other Non-Executive Directors and for the termination or suspension of office of the Chairman and other Directors are contained in the Constitution of the Trust.

2.10 **Appointment of Deputy Chairman**

Subject to SO 2.11 below, the Council of Governors will appoint one of the Non-Executive Directors to be Deputy Chairman, following recommendation by the Chairman for such period, not exceeding the remainder of his term as a Director, as they may specify on appointing him/her.

2.11 Any Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman. The Council of Governors may thereupon appoint another Non Executive Director as Deputy Chairman in accordance with the provisions of Standing Order 2.10

2.12 **Powers of Deputy Chairman**

Where the Chairman of the Trust has died or has ceased to hold office, or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Deputy Chairman.

2.13 **Appointment and Powers of Senior Independent Director**

Subject to SO 2.14 below, the Board of Directors may appoint one of the independent Non Executive Directors (as defined in the NHS Foundation Trust Code of Governance published by Monitor) to be the Senior Independent Director, in consultation with the Council of Governors for such period, not exceeding the remainder of his term as a Director, as they may specify on appointing him. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Job Description", as amended from time to time by resolution of the Board.

2.14 Any Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman. The

Board of Directors, in consultation with the Council of Governors, may thereupon appoint another independent Non Executive Director as Senior Independent Director in accordance with the provisions of Standing Order 2.13.

2.15 The posts and duties of the Deputy Chairman and Senior Independent Director may be combined. This decision may be reviewed at any time by the Board of Directors, in consultation with the Council of Governors.

2.16 The role of the Senior Independent Director will include acting as a conduit for concerns to be raised by governors if the usual mechanisms of contact and discussion have been exhausted and, subject to the agreement of the Council of Governors, making arrangements for the annual evaluation of the performance of the Chairman. The process to achieve this evaluation and its outcome will be agreed with and reported to the Council of Governors.

2.17 **Joint Executive Directors**

Where more than one person is appointed jointly to an Executive Director post those persons shall count as one person for the purposes of these standing orders:-

(a) either or both of those persons may attend or take part in meetings of the Board;

(b) if both are present at a meeting they should cast one vote if they agree;

(c) in the case of disagreements no vote should be cast;

(d) the presence of either or both of those persons should count as the presence of one person for the purposes of a quorum.

2.18 **Role of Directors**

The Board will function as a corporate decision-making body, Executive and Non Executive Directors will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

(1) **Chief Executive**

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the Accounting Officer for

the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives.

(2) **Non-Executive Directors**

The Non Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

(3) **Chairman**

The Chairman shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.19 **Corporate role of the Board**

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.20 **Scheme of Reservation and Delegation of Powers**

The Board may resolve that certain powers and decisions be exercised only by the Board. These powers and decisions are set out in the Reservation of Powers to the Board of Directors . Those powers which it has delegated to officers and other bodies are also contained in the Standing Financial Instructions and Detailed Scheme of Delegation.

3. MEETINGS OF THE BOARD

3.1 **Calling Meetings**

Ordinary meetings of the Board shall be held at such times and places as the Board may determine. All l meetings of the Board are to be held in public pursuant to clause 34 of the Constitution. ~~.A public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three clear days before the meeting.~~ Parts of these meetings may be held in closed session for special reasons.

3.2 The Chairman may call a meeting of the Board at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of directors, has been presented to him/her, or if, without so refusing, the Chairman does not call a meeting within fourteen days after such requisition has been presented to him, at the Trust's Headquarters, such one third or more directors may forthwith call a meeting.

3.3 **Notice of Meetings**

Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer of the Trust authorised by the Chairman to sign on his behalf shall be delivered to every director, or sent by post to the usual place of residence of such director, so as to be available to him at least six clear days before the meeting. The agenda will be sent to Directors six days before the meeting. The open agenda will be sent to the Council of Governors at the same time. Supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three clear days before the meeting, save in emergency. A public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices, or on its website at least three clear days before the meeting.

3.4 Lack of service of the notice on any director shall not affect the validity of a meeting.

3.5 In the case of a meeting called by directors in default of the Chairman, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

3.6 A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post or otherwise the day following electronic ~~or facsimile~~ transmission.

3.7 **Setting the Agenda**

The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and that for special reasons certain items should be heard in a separate closed session.

3.8 A director desiring a matter to be included on an agenda shall make his/her request in writing or orally to the Chairman or the Trust Secretary at least 15 clear days before the meeting, subject to Standing Order 3.3. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.9 **Chairman of Meeting**

At any meeting of the Board, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he/she is present, shall preside. If the Chairman and Deputy Chairman are absent such non-executive director as the directors present shall choose shall preside.

3.10 If the Chairman is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are absent, or are disqualified from participating, such non-executive director as the directors present shall choose shall preside.

3.11 **Notices of Motion**

A director of the Board desiring to move or amend a motion shall send a written notice thereof at least 15 clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations.

Emergency Motions:- Subject to the agreement of the Chairman, a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include or exclude the item shall be final.

3.12 **Motions: Procedure at and during a meeting**

i) **Who may propose**

A motion may be proposed by the Chairman of the meeting or any member present. It must also be seconded by another member.

ii) **Contents of motions**

The Chairman may exclude from the debate at their discretion any such motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

- the reception of a report;

- consideration of any item of business before the Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

iii) **Motion once under debate**

When a motion is under discussion or immediately prior to discussion it shall be open to a director to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business. (*)
- the appointment of an ad hoc committee to deal with a specific item of business.
- the motion be now put. (*)
- that a member/director be not further heard;

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a director who has not previously taken part in the debate.

iv) **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board. The Chairman's decision on this will be final

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

v) **Rights of reply to motions**

a) <u>Amendments</u>

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) <u>Substantive/original motion</u>

The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.13 **Withdrawal of Motion or Amendments**

A motion or amendment once moved and seconded may be withdrawn by the proposer

3.14 **Motion to Rescind a Resolution**

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director(s) who gives it and also the signature of three other directors. Before considering any such motion of which notice shall have been given, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any director other than the Chairman to propose a motion to the same effect within six months; however the Chairman may do so if he/she considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.15 **Chairman's Ruling**

Statements of directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevance, regularity and any other matters shall be observed at the meeting.

3.16 **Voting**

Every question at a meeting shall be determined by a majority of the votes of the directors present and voting on the question. In the case of any equality of votes, the Chairman shall have a further or casting vote.

3.17 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

3.18 If at least one-third of the directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each director present voted or abstained.

3.19 If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.20 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

- A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Executive Director, at the Chairman's discretion.

- A manager attending the Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director, unless approved by the Chairman. An Officer's status when attending a meeting shall be recorded in the minutes.

- For the voting rules relating to joint Executive Directors see Standing Order 2.17

3.21 Virtual Voting

In the event that a decision is required ahead of the next Board of Directors' meeting a virtual vote will be proposed. The vote will be passed if 75% of the Board members vote in favour and at least 50% of those voting are non-executive directors. The decision will be ratified at the next Board of Directors meeting.

3.22 **Minutes**

The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it. A copy of the public minutes will be sent to the Council of Governors as soon as practically possible after the meeting.

3.23 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.24 **Waiver of Standing Orders**

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Except where this would contravene any statutory provision or any guidance issued by Monitor or NHS Improvement, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and two Non Executive Directors, and that a majority of those present vote in favour of suspension.

3.25 A decision to waive Standing Orders shall be recorded in the minutes of the meeting.

3.26 The Audit Committee shall review every decision to waive Standing Orders.

3.27 **Suspension of Standing Orders**

Except where this would contravene any statutory provision or any guidance issued by Monitor or NHS Improvement, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive director and two non-executive directors, and that a majority of those present vote in favour of suspension.

3.28 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.29 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

3.30 No formal business may be transacted while Standing Orders are suspended.

3.31 The Integrated Audit and Governance Committee shall review every decision to suspend Standing Orders.

3.32 **Variation and Amendment of Standing Orders**

These Standing Orders shall only be amended in accordance with paragraph 48 of the Constitution.

3.33 **Record of Attendance**

The names and titles of the directors present at the meeting shall be recorded in the minutes.

3.34 **Quorum**

No business shall be transacted at a meeting of the Board unless at least one third of the whole number of the directors are present including at least one executive director and two non-executive directors.

3.35 If a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 6 or 7) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one executive director to form part of the quorum shall not apply where the executive directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration Committee).

3.36 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.37 **Admission of public and the press**

3.37.1 Subject to paragraph 3.36.2, Board meetings shall be held in public but the whole or any part of the meeting may be held in closed session if the Board so resolves or any change in legislation dictates.

3.37.2 Individual members of the public and the press may, at the absolute discretion of the Chairman, be admitted to all or part of a closed session of a Board meeting**.**

3.37.3 When the public and press are admitted to all or part of a Board meeting, the Chairman (or Deputy Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption

3.37.4 In the event that the public and press are admitted to all or part of a Board meeting they shall be required to withdraw if the Board so resolves.

3.37.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of

the Board or Committee thereof. Such permission shall be granted only upon resolution of the Board of Directors

3.38 **Observers at closed sessions of the Board of Directors meetings**

The Board will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the closed session of the Board of Directors meetings and may change, alter or vary these terms and conditions as it deems fit.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 **Exercise of functions**

Subject to the Statutory Framework and such guidance as may be issued by Monitor or NHS Improvement, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 5.1 or 5.2 below or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board thinks fit.

4.2 **Emergency Powers**

The powers which the Board has retained to itself within these Standing Orders (SO 2.5) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman, after having consulted two non executive directors where possible. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board for formal ratification.

4.3 **Delegation to Committees**

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or subcommittees, and their specific executive powers shall be approved by the Board.

4.4 **Delegation to officers**

Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committees or sub-committees or joint-committees shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will

perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

4.5 The Chief Executive shall prepare a schedule of matters reserved to the Board and a scheme of delegation (Scheme of Reservation and Delegation of Powers) identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Reservation and Delegation of Powers which shall be considered and approved by the Board as indicated above.

Nothing in the Scheme of Reservation and Delegation of Powers shall impair the discharge of the direct accountability to the Board of the Finance Director or other executive director to provide information and advise the Board in accordance with any statutory requirements or guidance issued by Monitor or NHS Improvement. Outside these statutory requirements the roles shall be accountable to the Chief Executive for operational matters.

4.6 Overriding Standing Orders – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Board Directors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive or Chairman of the Integrated Audit and Governance Committee as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Statutory Framework and any guidance as may be issued by Monitor or NHS Improvement, the Board may and, if so required by Monitor or NHS Improvement, shall appoint committees of the Board, consisting wholly of directors of the Board. The Trust shall determine the membership and terms of reference of these committees and shall if it requires to, receive and consider reports from them.

5.2 A committee appointed under SO 5.1 may, subject to any guidance issued by Monitor or NHS Improvement and to any restriction imposed by the Board, appoint subcommittees consisting wholly of one or more members of the committee.

5.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Board.

5.4 Each such committee or sub-committee shall have such terms of reference and powers ,reviewed annually, and be subject to such conditions (as to reporting back to the Board), as the Board shall decide..

5.5 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.6 The Board shall approve the appointments to each of the committees which it has formally constituted

5.7 **Confidentiality**

A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.8 A Director shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

5.9 **Committees established by the Board of Directors**

The Board will establish committees required of it by legislation or Monitor or NHS Improvement's NHS Foundation Trust Code of Governance. These will include:

5.9.1 **Integrated Audit and Governance Committee**

In line with legislation and the Code of Governance, the Board of Directors will establish and constitute an Integrated Audit and Governance Committee to provide the Board with an independent and objective review of its financial and non-financial internal control systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The terms of reference will be approved by the Board and reviewed on an annual basis.

The Integrated Audit and Governance Committee will be composed of a minimum of three independent non-executive directors, of which one must have significant, recent and relevant financial experience.

5.9.2 **Remuneration Committee**

A Remuneration Committee will be established and constituted by the Board of Directors, comprised of the independent non-executive directors. The terms of reference of the Committee will be approved by the Board and reviewed on an annual basis.

The purpose of the Committee will be:

5.9.2.1 to decide on the appropriate remuneration, allowances, and terms of and conditions of service for the Chief Executive and other Executive Directors including:

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

5.9.2.2 The Committee may also recommend and monitor the level and structure of remuneration for senior management

5.9.3 **Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

5.9.4 **Nominations Committee**

The Board shall appoint from time to time an Nominations Committee comprised of the Chairman, the other Non-Executive Directors and the Chief Executive (except in the case of appointment of the Chief Executive). The purpose of the Nominations Committee shall be to appoint the Executive Directors and the Chief Executive. The appointment of the Chief Executive shall require the approval of the Council of Governors.

5.9.5 **Other Committees**

The Board may also establish such other committees as required to discharge its responsibilities~~,~~. ~~for example a Finance and Investment Committee~~

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of Interests**

The Directors shall declare any interests in accordance with paragraph 36 of the Constitution. All existing directors shall declare such interests. Any directors appointed subsequently shall do so on appointment or as soon as they arise.

6.2 Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered. If directors have any doubt about the relevance of an interest, this should be discussed with the Chairman, or the Trust Secretary.

6.3 At the time directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

6.4 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a board meeting, if a conflict of interest is established, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 **Register of Interests**

The Trust Secretary will ensure that a Register of Interests is established to record formally declarations of interests of directors. In particular the Register will include details of all directorships and other interests which have been declared by both executive and non-executive directors,. Attendees of Board Committees who are not Board directors will be required to declare any interests in accordance with paragraph 36 of the Constitution.

6.7 These details will be kept up to date on a regular basis, and the Register will be formally reviewed once a year.

6.8 The Register will be available to the public and the Trust Secretary will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.9 In establishing, maintaining, updating and publicising the Register, the Trust shall comply at all times with the Statutory Framework and any guidance issued by Monitor or NHS Improvement. In the event of conflict between these Standing Orders and the Statutory Framework or guidance issued by Monitor or NHS Improvement, the latter shall prevail.

6.10 Standing Order 6 applies to a committee or sub-committee of the Board as it applies to the Board and applies to all members of any such committee or sub-committee whether or not he or she is also a Director.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Policy

Staff must comply with the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS staff', which has been adopted by the Trust as its Code of Conduct, and any guidance issued by Monitor or NHS Improvement. In addition, they must adhere to the Trust's Counter Fraud Policy and Procedure for East Kent Hospitals Staff, Trust Values, and any other guidance produced by the Trust

7.2 Interest of Officers in Contracts

If it comes to the knowledge of a director or an officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. The Chief Executive will ensure that such declarations are formally recorded.

7.4 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of directors or governors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

7.5 A director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.7 **Relatives of Directors or Officers**

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

7.8 The directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

7.9 On appointment, directors (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Trust whether they are related to any other director or holder of any office within the Trust.

7.10 Where the relationship of an officer or another director to a director of the Trust is disclosed, Standing Orders 6 and/or 8.2 may apply.

8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

8.1 **Custody of Seal**

The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place.

8.2 **Sealing of Documents**

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Directors of the Board, not from the originating department, and shall be attested by them. A report of all sealings shall be made to the Board at least quarterly.

8.3 **Register of Sealing**

The Trust Secretary shall keep a register in which he/she, or another manager of the Trust authorised by him/her, shall enter a record of the sealing of every document.

9. SIGNATURE OF DOCUMENTS

9.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive or his nominated deputy, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings. .

9.2 In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Reservation and Delegation of Powers but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed), which may only be signed by the Chief Executive or his nominated deputy with a second Director as in 9.2 for documents requiring sealing.

10. MISCELLANEOUS

10.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

10.2 Review of Standing Orders

Standing Orders shall be reviewed annually by the Trust.

ANNEX 9 – FURTHER PROVISIONS

1. Membership of the Foundation Trust.

1.1 With reference to Section 12 and paragraph 12.4 of the constitution if a member of the Trust ceases to meet the criteria for initially becoming a member, he or she will be automatically disqualified from membership.

1.2 Other criteria for exclusion or disqualification from membership are as follows:

- Anyone under the age of 16
- Anyone who has been involved in any act of violence or aggression against Trust staff (whether directly employed or not), or a Trust volunteer in the five years leading up to the next election. This will apply whether or not the act occurred on or off the Trust premises.
- Anyone who has been identified by court order as a vexatious complainant

2. Chairman and Non executive Directors.

2.1 With the exception of the arrangements set out section ~~23~~ 28 of the constitution the first term of appointment of Chairman and Non Executive Directors will be by competition for a maximum of three years. Reappointment may be considered for a further three year term The Council of Governors will determine whether competition is required after discussion with the Chairman or Senior Independent Director (in the case of the reappointment of the Chairman).

Non Executive Directors may in exceptional circumstances serve longer than six years (e.g. two three year terms following authorisation of the NHS Foundation Trust) subject to annual appointment and to serving up to a maximum of three further years (making nine years in total).

2.2 Neither the Chairman nor the Non Executive Directors of the Trust may otherwise be employees of the Trust

2.3 Non executive directors will be subject to additional exclusion requirements over the mandatory ones. These are if:

- He or she is an executive director of the Trust or, a governor, non-executive director, chairman, or chief executive of another NHS Foundation Trust
- He or she is incapable by reason of mental disorder, illness or injury of managing and administering his property and affairs
- He or she ceases to be a member of the Trust

- He or she has had their name placed on registers of Schedule 1 offenders pursuant to the Sex Offenders Act 1977 and/or the Children and Young Person Act 1933
- He or she has failed to declare a significant conflict of interest
- He or she has a conflict of interest making appointment or continuation as a non executive director untenable
- He or she is guilty of conduct or actions prejudicial to the Council or the Trust.
- He or she is a person who has found through due process not to be a fit and proper person on the grounds of a serious misconduct or incompetence.

In addition non executive directors will be expected to adhere to the Code of Conduct for Directors

2.4. The Chairman should meet the qualification requirements for Non Executive Directors set out in the constitution, and be subject to the same disqualification and exclusion criteria

3. Statutory /Required Committees

3.1 The Trust will establish committees required by statute or by ~~Monitor~~NHS Improvement.

4. NHS Foundation Trust Code of Governance

4.1 The Trust will have due regard to the Code of Governance published by Monitor, as providing advice on good practice. In accordance with Monitor or NHS Improvement's requirements it will make a disclosure statement concerning its compliance with the code, and give an explanation where it does not meet its provisions

5. Trust Secretary.

5.1 The Trust will appoint a Trust Secretary and define his or her role and responsibilities. The appointment and removal of the Trust Secretary will be a matter for the Chief Executive and the Chairman jointly

6. Resolution of disputes.

6.1 Monitor's code of Governance requires foundation trusts to put in place a procedure for addressing disagreements between the Council of Governors and Board of Directors (see para 6.4 to 6.8 in this Annex 9).

6.2 As with all grievances, a dispute should be declared only as a last resort. Established processes should be employed whenever possible to resolve disagreements between two key groups.

6.3 Any dispute not resolved by informal means should be subject to external review and dealt with in a timely manner. The

recommendations arising from the external review will be binding on all parties.

6.4 In order for a dispute to be declared a majority of the Council of Governors or the Board of Directors must agree to this course of action.

6.5 **Level one.** The Chair will be informed, by Governors or Directors' that they consider there are grounds to declare a dispute. The Chair will seek to resolve matters informally, normally by asking the Senior Independent Director to investigate the issues and seek resolution. The Senior Independent Director will be assisted by the Trust Secretary. If there is no resolution at this stage a formal dispute will be declared and the process will move to level two.

6.6 **Level two**. The Senior Independent Director, Lead Governor and the ~~Director of Human Resources and Corporate Affairs~~Trust Secretary will arrange for independent individuals with relevant experience, for example, Chair, Non Executive Director, Governors of other Foundation Trusts to undertake an investigation. The investigation team will be assisted by the Trust Secretary. The investigation report will be received by the Senior Independent Director, Lead Governor and the ~~Director of Human Resources and Corporate Affairs~~Trust Secretary who will discuss the recommendations and agree an action plan for implementation.

6.7 In the event of any dispute about the entitlement to membership the dispute shall be referred to the Trust Secretary who shall make a determination on the point in issue. If the Member or applicant is aggrieved at the decision of the Trust Secretary he may appeal in writing within 14 days of the Trust Secretary's decision to the Chairman whose decision shall be final.

6.8 In the event of any dispute about the eligibility and disqualification of a Governor the dispute shall be referred to the Council of Governors whose decision shall be final.

7. Indemnity

7.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

7.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, Council members or Directors to meet all or any

liabilities which are properly the liabilities of the Trust under the paragraph above.

8. Amending the constitution.

8.1 The constitution will be reviewed at least every two years. Any changes to it may only be made in accordance with paragraph 48 of the Constitution. The population figures of the Public Constituencies will be reviewed every five years.

ANNEX 10 – ANNUAL MEMBERS' MEETINGS

1. Interpretation

1.1. Any expression to which a meaning is given in the National Health Service Act 2006 has the same meaning in this interpretation and in addition:

CHAIRMAN is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole;

MEMBER means a person who is a member of the Trust and whose name has been entered in the register of members;

OFFICER means an employee of the Trust;

TRUST means East Kent Hospitals University NHS Foundation Trust.

1.2. Save as permitted by law, the Chairman of the Trust shall be the final authority on the interpretation of these Standing Orders (on which he/she shall be advised by the Chief Executive or Trust Secretary).

2. General Information

2.1. The purpose of the Standing Orders for Annual Members' Meetings is to ensure that the highest standards of corporate governance and conduct are applied to all Annual Members' Meetings.

2.2. All business shall be conducted in the name of the Trust.

3. Attendance

3.1. Each Member shall be entitled to attend an Annual Members' Meeting.

4. Meetings in Public

4.1. Annual Members' Meetings must be open to the public.

4.2. The Chairman may exclude any member of the public from an Annual Members' Meeting if he is interfering with or preventing the reasonable conduct of the meeting.

4.3. Annual Members' Meetings shall be held at such times and places that the Chairman may determine.

5. Notice of Meetings

5.1. At least 14 days before each Annual Members' Meeting, a notice of the meeting, specifying the business proposed to be transacted at it, and

signed by the Chairman, or by an officer of the Trust authorised by the Chairman to sign on his behalf, shall be displayed at the Trust's head office and posted on the Trust's website.

6. Setting the Agenda

6.1. The Chairman shall determine the agenda for Annual Members' Meetings in consultation with the Council of Governors.

7. Chairman of Annual Members' Meetings

7.1. The Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman shall preside.

8. Chairman's Ruling

8.1. Statements made by any person at an Annual Members' Meeting shall be relevant to the matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

9. Voting

9.1. Decisions at meetings shall be determined by a majority of the votes of the Members present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

9.2. All decisions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands.

9.3. A Member may not vote at an Annual Members' Meeting unless he/she has made a declaration in the specified form that he/she is a member of a Public Constituency.

9.4. The form and content of the declaration for the purposes of paragraph 9.3 above shall be specified and published by the Trust from time to time and shall be so published not less than 28 days prior to the Annual Members' Meeting.

9.5. In no circumstances may an absent Member vote by proxy.

10. Suspension of Standing Orders

10.1. Except where this would contravene any statutory provision, any one or more of these Standing Orders may be suspended at an Annual Members' Meeting, provided that a majority of Members present vote in favour of suspension.

10.2. A decision to suspend the Standing Orders shall be recorded in the minutes of the meeting.

10.3. A separate record of matters discussed during the suspension of the Standing Orders shall be made and shall be available to the Members.

10.4. No formal business may be transacted while the Standing Orders are suspended.

10.5. The Trust's Audit Committee shall review every decision to suspend the Standing Orders.

11. Variation and Amendment of Standing Orders

11.1. These Standing Orders may be amended in accordance with paragraph 48 of the Constitution.

12. Record of Attendance

12.1. The Secretary shall keep a record of the names of the Members present at an Annual Members' Meeting.

13. Minutes

13.1. The Minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted for agreement at the next Annual Members' Meeting where they will be signed by the person presiding at it.

13.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

13.3. The Minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website.

14. Quorum

14.1. No business shall be transacted at an Annual Members' Meeting unless at least 20 Members are present.

14.2. If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such other time and place as the Chairman shall determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of Members present at the adjourned meeting is to be the quorum.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS Improvement (NHSI), NHS England (NHSE), Department of Health and other key stakeholders.

The monthly report from the Chief Executive provides the Board of Directors with key issues related to:

- **IMPROVEMENT JOURNEY / CARE QUALITY COMMISSION (CQC)**
- **FINANCIAL PERFORMANCE**
- **ACTIVITY AND PERFORMANCE**
- **CLINICAL STRATEGY UPDATE AND STP PUBLICATION**
- **FEEDBACK FROM MANAGEMENT BOARD**
- **CHIEF EXECUTIVE ACTIVITY**
- **GOOD NEWS STORY**
- **TRUST SEAL ACTIVITY**

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks around ED, Financial Recovery are covered in more detail elsewhere on the Board agenda.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	*ED, Financial Recovery, clinical strategy all link to the strategic risk register.*
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Executive Management Team have reviewed the Board Governance Review Action Plan

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

RECOMMENDATIONS AND ACTION REQUIRED:
To note the report.

CHIEF EXECUTIVE'S REPORT

1 EXECUTIVE SUMMARY

1.1 CQC Visit Update / Improvement Journey

Progress on our improvement journey has continued at pace. The High Level Improvement Plan and supporting Clinical Divisional Improvement Plans were signed off in March and are reported on monthly both at Divisional Governance and at Improvement Board level. The Improvement Plan Steering Group continues to meet fortnightly, chaired by the Chief Nurse, with the Quality Improvement and Innovation Hubs as a key mechanism for communication and engagement of staff.

In June 2017 the CQC produced revised guidance about how they would monitor, inspect and regulate Trusts. The CQC will focus on a model of continual monitoring – via a new system called 'CQC Insight'. The system pulls together a range of data – from harder data regarding mortality rates, incident reporting and staffing indicators to softer intelligence such as patient and carer feedback. This data will be shared with the Trust and discussed at monthly CQC meetings that are held with our lead CQC Relationship Manager. It is anticipated that there will be at least one announced inspection between now and spring 2019 in addition to unannounced inspections which can happen at any time.

Within the new guidance the CQC have updated the Key Lines of Enquiry and prompts which are used during inspections. During July we have started to discuss these changes with our staff and engage them in using the new Key Lines of Enquiry to self-assess our own services, discuss challenges and drive further improvement.

1.2 Financial Performance

The Trust's I&E deficit in June (month 3) was £1.1m (consolidated position excluding Sustainability and Transformation Funds and after technical adjustment) against a plan of £1.5m.

The year to date I&E deficit is £6.6m against a plan of £8.2m (£1.6m better than plan). A reconciliation of the various adjustments is presented below.

	Actual June £'000	Actual YTD £'000	Plan YTD £'000	Variance YTD £'000
Surplus/ (Deficit)	-680	-5,239	-6,311	-1,072
Remove STF	-509	-1,527	-2,181	-654
Surplus/ (Deficit) - Excl STF	**-1,189**	**-6,766**	**-8,492**	**-1,726**
Add back Impairments/ Net Donated assets	78	234	234	0
Technical Surplus/ (Deficit) - Excl STF	**-1,111**	**-6,532**	**-8,258**	**-1,726**
Adjust for Spencer Wing	17	-83	43	126
Consolidated Position	**-1,094**	**-6,615**	**-8,215**	**-1,600**

A full report on the EKMS/Spencer Wing reported deficit at Q1 has been requested.

Pay costs in the month of £28.7m were £0.2m up on May but also £0.2m better than plan. Permanent staff reduced by £0.3m, bank staff was unchanged, but overtime increased by £0.1m and agency/locum staff by £0.4m. The move of Kent and Canterbury medical trainees to WHH and QEQM took place on 19 June necessitating additional costs. Invoicing from NHSP continues to be investigated. Temporary staff spend in month is a concern and will need to see a reduction in future months if

workforce CIPS are to be delivered. Waiting list payments continued to be depressed at £0.16m, a small increase on May. Pay is now £1.5m better than plan year to date.

Activity/income was £1.2m better than plan in month with total income now £0.9m better than plan ytd.

Against the £32m CIPS target, including income, £1.79m was reported in month against a target of £1.97m. Year to date £5.2m is reported against a plan of £4.7m. Of the reported position, £1.3m (25%) is non recurrent and steps are being taken to ensure that this is made up recurrently.

The cash balance as at the end of May was £7.9m. No new borrowings were required.

Headline agreement on the 2016/17 outstanding contract issue with outturn value and CQUIN has been reached with East Kent CCG commissioners. A more detailed proposal is being developed and we hope to conclude this by end August.

The Trust's Financial Recovery Plan has been received and accepted by NHSI. This is for an £18.9m deficit target (excluding Sustainability and Transformation Funds). The fourth review meeting took place on 1 August and was a constructive and positive discussion. The Trust remains in Financial Special Measures but NHSI colleagues have commended the work and position in quarter one, have discussed the expenditure and income risks and the work we need to do to continue positive progress so that we can look to come out of Financial Special Measures once ready.

1.3 Activity and performance Update

Referral to treatment (18 weeks) has remained static reporting at 85%. As reported last month, this is positive particularly as the Trust continues to see an increase in referrals and additions to our admitted waiting list but further work is required to make improvements in compliance. I am pleased to report that the number of patients treated beyond 52 weeks has reported a decrease in June compared to the previous month. Work on this continues as a priority.

Cancer 2 week wait performance continues to report a compliant position. Unfortunately, breast symptomatic 2 week wait performance reported a non-compliant position in June at 89.87% and work is underway to address that for the future. Cancer 62 day performance remains a challenge in particular specialties and focussed work continues as we work to achieve compliance from September 2017 data.

We have seen a very slight improvement in our A&E 4 hour performance for June 2017 reporting at 78.59% compared to the position in May 2017 which reported at 76.78% but this continues to be a very significant concern as it remains well below the expected level and following the Canterbury changes to the acute medical take in June, our focus is now on embedding the model and improving 4 hour performance. This will take time and one of the key drivers for this continues to be staffing issues across our emergency departments and this and other issues are currently being examined and solutions being identified to help improve performance ahead of the winter.

1.4 Preparation for Winter 2017/18

Correspondence has been received from NHSI in July 2017 outlining priorities for the next few months, together with actions that have already been taken to build resilience ahead of next winter. These include:

- Ensuring there is enough capacity to meet the pressures of winter: Reducing delayed transfers of care; reducing variation in best practice; and primary care streaming.
- Reforming and redesigning the wider Urgent and Emergency Care System: Urgent care treatment centres; ambulance response programme.
- Flu planning.

NHS England and NHS Improvement will be more aligned to better support local systems through the winter months. For the first time, 2017/18 will see formal winter planning starting in July, with final local plans to be submitted in early September as per the timetable below. To ensure local systems have sufficient time for proper planning and discussion with partners, we are setting out the key planning and assurance dates for the entire winter period, with general resilience plans right up to Easter.

Local A&E Delivery Boards have been asked to prioritise the following:

- Demand and capacity plans
- Front door processes and primary care streaming
- Flow through the UEC pathway
- Effective discharge processes
- Planning for peaks in demand over weekends and bank holidays
- Ensuring the adoption of best practice as set out in the NHS Improvement guide: *Focus on Improving Patient Flow.*

The key actions and dates are set out below:

	Description	**Deadline**
Overall winter plans submitted	Local A&E Delivery Boards to submit final winter plans covering resilience arrangements from the start of December up to Easter. More information on what these plans should cover is given in the annex.	Submitted to NHS E/I regional teams on Friday 8 September 2017
Late December/Early January plans submitted	Local A&E Delivery Boards to submit more detailed plans setting out what resilience arrangements are in place to get them through the Christmas/New Year bank holiday and highly pressured early January period.	Submitted to UNIFY on Friday 1 December 2017
Easter bank	Local A&E Delivery Boards to submit plans to	Submitted to
holiday plans submitted	ensure system resilience during and immediately after the Easter bank holiday	NHS E/I regional teams on Friday 2 March 2018

2 KENT AND CANTERBURY HOSPITAL ACUTE MEDICAL TAKE TEMPORARY CHANGES

The transfer of acute medicine from the Kent & Canterbury Hospital was implemented on 19 June 2017 following the removal of doctors in training in stroke,

HCOOP and medicine (including Cardiology) by Health Education England, which resulted in the Trust not being able to provide these services at the K&C.

Working up to this date, critical success factors were identified and measures put into place by the Trust working with its partners across the health and social care system, with oversight from the regulators NHS England and NHS Improvement, to get ready for the emergency transfer of services.

For the initial two weeks, Ambulance and Community Trust staff worked with the Trust on site to monitor and manage the impact of the temporary changes. Following this initial period, this was replaced with weekly calls involving all partners.

The Trust's Executive Team is visiting sites and meeting with staff daily to listen to and support them during this period of significant change and is working with staff to address issues as they arise.

The Trust attended Kent County Council's Health Overview and Scrutiny Committee to discuss the transfer and answer members' questions, has met with local MPs and attended public meetings.

The current model of care includes additional ambulatory (day) care, increased ward rounds and more timely discharge processes so patients are not waiting longer than they need to before being able to go home, additional care packages and patient transport.

A range of key performance metrics are being used to monitor and evaluate the model and we are focussing on improving A&E waiting times to further improve the experience for patients as set out above.

3 CLINICAL STRATEGY UPDATE AND STP PUBLICATION

The clinical service models for Emergency Department, Acute Medicine , Elective Orthopaedics and Stroke have been shared with the South East Coast Clinical Senate and all relevant CCGs. Feedback has been received and the work updated where possible. Clinical groups have been established to look at the areas requiring more clinical detail.

Public Engagement: phase 2 listening events are currently on-going across east Kent (EK) to share the models of care with the public and to gather their input and feedback on the evaluation criteria. Events have been held in Canterbury, Ashford, Deal, Romney Marsh and Thanet. West and North Kent are in the process of starting their listening events. EK, North and West Kent are continuing with both internal and external engagement with staff, patients and public. The CCG governance and approval process and required changes were discussed at the last EK delivery board meeting held on 8 June and a positive way forward has been agreed.

The STP has commissioned an Integrated Impact Assessment (IIA) for a range of areas and the results of this will feed into the evaluation to ensure all geographical and minority areas are considered. .

The next meeting with the Clinical Senate to gain final approval of the clinical models will be held in early September and a pre consultation case is then expected to be submitted to NHS England the by end of September 2017. We are working to a public consultation in the early part of 2018.

The Trust continue to positively work with other organisations across Kent and Medway to progress the K&M STP work as required

4 FEEDBACK FROM MANAGEMENT BOARD

Since the last Board meeting, the Trust's Management Board Meeting met on 28 June 2017 and 2 August 2017. Items taken and decisions made are listed below:

Improvement Plans and Integrated Performance Report:

- The Trust has in place an Integrated Improvement Plan. The Trust's Transformation Board will receive regular updates against the Improvement Plan. The Transformation Board will report regularly to the Board of Directors on progress against the whole transformation programme.
- Activity and performance updates were received, in line with those reported in the Integrated Performance Report and CEO Report.
- The latest financial position was reported, together with the latest position regarding the Trust's financial recovery plan.
- The latest workforce data was reviewed.

Other reports received:

- CQUINS 2016/17 and 2017/18: An update report was received. Management Board will continue to receive updates, particularly focussing on identified risks.
- Corporate Risk register: Consideration of new and emerging risks. A paper is a standing item on the Board agenda.
- Update on the Trust's Matrons Review.
- Research and Innovation update: positive progress had been made against strategic objectives. Updates are received by the Board's Quality Committee and the Annual Report will be presented to the Board.
- Anaesthesia Clinical Services Accreditation Scheme: Management Board endorsed this voluntary scheme developed by the Royal Colleage of Anaesthetics. The scheme would enable the Trust to benchmark quality of its services.
- Health and Social Care Pre-Employment Schemes: Management Board endorsed the training programme for young people funded by the Prince's Trust.
- Dementia Village Proposal: Management Board approved the recommendation to proceed to the next stage in the process. The business case has also been received by the Finance and Performance Committee and has been approved by the Board.
- Quality Strategy Quarter 1: Management Board received the quarter 1 update. The report will be presented to the Board's Quality Committee for onward reporting to Board.
- Board Assurance Framework and Annual Priorities Update: Management Board received the report. The report will be presented to the Board as part of the Integrated Audit and Performance Committee Chair Report.
- Inpatient Survey / Emergency Department Surveys: These reports were received and action plans to address areas where improvement is required will be monitored by Management Board going forward.
- Clinical Activity Management: The Trust is working with NHSI to roll out this programme. Management Board sought clarity on measurable and cost improvements which will be presented to the next meeting.
- Community Pharmacy at Kent and Canterbury Hospital: Management Board approved the creation of a subsidiary company to run a community pharmacy at Kent and Canterbury Hospital.
- Nuclear Medicine Gamma Camera Replacement with Spect/CT: Management Board considered the business case for replacement equipment prior to presentation to the Finance and Performance Committee.
- Updates from the Vacancy Control Panel, Strategic Investment Group and Information Assurance Board were received.
- Horizon Scanning – Standard item to note

5 CHIEF EXECUTIVE ACTIVITY – JUNE AND JULY 2017

The following is an example of some of the meetings I, as CEO, have attended during June and July 2017 and their purpose:

- Various meetings with NHSI, including a Performance Review Meetings, Single Oversight Meetings and Progress Check Review Meetings linked to financial special measures
- Board of Directors meeting plus Board Development Day
- CQC Engagement Meeting
- East Kent Governing Body Meetings
- Kent and Medway Cancer Alliance Board
- A variety of 1:1s with a range of staff
- Various MP meetings
- Improvement Plan Delivery Board
- A number of Sustainability and Transformation Plan meetings
- Various Staff Briefings and Leadership Forums
- GIRFT Orthopaedic Visit

I chair the following Executive meetings on a regular basis as part of the Trust's governance structure that ensures upward reporting through Board Committees to Board. I will be reviewing the purpose of each group and assessing how they work before making a judgement about any changes that are necessary as we move into the next stage of the Trust's development.

- Executive Team Meetings (weekly) plus
- EMT/Divisional Director meeting (monthly)
- Management Board (monthly)
- Executive Performance Review Meetings (monthly)
- Financial Improvement Committee

6 GOOD NEWS STORIES

Association of Pharmacy Technicians (APTUK)

A grand total of four awards have been given to the Trust at the annual Association of Pharmacy Technicians (APTUK) award ceremony. APTUK is open to all pharmacy technicians in the UK and from all sectors, including hospital, community and primary care.

Awards included 'Pre-registration Trainee Pharmacy Technician of the Year'. This award is given to the trainee who, in the opinion of the judges, demonstrates outstanding effort and commitment.

APTUK invited people to create and display a poster to present at the event, to share ideas and best practice. These were then entered into their own award category. Although there were dozens of entries, the Trust's, Lead Clinical Pharmacy Technician, was awarded first place. Third place went to our Education, Training, Learning and Development Pharmacy Technician. The team also won 'APTUK Branch of the Year'. The award acknowledges the ongoing dedication, enthusiasm and commitment of Pharmacy Technicians members running local branches voluntarily in their community.

New Data Collection System

A data collection system, developed by EKHUFT and the Kent Surrey Sussex Academic Health Science Network, is being rolled out nationally, saving the NHS thousands of man hours each year. The system, developed by Beautiful Information

will see all of the winter sitrep data that is normally uploaded manually by trusts on a daily basis, automatically uploaded to NHS Improvement's databases.

Royal College of Physicians National Conference – 7 September 2017

Mr Kuma Rudra, one of the Trust's Consultants in Health Care of Elderly People (HCOOP) has been selected by the Royal College of Physicians to speak at their national conference on College Tutors and their roles. Mr Kumar works as a college Tutor for Post Graduate Medical Education and Training in QEQM.

Emergency Department (ED) Education Collaborative

Senior members of the Trust's Emergency Departments have been pivotal in forming a Kent-wide Emergency Department Education Collaborative. This incorporates all of Kent's Emergency Departments and the Emergency Department at the Royal Sussex County Hospital in Brighton. The purpose of the Collaborative is to provide university standard and accredited education to employees within our neighbouring Trusts at either reduced rates or on occasions free. Each Trust will provide specific ED training.

Haemophilia Research at Kent and Canterbury

The Kent Haemophilia and Thrombosis Centre based at Kent & Canterbury Hospital has become the first centre in the UK to enrol patients in a new study about haemophilia treatments.

The study, called A-SURE, is gathering important information on how patients respond to a newer, longer- lasting Factor VIII treatment. This will hopefully improve haemophilia care for patients both current and in the future. The study is being run in nine European countries.

7 TRUST SEAL ACTIVITY

The following summarises Trust Seal Activity since my last report to the Board:

- Lease for Little Oaks Nursery
- Arundel House Works
- Grant of Lease – Paula Carr Centre
- Development of Agreement for Leas for PET CT Project at WHH
- Contract re works at fracture centre
- RVH – Overage Dead of Release Contract / sale transfer TPI contract
- Little Oaks Early Years Ltd Leases – WHH and QEQM
- Lease of substation to UKPN at K&C

Matthew Kershaw
Chief Executive

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**DEPUTY DIRECTOR OF RISK, GOVERNANCE AND PATIENT SAFETY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: CORPORATE RISK REGISTER (BY RESIDUAL RISK RANKING) DATED 03/08/2017** **APPENDIX 2: HIGHEST MITIGATED STRATEGIC RISKS DATED 03/08/2017** **APPENDIX 3: EMERGING RISKS REPORT DATED 03/08/2017**

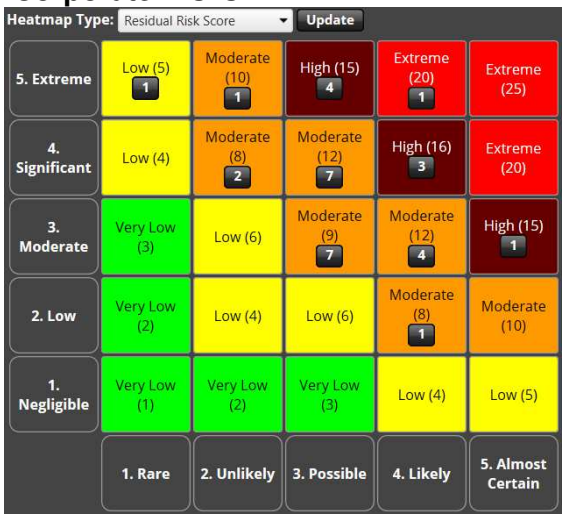
BACKGROUND AND EXECUTIVE SUMMARY

This report provides the Board of Directors with an update of the full Corporate/Highest Mitigated Strategic Risks at 03 August 2017 and the new Corporate risks approved for inclusion to the Corporate Risk Register. The risks rated as "high" post mitigation (residual) on the Strategic and the full Corporate Risk Register was reviewed by the Board on 09 June 2017. The highest mitigated risks on the Strategic and Corporate Risk Registers was last reviewed by the Integrated Audit and Governance Committee on 28 July 2017. The Quality risks were last reviewed and discussed at the Quality Committee on 09 August 2017.

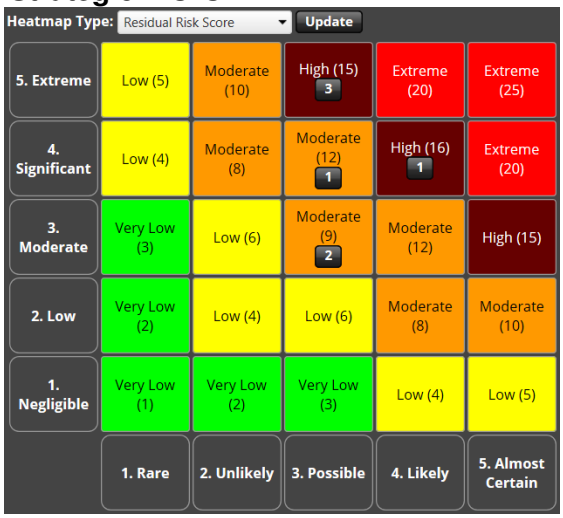
Monthly meetings are being held with the responsible Executive lead to review the scoring, actions and the specific wording for each strategic and corporate risk.

Risk Register Heat Map (by Residual risk score)

Corporate Risks



Strategic Risks



Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register

1 No changes were made to residual risk scores during this period. However, risk action plans are progressing and updates have been provided against actions. Where actions have been implemented, controls (assurance levels) have been strengthened but this

has not resulted in reduction in the residual risk scores.

Corporate Risk Register

2 The changes to residual risk scores during the period under review are presented in the table below. The text in red italics in the risk title column summarises the rational for the change:

Risk Ref.	Risk Title	Residual Score June 17	Residual Score Aug 17	Direction of travel	Target Score
CRR 53	Failure to deliver the CQUIN programme for 2017/18 *The residual impact score has been increased to reflect the impact of the risk to the Trust more appropriately.*	9 Moderate	12 Moderate		**6 Low**
CRR 48	Challenges in embedding a mature and developed Patient safety culture across Obstetrics and Maternity *Although the mitigating actions are progressing well, the residual impact score has been increased to reflect the impact of the risk more appropriately.*	9 Moderate	12 Moderate		9 Moderate

Risks approved for closing on the Corporate Risk Register (02 August 2017 - Management Board)

3 The following risk was approved for closure on the Corporate Risk Register. The text in red italics in the risk title column summarises the rationale for closing:

Risk Ref.	Risk Title	Residual Score June 17	Residual Score Aug 17	Direction of travel	Target Score
CRR 52	Possible Nursing Staff Industrial Action on Pay *The key action relating to this risk has been implemented and the target risk met. There is no support for industrial action from the Royal College of Nursing (RCN). The on-going discussions around the public sector pay cap will pick up on the nursing pay concerns.*	9 Moderate	6 Moderate		6 Moderate

New Corporate Risks approved by the Management Board on 02 August 2017 (attached as Appendix 3)

4 **CRR 55 - Inadequate sharing of Patients healthcare records with Community Trusts (Executive Lead – Chief Nurse and Director of Quality)**

This risk was previously brought to the attention of the Board as an emerging risk (risk Ref. CRR 50) and has now been approved by the Management Board following the deep-dive into the risk at the IAGC on 28 July 2017.

There are concerns that the EKHUFT patient healthcare records are being sent to various locations within Kent Community Health NHS Foundation Trust (KCHFT) and other providers of continuing care across Kent, at the point of discharge. This is a historic process but there are both data protection concerns regarding EKHUFT as remaining the data controller and medicines governance issues as the Community Trust use the prescription chart from EKHUFT. There is a balance between these risks and the continuity of care.

This risk will become greater with the introduction of the GDPR in May 2018, where the responsibility of the data controller will be more rigorously applied; the fines associated could be considerable. This may also affect the ability of the episode to be coded as the records are no longer available. The key controls in place to mitigate this risk include the updated SOPs and policy which the Trust is currently working to.

A meeting took place in July 2017 with KCHFT, attended by the Legal Service Manager with responsibility for Information Governance and Assurance where the risks to EKHUFT were acknowledged. The proposed changes still need to be discussed at KCHFT and a plan outlined. The changes would include a copy of the relevant section of the current in-patient records as well as the patient eDN being transferred with the patient; the main body of the records would remain under the responsibility of EKHUFT as the data controller. This is the process for all patients transferred to all tertiary/specialist centres and those repatriated back to EKHUFT.

The risk is one associated with potential breach of the data protection act 1998, potential patient safety concerns, legal challenge, financial loss (potential missed income) and reputational damage to the Trust.

5 **CRR 56 - Inadequate critical care capacity (Executive Lead – TBA)**

This risk was escalated by the Surgical Services Division as a result of concerns that the critical care bed provision for the Trust is inadequate. Nationally, for every 100,000 head of population approximately 6.6 critical care beds are provided. At EKHUFT the figure is 3.6 per 100,000 head of population which is below the national average. The cause of this risk is multi-factorial, including historical chronic under-resourcing of critical care beds; significant growth in emergency demand nationally for critical care beds being insufficient to meet acuity; more patients surviving with comorbidities; increased activity of the pPCI service in WHH - out of hospital cardiac arrests that require increased length of stay.

Some of the key controls in place to mitigate this risk include the Admissions, Discharge and Transfer policy and the Critical Care Escalation plan which includes plans for a surge in demand for the 3 acute sites.

The plans required to mitigate this risk include;

- Producing a business case to fund the current gaps; and
- In-depth modelling and analysis regarding future planning (future projections)

The risk is one associated with potential patient safety concerns due to cancellations of elective surgery and delays in admission of critically ill patients amongst other effects.

Emerging Risk discussed at Management Board on 02 August 2017

6 **Supply chain shortages**

The risk of supply chain shortages was discussed at the Management Board and there was a real appetite to add this risk to the Corporate Risk Register. There are concerns that supply chain problems of widely used drugs may put patients and staff at risk. This includes enoxaparin (CRR 54), the Hepatitis B vaccine and some antibiotics (e.g. piperacillin-tazobactam 'Tazocin'). A joint risk review meeting will be facilitated by the Trust Risk Manager to properly articulate and assess this risk. The plan is to have this risk added as a Corporate Risk and Divisions with specific shortages will add those to their Divisional/Local risk registers which will then be linked to the Corporate risk.

Key issues for the Board's attention

7 **Risk Ref. CRR 28 – Potential delays in treatment of Patients requiring Emergency Care**

There are concerns that despite efforts to mitigate the risk, there are still delays in treatment of patients requiring emergency care. There was a formal review and discussion of this risk at the Management Board on 02 August 2017 and the risk will be updated in light of this by the Executive Lead during the August risk review session.

8 **Risk Ref. CRR 51 – Patient safety may be compromised as a result of the move of acute medicine, acute geriatric medicine and Stroke from the K&C site**

This risk is at a critical stage following the transfer of acute medicine from the K&CH site. Of the ten action areas identified nationally as being key to enabling flow of patients through the emergency care pathway, staffing shortages compromise in particular: streaming of patients to primary care at the front door; provision of 18/7 ambulatory care; 'pulling' of patients from the front door by specialties; and timely discharge/transfer of patients from the acute sites. There was a formal review and discussion of this risk at the Management Board on 02 August 2017 and the risk will be updated in light of this by the Executive Lead during the August risk review session.

9 **Risk Ref. CRR 34 – Inadequate Health & Safety (H&S) systems embedded within the Divisions**

In order to provide assurance to the Trust Board about the management of this risk, a deep-dive of this risk will be presented to the October 2017 Integrated Audit & Governance Committee (IAGC) meeting. This will entail each Divisional Director presenting the progress of the actions planned to mitigate this risk and the progress made by each Division to embed H&S systems across the Division.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The attached risk registers reflects the corporate risks and the highest mitigated strategic risks facing the Trust and the mitigating actions in place.
LINKS TO STRATEGIC OBJECTIVES:	The corporate and strategic risks align to all of the four Strategic Priorities: **Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other

	organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the full corporate risks and the highest mitigated strategic risks for the Trust.
RESOURCE IMPLICATIONS:	None specifically identified other than identified in the Risk Register.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	The Risk Group and Management Board review any new corporate risks and the scoring of the existing risks. The IAGC review the Corporate Risks and the Board Assurance Framework.

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

RECOMMENDATIONS AND ACTION REQUIRED:

1. The Board of Directors are invited to review the Corporate Risks and Highest Mitigated Strategic Risks Report that is appended; note and discuss the new/emerging Corporate risks.

2. The Board is invited to consider the sufficiency of the corrective actions identified in relation to the risks and provide positive challenge where necessary.

Corporate Risk Register Report (By Residual Risk Ranking)

Report Date	03 Aug 2017
Comparison Date	In the past 60 Day(s)

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 28	Potential delays in treatment of Patients requiring Emergency Care **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 23 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** This risk needs to be formally reviewed at management board because despite all controls and actions to date delays in treatment of patients requiring emergency care are occurring	06 Jul 2016	**Cause** * Overcrowding in the Emergency Departments due to lack of flow through the Emergency Care Pathway *The emergency transfer of acute medicine from K & C may lead to further overcrowding on the WHH and QE sites *Increased and unplanned local demand for emergency services that the Trust is unable to meet with the resources and infrastructure available *Over time the demography, comorbidity and acuity of ED attendees has changed, together with the rise in number of attendees, resulting in an increased requirement for conversion to admission *Inability to recruit into consultant and middle grade posts * Lack of availability of Consultants due to sickness * Surge resilience plans do not meet unprecedented demand * Lack of robust escalation plans * Failure to respond appropriately to the Operational Pressure Escalation Framework **Effect** * Poor Patient experience * Harm to Patients * Breach of licence * Regulatory concerns * Failure to retain STF funding * Reputational damage * Low staff morale	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	"Time to make a Difference" (A&E recovery) plan in place supported by ECIP **Control Owner:** Jane Ely	Adequate	I = 5 L = 4 Extreme (20)	Implementation of the Safer Bundle in QEQM **Person Responsible:** Paul Stevens **To be implemented by:** 31 Jul 2017	High	**20 Jun 2017** The SAFER bundle is being implemented with increasing success across the site but further work is needed	I = 5 L = 2 Moderate (10)
						Accident and Emergency Delivery Board in place **Control Owner:** Matthew Kershaw	Limited		Implement "Time to make a Difference" (A&E Recovery Plan) **Person Responsible:** Jane Ely **To be implemented by:** 31 Jul 2017	High	**05 Jul 2017** Plan needs to be revised as a result of the K&C transfer being completed.	
						Acute Medical Model in place **Control Owner:** Jonathan Purday	Adequate		Implementation of the SAFER bundle in K&CH **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Jul 2017	High	**20 Jun 2017** The SAFER bundle is being implemented with increasing success across the site but further work is needed	
						Daily intensive review/bed matching for emergency admissions not placed at time of review **Control Owner:** Jane Ely	Adequate		Implementation of the Safer Bundle in WHH **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Jul 2017	High	**20 Jun 2017** The SAFER bundle is being implemented with increasing success across the site but further work is needed	
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Jane Ely	Adequate					
						Single Health Resilience Early Warning Database (SHREWD) has been revised . It is expected that when the Trust is under pressure the system will respond with agreed actions **Control Owner:** Jane Ely	Limited					
						Support from the Emergency Care Improvement Programme (ECIP) **Control Owner:** Jane Ely	Limited					
						Urgent Care Recovery Plan in place and updated in line with national priorities (Streaming, Access to advise, Ambulatory Care, Patient flow (Safer Bundle) and Discharge (External capacity) **Control Owner:** Jane Ely	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 3	Inability to respond in a timely way to changing levels of demand for elective services **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 23 Jun 2017 **Latest Review Date:** 06 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change in risk scores. Progress of actions updated. Still awaiting sign off of the New Operational Plan (2017 - 2019) by the CCG. Meeting planned with the CCGs to review the 2017/18 plan. New actions added to risk including "a review of the demand and capacity plan in light of the K&C transfer and other operational changes."	05 Feb 2016	**Cause** * There is a increased and unplanned local demand for elective services that the Trust is unable to meet with the resources and infrastructure available. *Poor demand management. * Inability to recruit into Consultant and middle grade posts. *Lack of availability of Consultants due to sickness *Delays in information about Health/Screening campaigns *Backlog rollover from previous years *Demand from CCG's higher than agreed BP *No mechanism to sufficiently influence CCGs to improve pathways/tiers of care * Inpatient activity (DC, inpatients) not meeting BP * Failure to access our own surgical remit for the usage of beds for surgical patients/Emergency medical outliers in surgical beds *Failure to complete job planning *Referral management mechanisms in CCGs have resulted in a higher conversion rate to Surgery *Equipment failure leading to cancellations *Theatre unavailability **Effect** * Fail to meet RTT Standard * Harm to Patients * Breach of licence * Regulatory concerns * Reputational damage *Failure to retain STP Funding *Poor patient outcomes *Financial loss due to outsourcing of activities to the independent sector)	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Annual business plan in place **Control Owner:** Jane Ely	Limited	I = 4 L = 4 High (16)	Finalise remaining job plans **Person Responsible:** Christine Hudson **To be implemented by:** 31 Mar 2017	High	**05 Jul 2017** 108 out of 147 job plans completed (73%). Of the remaining 27%, 18% are in discussion and the remaining in progress).	I = 3 L = 2 Low (6)
						Daily intensive review/bed matching in place for elective admissions **Control Owner:** Jane Ely	Adequate		New Operational Plan (Business plan) to be agreed for 2017-2019 **Person Responsible:** Jane Ely **To be implemented by:** 30 Jun 2017	High	**05 Jul 2017** Plan for 2017/18 is now with the Director of Finance and Chief Executive to resolve with the accountable Officers in the CCGs	
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Jane Ely	Adequate		Review the Demand and Capacity plan in light of the K&C transfer and other operational changes **Person Responsible:** Jane Ely **To be implemented by:** 04 Aug 2017	High		
						Detailed Q1 2017/18 planning in place to ensure outpatient and surgical capacity meets BP **Control Owner:** Jane Ely	Adequate		Detailed review of the quarterly plans for 2017/18 (demand) - linked to recruitment of new Consultants **Person Responsible:** Jane Ely **To be implemented by:** 18 Aug 2017	High		
						Each speciality supports dedicated validation time **Control Owner:** Christine Hudson	Adequate		For specific specialties identified, commence specific training for clinicians with regard to RTT outcomes **Person Responsible:** Christine Hudson **To be implemented by:** 29 Sep 2017	High	**09 May 2017** NHS elect doing training programme to consultants on September 12th 2017	
						Elective demand - Continuing to alert CCG colleagues to excessive demand and collaborating with them to provide alternatives to referral e.g. advice and guidance **Control Owner:** Jane Ely	Adequate					
						Escalations of capacity for outpatients and theatres happen as required **Control Owner:** Christine Hudson	Limited					
						Inpatient bed requirements for Surgical division completed **Control Owner:** Christine Hudson	Adequate					
						Numerical table of residual gap analysis in terms of capacity reported to Finance & Performance Committee **Control Owner:** Jane Ely	Adequate					
						Regular review of Performance for RTT where improvement plans have not delivered the required results **Control Owner:** Christine Hudson	Adequate					
						RTT - A joint improvement plan is in place and supported by NHS Elect **Control Owner:** Christine Hudson	Limited					
						RTT - Recovery trajectory in place **Control Owner:** Christine Hudson	Limited					
						Support from the National Intensive Support Team (National team) - training and capacity planning (demand management for etc **Control Owner:** Christine Hudson	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						The Surgical Division continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations **Control Owner:** Christine Hudson	Limited					
CRR 49	Negative impact of the implementation of the new HRMC- IR35 tax regime **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** **Last Updated:** 12 Jul 2017 **Latest Review Date:** 10 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Sandra Le Blanc. No change to risk scores. Progress notes added to actions. A process has been agreed with Divisions for a standard return using job types instead of individual assessments. This is in progress. A policy needs developing.	28 Mar 2017	**Cause** *The new tax regime means that HMRC will treat all Public sector 'self-employed' contractors using Personal Services Companies (PSCs) as falling under IR35 and therefore treat them as employees for tax purposes. * NHSIs expectation is that Trusts put in place measures to ensure all locums, agency and bank staff are subject to PAYE and on payroll from 1 April 2017. *NHSI provided updated guidance on 30th May 2017 which requires the Trust to individually assess whether locum, agency or bank staff should be considered as employed for tax purposes. *Lack of awareness of IR35 and appropriate systems to support organisational compliance with tax legislation **Effect** *Locum and Agency staff refuse to work for the Trust *Difficulty in delivering patients services in areas where there is a high reliance on agency / locum staff *Difficulties in securing locums to cover medical rotas (signifiant gaps in ED Doctor rotas) *Potential impact on patient outcomes and experience *Financial loss as a result of potential fines for non-compliance and / or non delivery of service / performance standards *Potential legal challenge *Increased costs to the Trust due to the employers NICs that need to be accounted for * Reputational damage * Potential negative impact on substantive staff health and wellbeing. *Potential that there will be substantial administrative burden to undertake individual assessments	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 5 Extreme (20)	Communication sent out to all clinical staffing recruiters notifying them of Trust policy and requirements for information regarding IR 35 status of temporary staff **Control Owner:** Sarah Charman	Limited	I = 4 L = 4 High (16)	Trust to develop a contingency plan where operational activities continue to be impacted in high risk areas. **Person Responsible:** Jane Ely **To be implemented by:** 31 May 2017	High	**05 Jul 2017** The RMOs have been investigated and are unable to plug the ED gaps. The contingency plan includes the EMP Business case; the new salary scale for the ED middle grade doctors and the Business case for Acute Care Practitioners and the Acute Physicians and continued recruitment to Acute Care Consultant posts.	I = 4 L = 3 Moderate (12)
						Financial costs to the Trust associated with the new tax regime determined **Control Owner:** Nick Gerrard	Limited					
						Reviewed Bank Rates for those high risk areas impacted by this change **Control Owner:** Sandra Le Blanc	Limited		Develop a workable plan for compliance with IR35 **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Aug 2017	Medium	**06 Jul 2017** In progress - Discussions have been had with HMRC. They confirm the Trust does not need to complete individual assessments for each worker and recommend that the Trust produces one for each job type we employ. A plan is in place to work with Divisions to create a standard return for each job type we employ and use this to support similar roles. Where the roles do not fit in neatly to a job type, individual returns will be made. A policy will be developed to cover the above.	
									Ensure the Trust determines the IR35 status of all agency staff/locum engagements **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Aug 2017	Medium	**06 Jul 2017** In progress - Discussions have been had with HMRC. They confirm the Trust does not need to complete individual assessments for each worker and recommend that the Trust produces one for each job type we employ. A plan is in place to work with Divisions to create a standard return for each job type we employ and use this to support similar roles. Where the roles do not fit in neatly to a job type, individual returns will be made. A policy will be developed to cover the above.	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 47	Inability to prevent deterioration in the number of healthcare associated infection metrics **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Valerie Harmon **Last Updated:** 18 Jul 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Next month we will have a "critical friend" review by Mercia Spare from NHSI to review the IPC action plan and provide external assurance	07 Feb 2017	**Cause** Lack of adherence to basic infection prevention control policies and procedures **Effect** * Increased exposure of Patients to Healthcare Associated Infections (HCAIs) such as MRSA, E.coli, C.difficile and Glycopeptide Resistant Enterococcus (GRE). *Poor patient outcomes Increased hospital length of stay *Failure to meet targets *Financial loss - financial penalty *Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Back to basics campaign with a focus on hand hygiene rolled out **Control Owner:** Valerie Harmon	Adequate	I = 4 L = 4 High (16)	Infection Prevention & Control Critical Review Visit by Mercia Spare (Head of quality at NHSI) to provide a critical appraisal of the IPC action plan **Person Responsible:** Paul Stevens **To be implemented by:** 11 Aug 2017	High		I = 4 L = 2 Moderate (8)
						Dedicated Infection Prevention and Control Team (IP&CT) **Control Owner:** Paul Stevens	Adequate					
						Detailed annual programme of infection and prevention control in place **Control Owner:** Paul Stevens	Adequate		Agree and implement an infection prevention and control action plan which encompasses reporting on indicators, mandatory training etc. **Person Responsible:** Valerie Harmon **To be implemented by:** 31 May 2018	High	**13 Jun 2017** Infection prevention and control action plan has now been agreed and finalised with the commissioners.	
						Environmental cleaning audits in place **Control Owner:** Valerie Harmon	Adequate					
						Infection prevention and control action plan in place which encompasses reporting on indicators, mandatory training etc. **Control Owner:** Valerie Harmon	Adequate					
CRR 54	Inability to provide an anticoagulant drug (Enoxaparin) to patients **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Will Willson **Last Updated:** 17 Jul 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Risk reviewed	28 Jun 2017	**Cause** Supply shortage into UK from Sanofi Aventis, manufacturer of Enoxaparin **Effect** Trust at risk of running out at short notice of Enoxaparin for: Prophylaxis of VTE Treatment of PE/DVT Patients in community on long term treatment unable to source supply from local pharmacies so coming into hospital for stock/as a result of treatment failure	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	Clinical Pharmacy **Control Owner:** Emma Dodridge	Adequate	I = 5 L = 3 High (15)	DoH Options for alternative suppliers being investigated because there is not sufficient stock to cover every trust is clexane supply fails **Person Responsible:** Will Willson **To be implemented by:** 28 Jul 2017	High	**18 Jul 2017** In progress	I = 5 L = 2 Moderate (10)
						National Pharmacy procurement WW liaising along with Heather McAdam with regional procurement lead into DoH The key here is the national control to arrest panic buying which will make situation rapidly worse and this needs to be controlled by DoH Options for alternative suppliers being investigated because there is not sufficient stock to cover every trust is clexane supply fails. completing a cost modelling as risk is price will rise **Control Owner:** Will Willson	Adequate		Complete cost modelling (risk is price will rise) **Person Responsible:** Will Willson **To be implemented by:** 28 Jul 2017	High	**18 Jul 2017** In progress	
						Pharmacy procurement and Distribution **Control Owner:** Heather McAdam	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 51	Patient safety may be compromised as a result of the move of acute medicine, acute geriatric medicine and Stroke from the K&C site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 23 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** This risk is at a critical stage currently (4 weeks post-implementation of the transfer of acute medicine off the K&CH site). Of the 10 action areas identified nationally as being key to enabling flow of patients through the emergency care pathway staffing shortages compromise in particular: streaming of patients to primary care at the front door; provision of 18/7 ambulatory care; 'pulling' of patients from the front door by specialties; and timely discharge/transfer of patients from the acute sites.	11 Apr 2017	**Cause** *Temporary transfer of acute medicine, geriatric medicine and Stroke from the K&C site *On K&C site we may not have the right level of medical cover for all the specialties that remain on the site *Ambulance handover delays *Patients transferring between sites *Imbalance between substantive consultants and locum consultant posts leading to unsatisfactory trainee doctors education experience **Effect** *Potentially avoidable moderate or severe harm or death *Overcrowding at WHH & QEQM (negative bed position) *Reputational damage *Legal challenge *Regulatory concerns *Additional costs required for changes to services	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Framework in place to measure the overall gap in bed occupancy and contribution from interventions that will close the gap **Control Owner:** Jane Ely	Adequate	I = 5 L = 3 High (15)	Recruitment to substantive medical posts to fill establishment **Person Responsible:** Lesley White **To be implemented by:** 05 Apr 2018	High		I = 5 L = 2 Moderate (10)
						High level action plan in place to deliver the requirements for readiness **Control Owner:** Jane Ely	Limited		Fully implement the acute medical model on WHH & QEQM sites **Person Responsible:** Jonathan Purday **To be implemented by:** 05 Apr 2018	High	**18 Jul 2017** In progress	
						Implementation of the Business Continuity Plans in the Operation Oakleaf Action Plan **Control Owner:** Jane Ely	Adequate		Implementation of the East Kent Clinical Strategy through the STP process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**14 Jun 2017** First draft of the PCBC is due end July 2017	
						Increased proportion of patients treated through ambulatory care **Control Owner:** Jonathan Purday	Adequate					
						Oversight group in place **Control Owner:** Jane Ely	Adequate					
						Provision of extra ten placements per site per day from our healthcare partners **Control Owner:** Jane Ely	Limited					
						Return of the medically optimised patients to the K&C site **Control Owner:** Jane Ely	Adequate					
						Safe transfer of medically stable patients from the two acute sites back to K&C for ongoing rehabilitation and discharge from hospital **Control Owner:** Jane Ely	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 22	Failure to record/carry out timely Venous Thromboprophylaxis (VTE) risk assessments **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Gillian Evans **Last Updated:** 01 Aug 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** current performance Trustwide is 90%	26 May 2016	**Cause** *Ineffective VTE risk assessment process - two step process that involves paper-based prescribing and electronically based VTE risk assessment **Effect** - Non-compliance with NICE CG92 - Non-compliance with NICE Quality Standard (QS3) VTE in adults - Harm to patients - Reputational damage - Increased Complaints - Legal Claims - Financial Loss (£7.2million potential contract penalty to EKHUFT for non-compliance)	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	Consultants iPads able to access the VitalPAC system **Control Owner:** Paul Stevens	Adequate	I = 5 L = 3 High (15)	Ensure all Clinical Staff check Patients VTE recording status and escalate to the responsible doctor **Person Responsible:** Karina Greenan **To be implemented by:** 30 Jun 2017	High		I = 3 L = 2 Low (6)
						Email alert from VitalPAC for patients whose VTE assessment has not been completed has been introduced. **Control Owner:** Paul Stevens	Limited		Ensure all Clinical Staff check Patients VTE recording status and escalate to the responsible doctor **Person Responsible:** Elizabeth Mount **To be implemented by:** 30 Jun 2017	High	**10 Jul 2017** The Division has achieved 94%. Action plan in place for Womens Health to improve their risk assessment percentage which entails the nursing staff compiling a list of patients who require a VTE risk assessment for discussion at the daily Board rounds. The Division continues to report improvements and review actions at itsDivisional Board	
						No Patient is allowed to leave Clinical Decisions Units/A&E without VTE assessment **Control Owner:** Jonathan Purday	Limited		Ensure all Clinical Staff check Patients VTE recording status and escalate to the responsible doctor **Person Responsible:** Heather Munro **To be implemented by:** 30 Jun 2017	High	**30 Jun 2017** I am not the responsible person for this risk and as so will not be updating. this should be allocated to DMD for the surgical division	
						No patient is allowed to leave the Theatre recovery area without VTE assessment being recorded **Control Owner:** Nicholas Goodger	Limited		Ensure all Clinical Staff check Patients VTE recording status and escalate to the responsible doctor **Person Responsible:** Julie Barton **To be implemented by:** 30 Jun 2017	High	**03 Jul 2017** Actioned by Surgical Services. Interventional Radiologists to ensure this is included in their risk register.	
						Trust-wide VTE Action Plan in place to ensure compliance (£7.2million potential contract penalty to EKHUFT for non-compliance) **Control Owner:** Chiara Hendry	Limited		Ensure e-Prescribing is compatible with the VTE electronic risk assessments **Person Responsible:** Chiara Hendry **To be implemented by:** 31 Jul 2017	High		
						VTE assessment recording data extracted from the VitalPAc system **Control Owner:** Paul Stevens	Adequate		Division to devise Action Plans to ensure they meet the 95% VTE risk assessment target **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Jul 2017	High		
									Division to devise Action Plans to ensure they meet the 95% VTE risk assessment target **Person Responsible:** Elhussein Rfidah **To be implemented by:** 31 Jul 2017	High		

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									Division to devise Action Plans to ensure they meet the 95% VTE risk assessment target **Person Responsible:** Nicholas Goodger **To be implemented by:** 31 Jul 2017	High		
									Implement the Trust-wide VTE Action Plan 2016/17 **Person Responsible:** Gillian Evans **To be implemented by:** 29 Sep 2017	High	**05 Jul 2017** Action plan in progress. Two actions (remedial actions) linked to the CPN require completing by September 2017.	
									Produce and Implement Trust-wide VTE Action Plan 2017/18 **Person Responsible:** Gillian Evans **To be implemented by:** 30 Mar 2018	High		

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 42	Inappropriate management/use of pre-labelled medicines (over-labelled products) **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Julie Barton **Last Updated:** 05 Dec 2016 **Latest Review Date:** 09 Jun 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** The 3 actions require review in terms of implementation. Full implementation should reduce the likelihood of this risk	05 Dec 2016	**Cause** *Insufficient control and governance of these medicines across the Trust to meet regulatory & professional requirements (NMC) in response to the Medicines Act. * The Pharmacy Department has been unable to provide a sufficient number of Pharmacists to deliver a safe clinical service. This has led to changes in practice and increase in use of pre-labelled medicines. **Effect** *Poor Patient outcomes *Non-compliance with the relevant regulatory and professional requirements (NMC) in response to the Medicines Act *Complaints from patients and GP's when incorrect quantities / medicines are supplied to take home. *Reputational damage *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	The Pharmacy Department check patient's medicines for discharge from the EDN either at ward level or in Pharmacy. **Control Owner:** Michelle Groom	Limited	I = 3 L = 5 High (15)	Producing and implementing a new pre-labelled medicines policy **Person Responsible:** Michelle Groom **To be implemented by:** 31 Jan 2017	High	**21 Jul 2017** Policy has been approved. The following actions have already occurred: 1. Review of stock holdings of pre-labelled medicines across the Trust 2. Removal of many of these products from ward areas and limiting to A&E/MIU wherever possible 3. Communication with wards and pharmacy teams to not use pre-labelled packs where medicines can be dispensed in a timely manner (for example when an EDN is going to pharmacy anyway for supply of other drugs). 4. Pharmacy parts of the policy already implemented, for example procedure for procuring new packs needing approval. For action: Meeting with HoN to discuss reiterate requirements in the policy (July 17), particularly around recording the use of these products. Information session with nurses on this new policy. Supplying wards with registers to record the use of these packs.	I = 3 L = 3 Moderate (9)
									Roll out a Trust- wide training and education plan for an effective professional development framework which moves nurses from a dependency on PGD's and pre-labelled medicines to an increased number of autonomous independent prescribers **Person Responsible:** Jane Christmas **To be implemented by:** 31 Jan 2017	High	**02 May 2017** Medication Safety Officer in post - regular meetings in place between deputy chief nurse. Professional development framework in development. This development is being linked to Practice development team and Divisional heads of nursing with essential links with existing professional and medicines management meetings to promote future roll out.	
									Review the use of pre-labelled medicines across the Trust and agree a plan with relevant stakeholders which will create a framework for clinical use within the policy requirements / compliance **Person Responsible:** Michelle Groom **To be implemented by:** 31 Jan 2017	High	**21 Jul 2017** All use has been reviewed, and continues to be reviewed on an approximately bi-monthly basis. All low usage lines have been removed and most areas packs have been scaled back. See more detailed note on progress on other action. MG	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 4	Failure to recognise or treat Patients with sepsis in a timely way **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Michelle Webb **Last Updated:** 16 May 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Current performance (June 2017) has improved with 81% of patients receiving intravenous antibiotics within an hour of arriving in A&E	09 Feb 2016	**Cause** The opportunities and systems in place to recognise and manage patients presenting with or developing sepsis are not taken and/or the deteriorating patient is not recognised. Patients with cancer undergoing chemotherapy are susceptible to neutropenic sepsis. Previously fit and healthy adults may compensate clinically until they are critically ill. **Effect** Treatment is not administered in a timely way due to delayed recognition and and patients may suffer adverse outcomes.	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	A local rule base for coding for sepsis and severe sepsis **Control Owner:** Michelle Webb	Adequate	I = 5 L = 3 High (15)	Implement the Emergency medicine work stream that covers ambulance handover, streaming and Standing Operating Proceedings within the EDs (part of the "Time to make a Difference " (A&E recovery) plan) **Person Responsible:** Jane Ely **To be implemented by:** 31 Jul 2017	High	**05 Jul 2017** This is measured by the daily ERP dashboard. Clinician 1st seen is currently under 40%. Best in the past 8 weeks is about 50%. Still a bit of work to be done.	I = 5 L = 2 Moderate (10)
						All Point of Care testing equipment for blood gas analysis updated to include lactate measurements in EDs and respiratory wards. **Control Owner:** Michelle Webb	Adequate					
						Clinical staff issued with aide-memoire on sepsis management and compliance tested using CEM audit and local audit **Control Owner:** Michelle Webb	Adequate		Strengthening mandatory training and opportunities at induction to ensure all staff are aware of existing DOPs and local tools for screening and management of deteriorating patient, including sepsis. **Person Responsible:** Michelle Webb **To be implemented by:** 31 Jul 2017	Medium	**18 Jul 2017** Proposals to strengthen training (Clinical Induction) will be presented to the Management Board in August 2017	
						Deteriorating Patient Steering Group in place that brings together the various work streams (AKI, sepsis, recognition and escalation, NIV). **Control Owner:** Michelle Webb	Adequate					
						Documentation in all EDs revised to consistently record patients vital signs and blood test results **Control Owner:** Michelle Webb	Adequate					
						Sepsis screening in ward patients triggering an EWS of 4 or higher **Control Owner:** Michelle Webb	Limited					
						Staff training in place on the recognition of patients with sepsis in line with national best practice, including primary care and Ambulance service **Control Owner:** Michelle Webb	Adequate					
						update of eCasCard to accurately flag patients requiring sepsis screening in the EDs **Control Owner:** Michelle Webb	Adequate					
						VitalPac in place in all inpatient adult areas (exception labour wards) allowing for electronic capture of observations and automatic calculation of early warning risk score. **Control Owner:** Michelle Webb	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 18	Failure to comply with the recommendations in the Mazar's report which include case note review of each and every patient death **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 10 Jan 2017 **Latest Review Date:** 03 Aug 2017 **Latest Review By:** Jonathan Purday **Latest Review Comments:** Mortality Surveillance Group is meeting monthly. A SE network for mortality review has been developed. A group of consultants interested in doing mortality notes review is being collected.	24 Apr 2016	**Cause** * Insufficient capacity - 2690 deaths reported in 2015/16. Estimate that a minimum of 1345 hours of Consultant time will be required to undertake case note reviews. **Effect** * Potential failure to identify avoidable causes of death and inability to learn lessons from this. * Harm to future patients * Exposure to legal challenge * Reputational loss	AO1: Patients. Help patients take control of their own health	I = 3 L = 5 High (15)	Clinician oversight, using data from HSCIC, of all coded mortality alerting as outliers. Programme of retrospective case note review in place at divisional and corporate levels. **Control Owner:** Paul Stevens	Adequate	I = 3 L = 4 Moderate (12)	Implementation of the national tool for mortality review **Person Responsible:** Paul Stevens **To be implemented by:** 28 Jul 2017	High	**03 Aug 2017** The app is still being developed nationally	I = 3 L = 2 Low (6)
						Established programme of Mortality and Morbidity meetings across all specialties **Control Owner:** Paul Stevens	Limited					
						Mortality Surveillance Group in place - 1st meeting held in June 2016 **Control Owner:** Paul Stevens	Adequate					
						Review of M&M meetings and a template designed for presentations and for learning **Control Owner:** Helen Goodwin	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 34	Inadequate Health & Safety (H&S) systems embedded within the Divisions **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 15 Dec 2016 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No change to risk scores. Divisional deep dives planned at next IAGC (each Division to present the latest position of actions to embed H&S management within the Division)	09 Sep 2016	**Cause** * Failure to address H&S issues/incidents/themes within Divisions * Lack of appropriate H&S systems *Inconsistency in H&S processes **Effect** *Potential breach of H&S regulations which may result in penalty notices and significant fines *Harm to Staff *Reputational damage *Financial loss *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Annual H&S Toolkit Audit **Control Owner:** Elizabeth Shutler	Adequate	I = 4 L = 3 Moderate (12)	Implement training plan **Person Responsible:** Christine Hudson **To be implemented by:** 30 Jun 2017	High	**09 May 2017** Review and action to be taken at business board	I = 4 L = 2 Moderate (8)
						Divisional H&S structures in place **Control Owner:** Fin Murray	Limited		Implement action plans from the H&S toolkit audit **Person Responsible:** Lesley White **To be implemented by:** 30 Jun 2017	High	**17 May 2017** Discussed at the meeting with the Divisional Head of Nursing. Progress of this action will be tabled at the next Divisional Governance Board.	
						Divisional nominated H&S Link workers **Control Owner:** Fin Murray	Adequate		Implement action plans from the H&S toolkit audit **Person Responsible:** Christine Hudson **To be implemented by:** 30 Jun 2017	High	**09 May 2017** Being reviewed at Business Board and appropriate taken	
						H&S KPIs reported to Board monthly via the IPR **Control Owner:** Fin Murray	Adequate		Implement training plan **Person Responsible:** Mary Tunbridge **To be implemented by:** 30 Jun 2017	High	**03 Jul 2017** All TNAs now complete. Ongoing implementation of the training plan. Each Directorate provides updates around Training plan on a quarterly basis.	
						H&S module part of mandatory training for all staff **Control Owner:** Jacqui Siggers	Adequate		Implement training plan **Person Responsible:** Lesley White **To be implemented by:** 30 Jun 2017	High	**18 May 2017** Discussed at the meeting with the Divisional Head of Nursing. Progress of this action will be tabled at the next Divisional Governance Board.	
						Half yearly H&S toolkit audits for brown areas **Control Owner:** Fin Murray	Limited		Implement action plans from the H&S toolkit audit **Person Responsible:** Mary Tunbridge **To be implemented by:** 30 Jun 2017	High	**03 Jul 2017** Actions now being implemented as Business As Usual (BAU). As part of the Patient Safety visits H&S plans are also being reviewed.	
						Internal Audit Acton Plan in place **Control Owner:** Elizabeth Shutler	Limited		Implement action plans from the H&S toolkit audit **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Jun 2017	High	**26 May 2017** All specialities discuss H & S toolkit at Divisional Board highlighting compliance and exceptions.	
						Oversight by Trust Board **Control Owner:** Elizabeth Shutler	Adequate		Implement training plan **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Jun 2017	High	**26 May 2017** All relevant staff scheduled into training. Managed by Specialist Services Divisional PA.	
						Site based H&S Committee in place **Control Owner:** Fin Murray	Adequate		Transfer Divisional H&S risks to 4Risk **Person Responsible:** Lesley White **To be implemented by:** 30 Aug 2017	High	**17 May 2017** Discussed at the meeting with the Divisional Head of Nursing. Progress of this action will be tabled at the next Divisional Governance Board.	
						Site based Health and Safety Teams in place **Control Owner:** Fin Murray	Adequate					
						Strategic H&S Committee in place **Control Owner:** Elizabeth Shutler	Adequate					
						Training programme in place **Control Owner:** Fin Murray	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									Transfer Divisional H&S risks to 4Risk **Person Responsible:** Mary Tunbridge **To be implemented by:** 30 Aug 2017	High	**11 May 2017** All the directorates within CSSD have now moved their H&S risks onto the system, and are in the process of reviewing these and updating the risk as required. Progress with this will be reported in the quarterly H&S report August 2017.	
									Transfer Divisional H&S risks to 4Risk **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Aug 2017	High	**26 May 2017** Head of Nursing attended meeting 9th May 2017 re H & S risks . Wording and scoring modified on 4 risk. All actions complete.	
									Transfer Divisional H&S risks to 4Risk **Person Responsible:** Christine Hudson **To be implemented by:** 30 Aug 2017	High	**09 May 2017** H&S Divisional lead to taken forward at Business Board and appropriate will be taken	
									Divisional deep dives at IAGC (each Division to present the latest position of actions to embed H&S within the Division) **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Oct 2017	High		
									Develop and Roll out Human Factors training for high-risk Clinical and Non-Clinical areas **Person Responsible:** Fin Murray **To be implemented by:** 30 Mar 2018	Medium	**14 Jun 2017** Training planned for September 2017	
CRR 48	Challenges in embedding a mature and developed Patient safety culture across Obstetrics and Maternity **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 17 Jul 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Target risk altered. Updates made.	07 Feb 2017	**Cause** *Reports from both the Royal College of Obstetrics and Gynaecology (RCOG) and the Local Supervisory Authority (LSA) identified gaps in regulatory compliance and also other areas for improvement in maternity services *Recurrent incident themes *Difficulty in gaining engagement among some teams *Delays in prioritising quality transformation and education work streams *Low mandatory training figures (78% midwifery and 24% medical) *Failure to comply with policies/procedures **Effect** *Poor patient outcomes (potential harm to both pregnant women in our care and neonates) *Increased complaints/claims *Regulatory concerns *Reputational damage *Adverse effect on staff professional development	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Contract monitoring is in place bi-monthly with the CCGs. This provides assurance and progress against the plans and dashboard. **Control Owner:** Sharon Curtis	Adequate	I = 4 L = 3 Moderate (12)	Ensure mandatory training is prioritised and staff undertake the required training **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Jun 2017	High	**17 Jul 2017** Division did achieve 85% compliance to Mandatory Training. Skills and Drills is being arranged through the education programmes as part of the transformation work.	I = 3 L = 2 Low (6)
						Maternity Services Patient Safety Plan is in place and being implemented and monitored by the Division and Executive and CCGs. **Control Owner:** Sharon Curtis	Adequate		Produce and implement a transformation programme for Maternity which incorporates the outstanding actions from the existing action plans (including the RCOG Action Plan). **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Mar 2018	High	**17 Jul 2017** Quality Committee updates in place. Programme is going well.	
						Monthly performance meetings are in place as well as support meetings by the Executive Team. **Control Owner:** Sally Smith	Adequate					
						Support in place from the Service Improvement Team, Dr Ciaran Crowe leading transformation and the Executive team. **Control Owner:** Sally Smith	Adequate					
						The RCOG and LSA Combined Action Plan in place **Control Owner:** Graham Ross	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 41	Failure to manage Patients with challenging behaviour (Dementia and other mental health challenges) **Risk Owner:** Sally Smith **Delegated Risk Owner:** Sally Hyde **Last Updated:** 06 Apr 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed.	07 Nov 2016	**Cause** *Increased number of long-stay Patients/delayed discharge *National shortage of Mental Health Nurses **Effect** *Potential harm to Patients, Staff and Visitors	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Dementia friendly services, environment and specialist team **Control Owner:** Sally Smith	Adequate	I = 3 L = 4 Moderate (12)	Monitor compliance with the Smart tool usage through the Safeguarding & Dementia teams **Person Responsible:** Jane Christmas **To be implemented by:** 31 Aug 2017	High	**17 Jul 2017** Review of SAFE-ASSIST in progress.	I = 3 L = 3 Moderate (9)
						Psychiatric Liaison services to the EDs and UCC is 7 days per week and into the evening where patients are a seen and treated. **Control Owner:** Sally Smith	Adequate					
						Smart tool usage at Wards & Departments with Patients who display challenging behaviour **Control Owner:** Sally Hyde	Limited					
						Specialling Policy is in place **Control Owner:** Sally Smith	Adequate					
						Use of NHSP registered mental health nurses **Control Owner:** Sally Smith	Limited					
						Use of Safe Assist to maintain safety of Patients and Staff **Control Owner:** Fin Murray	Adequate					
CRR 32	Inability to share information about children and young people **Risk Owner:** Sally Smith **Delegated Risk Owner:** Trish Hubbard **Last Updated:** 26 May 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Updates made.	12 Aug 2016	**Cause** * Notice of cessation of the Children and Young Persons Liaison Service by the CCG from September 2016 **Effect** * Potential lack of recognition of frequent offenders and safeguarding concerns going unrecognised * Reputational damage * Legal challenge	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 4 L = 4 High (16)	Information sharing has been agreed across agencies. **Control Owner:** Carol Tilling	Adequate	I = 4 L = 3 Moderate (12)	To explore the addition of the Safeguarding review with the GP letter electronically. **Person Responsible:** Carol Tilling **To be implemented by:** 31 Aug 2017	High	**17 Jul 2017** New due date because of delays outside our control.	I = 4 L = 2 Moderate (8)
						Interim arrangements in place after the closure of the service - process for identifying children at risk in the EDs by the Child Safeguarding Team. **Control Owner:** Carol Tilling	Adequate					
CRR 16	Poor complaints management **Risk Owner:** Sally Smith **Delegated Risk Owner:** Jane Christmas **Last Updated:** 09 Feb 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Reviewed and updated	24 Apr 2016	**Cause** -There is an increasing complexity in the scope and nature of concerns raised. - The processes in divisions and within the Patient Experience Team have resulted in delays across the whole pathway. - There is a gap in communication between the PET and the divisional governance teams. - The divisional teams do not receive timely notification of written complaints. - Staff shortages are impacting on the management of complaints. **Effect** - The ability of the Trust to respond to the agreed first response time frame and within the 30 days of receipt is not being met consistently. - The time-frame agreed with the complainant is often being met but the quality of the Trust's response is sometimes failing to meet expectation. - There are a number of returners and dissatisfaction - Reputational loss	AO1: Patients. Help patients take control of their own health	I = 3 L = 5 High (15)	Complaints team in place with staff based on the three main sites. **Control Owner:** Jane Christmas	Adequate	I = 3 L = 4 Moderate (12)	Work with HR Systems to ensure training records are captured. **Person Responsible:** Jane Christmas **To be implemented by:** 30 Jun 2017	Low	**12 Jun 2017** Awaiting update.	I = 3 L = 3 Moderate (9)
						Process is in place to prevent data capture anomalies **Control Owner:** Jane Christmas	Adequate		A training programme needs to be developed and implemented for staff according to a training needs analysis. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Aug 2017	Medium	**12 Jun 2017** Trust wide TNA in progress and annual programme in development . over seen by the complaints steering group, completion of these plans / programme is scheduled August 2017	
						Regular review of the complaint KPIs with Divisional leads **Control Owner:** Jane Christmas	Adequate					
						The Datix system is used to record complaints and Trust responses. This system can monitor agreed time scales and record satisfaction with the responses. **Control Owner:** Helen Goodwin	Adequate		Implement a web-based complaints management system to interface with the existing web-based incident system. **Person Responsible:** Jane Christmas **To be implemented by:** 30 Sep 2017	High	**17 Jul 2017** Behind time, but project plan now progressing. September is the new completion.	
						The PET provide support and specific training in the management of complaints to staff in all clinical and non-clinical divisions. **Control Owner:** Sally Smith	Limited					
						The Trust responds to its legal and professional duty of candour **Control Owner:** Paul Stevens	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 40	Lack of robust antenatal and new-born screening programmes **Risk Owner:** Sally Smith **Delegated Risk Owner:** Rachael Chapman **Last Updated:** 30 Jun 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Detailed review undertaken.	07 Nov 2016	**Cause** *Lack of the awareness in the importance of offering haemoglobinopathy screening, the timeframes involved and the need to meet national standards. *Lack of tracking through the pregnancy adequately, including checking blood test results. *Lack of adequate follow up plan for women who have consented to screening and not had the blood test taken. *Discrepancy between documentation in hand held record and electronic records. *Obstetric ultrasound capacity utilisation is currently >95% *Lack of robust fail safe for the FASP screening program *NIPE Poor tracking of neonatal health care records *NIPE suspected congenital dislocation of the hips, lack of awareness within the radiology of the two week pathway. *New born blood spot screening programme, poor understanding of the national requirements within the acute hospital setting in particular NICU and SCBU. *Poor administration/process management and monitoring *PACS and RIS have further impacted on the First trimester and Fetal anomaly screening programmes **Effect** *Non-compliance with National Standards (haemoglobinopathy; chromosomal abnormalities (Down's or Edwards'/Patau's syndromes); Congenital dislocation of the hip; NIPE (newborn physical examinations); newborn blood spot) *Potential harm to unborn and new born babies *Delay in diagnosis of foetal abnormality *Legal challenge *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Antenatal Screening Steering Group in place for all stakeholders of the Screening Programme **Control Owner:** Rachael Chapman	Limited	I = 3 L = 4 Moderate (12)	Implement workforce and recruitment plans to address staffing shortfalls in imaging and retention of skilled ultra-sonographers **Person Responsible:** Lorraine Young **To be implemented by:** 31 Mar 2017	High	**24 May 2017** Awaiting update from Division	I = 3 L = 2 Low (6)
						Electronic referral system for US scan in place **Control Owner:** Rachael Chapman	Adequate					
						Fail safe tracking system for the New born blood spots screening programme (National/Local database) **Control Owner:** Rachael Chapman	Limited		Workforce and recruitment plans to address staffing and create resilience within the current service **Person Responsible:** Sharon Curtis **To be implemented by:** 01 Sep 2017	High	**19 Jun 2017** Band 7 vacancy filled across Trust Band 6 vacancy now very low Band 5 vacancy filled awaiting new starters in June Additional workforce given to screening team to assist in implementing failsafe checks for screening i.e. admin& NIPE Lead Work underway to resource ultra-sonography both inside and outside the Trust.	
						FASP - Daily review of demand, potential breaches and allocating appointments **Control Owner:** Rachael Chapman	Adequate					
						FASP - Escalation process in place to accommodate requests for first trimester scans when there is a late booking and to highlight women due to have scans within timelines **Control Owner:** Rachael Chapman	Limited		Nominate midwives and MCAs as 'blood spot champions' who will be trained in taking and checking NBS in the acute setting and be the nominated person to undertake the screening test when on duty **Person Responsible:** Rachael Chapman **To be implemented by:** 29 Dec 2017	Medium	**12 Jul 2017** Blood spot champions are being trained. Recent data has demonstrated that more avoidable repeats NBS come out of NICU at WHH. The NICU ward manager has invited the screening support midwife to present a teaching a session to nurses who, it is hoped, will be the nominated person for NBS on the ward. Nurses from Padua and the children's assessment units are also being invited.	
						FASP - Fail safe tracking system for combined screening for chromosomal abnormalities (Down's or Edwards'/Patau's syndromes) **Control Owner:** Rachael Chapman	Limited					
						FASP - Monthly meetings held between Maternity and Ultrasound teams **Control Owner:** Rachael Chapman	Limited		Rollout of New Born Blood Spot training and education to Nurses in SCBU/NICU and Postnatal Ward **Person Responsible:** Rachael Chapman **To be implemented by:** 29 Dec 2017	Medium	**12 Jul 2017** Training has commenced	
						IDSP/SCT - Community midwives keep a form of log book to check screening results within the recommended period. **Control Owner:** Rachael Chapman	Limited		Review and update the postnatal screening guidelines incorporating new standards. **Person Responsible:** Rachael Chapman **To be implemented by:** 29 Dec 2017	High		
						Mandatory training and education programmes is in place for midwives across the Trust. **Control Owner:** Rachael Chapman	Adequate					
						Maternity Information Task and Finish Group in place to review the Maternity Pathway **Control Owner:** Hannah Horne	Limited					

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						NIPE Smart System in place (tracking fail safe system for new born examination and referral for any abnormalities including hips) **Control Owner:** Rachael Chapman	Limited		Create a robust tracking system to follow women from booking to receiving their results for Fetal Anomaly Screening Programme. **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Mar 2019	High	**30 Jun 2017** 30-06-2017 The Trust has plans to implement a live web-based patient tracking system (PTL) in order to ensure all relevant maternity patients have their scans and blood tests performed in a timely manner. In order to do this, various data quality and system process have to be designed, and this work is being monitored through a working group as part of the Maternity Transformation work. It is envisioned that this PTL will be in place by 2018/19.	
						Nominated person appointed to oversee the NIPE screening program. **Control Owner:** Jeanett Salisbury	Adequate					
						Principal Sonographer reviews the number of women needing to be recalled for second trimester screening **Control Owner:** Rachael Chapman	Adequate		Maternity Information Task and Finish Group to review the maternity pathway (including standardising the booking process) **Person Responsible:** Hannah Horne **To be implemented by:** 31 Mar 2019	High	**12 Jul 2017** In early development	
						Screening guidelines in place and available to staff on SharePoint, Antenatal, Post-natal, Infectious diseases etc. **Control Owner:** Rachael Chapman	Limited					
						Short term planning in place to increase obstetric ultrasound capacity by introducing one appointment only for the nuchal/dating scan. **Control Owner:** Rachael Chapman	Limited					
CRR 12	Inadequate Ophthalmology follow up arrangements **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Christine Hudson **Last Updated:** 25 May 2017 **Latest Review Date:** 09 Jun 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Implementation of the Open Eyes software continues to be rolled out and the new Ophthalmology consultants are in post. However, it will take time to reduce the backlog and the consequence is that there are still instances of delay in treatment pathways leading to harm.	23 Feb 2016	**Cause** Due to historic PAS systems, the true patient follow up capacity gap has never been visible. Partial booking has given transparency to the issues facing patients requiring regular follow up. Ophthalmology specialties provide services in predicted high growth areas and these are expected to further increase with an aging demographic. **Effect** There are 7,550 patients waiting for a follow up appointment outside of their required timeframe to be seen. Nearly 1,500 patients are being validated as they are not indicated at speciality level. Therefore nearly 5,500 patients have been escalated as requiring an appointment that is overdue and require urgent follow-up within the specialty. There is a lack of out-patient capacity to manage the backlog and maintain the current patient cohort.	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	6 new consultant Ophthalmology posts have been recruited to **Control Owner:** Nicholas Goodger	Adequate	I = 4 L = 3 Moderate (12)	Implementation of the next phase of Open Eyes record management software **Person Responsible:** Christine Hudson **To be implemented by:** 29 Dec 2017	High	**17 May 2017** Open eyes roll out has commenced, broken down into sub-specialties. Cataracts live, emergency and medical retina being mapped to go live. Rest of the specialities to follow. Looking to a 6 month roll out completion.	I = 4 L = 2 Moderate (8)
						A pathway has been developed for the commissioners to enable the safe transfer of stable follow up glaucoma and WET AMD patients into the community **Control Owner:** Paul Stevens	Limited					
						Open Eyes software has been introduced to facilitate ophthalmological patient flow and follow. **Control Owner:** Paul Stevens	Adequate					
						Ophthalmology transformation strategy in place **Control Owner:** Paul Stevens	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 46	Delays in signing off and implementing Consultant job plans **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 23 Jun 2017 **Latest Review Date:** 03 Aug 2017 **Latest Review By:** Jonathan Purday **Latest Review Comments:** The new job planning policy has nearly been completed but methods to ensure the regular use of diary cards particularly to show hours of work undertaken during 'on call' periods are lacking	02 Feb 2017	**Cause** Complexity of job planning not well understood Original timetable was not realistic Competing demands **Effect** *Potential mismatch between capacity and demand. *Potential Poor Patient outcomes *Reputational damage *Unknown impact on financial plan *Negative impact on clinical engagement	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 4 High (16)	Job planning policy in place **Control Owner:** Paul Stevens	Limited	I = 4 L = 3 Moderate (12)	Finalise remaining job plans **Person Responsible:** Elhussein Rfidah **To be implemented by:** 31 Mar 2017	High	**13 Jun 2017** 44 out of 74 job plans completed (59%). Of the remaining 41%, 30%are in discussion and the remaining in progress).	I = 3 L = 2 Low (6)
						Job Plans in place **Control Owner:** Sandra Le Blanc	Limited		Finalise remaining job plans **Person Responsible:** Nicholas Goodger **To be implemented by:** 31 Mar 2017	High	**13 Jun 2017** 108 out of 147 job plans completed (73%). Of the remaining 27%, 18% are in discussion and the remaining in progress).	
									Finalise remaining job plans **Person Responsible:** Anne Greenhalgh **To be implemented by:** 31 Mar 2017	High	**13 Jun 2017** 46 out of 53 job plans completed (87%). Of the remaining 13%, 9% are in discussion and the remaining in progress).	
									Finalise remaining job plans **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Mar 2017	High	**13 Jun 2017** 30 out of 91 job plans completed (33%). Of the remaining 67%, 49%are in discussion and the remaining in progress).	
									Produce detailed analysis of job plans to ensure consistency of approach across the Trust **Person Responsible:** Paul Stevens **To be implemented by:** 28 Apr 2017	High	**30 May 2017** Some definite progress has been made. Support services division are virtually 100% job planned and specialist services are also virtually complete. The hold up has been in both surgical services and UC-LTC but again progress is being made. For those who have yet to complete the process the legal position in terms of visiting a job plan upon them is being checked.	
									Consultants who their job plans have not been approved will receive a letter from the Medical Director's office presenting a default Job plan - if not accepted will go to mediation **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Jul 2017	High		
									Review the job plan policy **Person Responsible:** Jonathan Purday **To be implemented by:** 29 Sep 2017	High	**20 Jun 2017** It's important that we get the Job Plan policy fit for purpose. There is therefore a delay until early September 2017.	
									Develop a diary card type review of commitments **Person Responsible:** Paul Stevens **To be implemented by:** 27 Oct 2017	Medium	**12 Jun 2017** Action reliant on Divisions completing the Job Planning	

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 53	Failure to deliver the CQUIN programme for 2017/18 **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 17 Jul 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Impact score increased.	18 Apr 2017	**Cause** *National schemes are very challenging *Communication of CQUINS inconsistent across Divisions *Lack of capacity and allocated resources to focus on the delivery of the CQUIN programme **Effect** Loss of income	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Designated leads for each scheme **Control Owner:** Sally Smith	Adequate	I = 4 L = 3 Moderate (12)	Produce and roll-out implementation plans for schemes **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2018	High	**17 Jul 2017** Meeting with CCGs in July - awaiting final confirmation.	I = 3 L = 2 Low (6)
						Monthly monitoring to ensure delivery of programme/no slippage **Control Owner:** Sally Smith	Limited					
						Two Programme Managers responsible for delivering programme **Control Owner:** Sally Smith	Adequate					
CRR 39	Delays in Radiological reporting **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Paul French **Last Updated:** 09 May 2017 **Latest Review Date:** 11 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by the Delegated Risk Owner. No change in risk scores. Recruitment progressing. Average (internal) average time on report waiting list 10.57days. 2 Week Wait average time on report waiting list CT 7.79 days and MRI 3.74 days.	04 Oct 2016	**Cause** *Increased demand *Lack of reporting capacity - Radiologist and Reporting Radiographers *Problems with PACS and RIS *Lack of scan capacity *Gaps in workforce (including staff turn over within Consultant Radiologist team) **Effect** *Failing to consistently meet 2WW and 18 week pathway access standards *Delays in Patients diagnosis and start of treatment *Potential harm to Patients *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	A number of weekday and weekend consultants are in place; and substantive radiologist in place **Control Owner:** Paul French	Limited	I = 4 L = 3 Moderate (12)	Source substantive and fixed term radiologist **Person Responsible:** Paul French **To be implemented by:** 31 Aug 2017	High	**11 Jul 2017** One Fixed term commenced appointment on 19/06/17. Three awaiting start date - 2 fixed term and 1 substantive. Two of three expected to commence in September and the third to commence October	I = 4 L = 2 Moderate (8)
						Additional outsourcing of reports. Increased allocation to existing providers and engagement with another company. **Control Owner:** Paul French	Adequate					
						Ca pathway and urgent referrals are prioritised by CT/ MRI, **Control Owner:** Paul French	Limited					
						Reporting of CT & MRI capacity. Review of activity against reporting. **Control Owner:** Paul French	Limited					
						Two full time locum radiologists in place and adhoc at weekends **Control Owner:** Paul French	Limited					

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 7	Potential delayed treatment of patients requiring emergency acute general surgery intervention at the Kent and Canterbury Hospital site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 20 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Since the 19th June 2017 there have been no further acute general medical admissions to the K&CH site. We do not yet know what the impact has been on the potential for inpatients on the K&CH site to require acute general surgical intervention	10 Feb 2016	**Cause** There is only provision for specialist vascular and urology surgery on the Kent and Canterbury site. In the past general surgical intervention, when needed, was covered by vascular surgeons. With the introduction and further development of Specialist Medical Training (Calman Report) the ability of surgeons to be deemed competent to perform procedures outside their registered speciality has decreased. **Effect** Patients requiring acute general surgical intervention are occasionally transferred or self-present to the K&CH site and require subsequent transfer to either the WHH or QEQMH after stabilisation. Some vascular surgeons do maintain core clinical competencies for general surgery but there is no acute general surgical rota at the K&CH site and this can result in delays to treatment.	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Change to SECAmb conveyance criteria to prevent patients with acute general surgical emergencies being conveyed to the K&CH site. These changes became live on the 9th May 2016. Further changes have occurred on 19th June 2017 when acute medical admissions are diverted to QE and WHH **Control Owner:** Paul Stevens	Adequate	I = 5 L = 2 Moderate (10)	Implement the communication strategy across East Kent to signpost availability of acute services led by the Trusts communications department **Person Responsible:** Jonathan Purday **To be implemented by:** 19 Dec 2017	Not Set	**20 Jun 2017** This communication strategy has commenced	I = 2 L = 2 Low (4)
						Clarity of the function of the K&CH site as not having the capability to manage general surgical emergencies communicated to external partners including SECAmb and GPs. **Control Owner:** Paul Stevens	Adequate		Implementation of the East Kent Clinical Strategy through the Kent & Medway STP process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**09 Jun 2017** There is a risk that consultation may be further delayed until April 2018	
						Clear guidance for the transfer of patients with possible surgical pathology to the acute sites (WHH & QEQMH) written, agreed and put in place 10th March 2016 **Control Owner:** Nicholas Goodger	Adequate					
						Emergency Care Centre re-designed to provide a Primary Care led Urgent Care Centre and a Minor Injuries Unit **Control Owner:** Paul Stevens	Adequate					
						Rapid assessment of patients and transfer out to the WHH and QEQMH or competent vascular surgical intervention at the K&CH, **Control Owner:** Paul Stevens	Adequate					
CRR 30	Failure to implement the Accessible Information Standard **Risk Owner:** Sally Smith **Delegated Risk Owner:** Bruce Campion-Smith **Last Updated:** 21 Oct 2016 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Reviewed and no change.	12 Aug 2016	**Cause** * No implementation plan * Failure to identify and recorded information and communication needs with service users **Effect** * Legal challenge from service users, support groups and charities * Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 3 L = 4 Moderate (12)	Action plan in place with monthly monitoring at the meetings. **Control Owner:** Bruce Campion-Smith	Limited	I = 3 L = 3 Moderate (9)	Implement Accessible Information Standard Action Plan **Person Responsible:** Bruce Campion-Smith **To be implemented by:** 31 Dec 2017	High	**17 Jul 2017** On track	I = 3 L = 2 Low (6)
						Audit tool in place. **Control Owner:** Bruce Campion-Smith	Adequate					
						Diversity and Inclusion Steering Group in place. **Control Owner:** Bruce Campion-Smith	Adequate					

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 6	Ineffective Clinical Audit Programme (including National Audits, Audit of the implementation of NICE guidance, compliance of NCEPOD recommendations and key local audits) **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Robin Ufton **Last Updated:** 24 May 2017 **Latest Review Date:** 12 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by the Delegated Risk Owner (Robin Ufton). No change in risk scores. The Clinical Audit Team are currently producing the first quarterly progress report which will be shared with the Divisions by August 2017. Report to be presented to the Quality Committee and the CAEC in September 2017.	09 Feb 2016	**Cause** * Lack of consistent participation in all areas of the national clinical audit programme * Limited audit of implementation of NICE guidance and compliance with NICE Quality Standards * Limited audit of compliance with NCEPOD recommendations * Inconsistent completion of divisional clinical audits **Effect** * The Trust is unclear of the areas where improvements are required * Loss of opportunities to learn from audits * Reduced standards of care	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 3 L = 4 Moderate (12)	Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Elhussein Rfidah	Limited	I = 3 L = 3 Moderate (9)	Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Nicholas Goodger **To be implemented by:** 31 Mar 2018	High	**12 Jul 2017** The Clinical Audit Team are currently producing the first quarterly progress report which will be shared with the Divisions by August 2017. Report to be presented to the Quality Committee and the CAEC in September 2017.	I = 2 L = 2 Low (4)
						Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Anne Greenhalgh	Limited		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Mar 2018	High	**12 Jul 2017** The Clinical Audit Team are currently producing the first quarterly progress report which will be shared with the Divisions by August 2017. Report to be presented to the Quality Committee and the CAEC in September 2017.	
						Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Jonathan Purday	Limited		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Anne Greenhalgh **To be implemented by:** 31 Mar 2018	High	**12 Jul 2017** The Clinical Audit Team are currently producing the first quarterly progress report which will be shared with the Divisions by August 2017. Report to be presented to the Quality Committee and the CAEC in September 2017.	
						Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Nicholas Goodger	Limited		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Elhussein Rfidah **To be implemented by:** 31 Mar 2018	High	**12 Jul 2017** The Clinical Audit Team are currently producing the first quarterly progress report which will be shared with the Divisions by August 2017. Report to be presented to the Quality Committee and the CAEC in September 2017.	
						Quarterly review of progress against the Clinical Audit Programme **Control Owner:** Robin Ufton	Limited					
						Six key improvement areas agreed with Divisions **Control Owner:** Robin Ufton	Limited					
						There are other quality improvement programmes in place that are nationally, regionally and locally driven that support the Trust clinical audit activity e.g. Renal Registry Returns, National Diabetes Returns **Control Owner:** Paul Stevens	Adequate					
CRR 19	Delays in the cancer pathway of over 100 days **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Paul Stevens **Last Updated:** 23 Jun 2017 **Latest Review Date:** 09 Jun 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Date for JAG inspection is set for September 2017. Latest data reviewed in the executive performance reviews is unchanged	24 Apr 2016	**Cause** * Diagnostic delays predominantly in the colorectal and prostate cancer pathways (access to endoscopy and MRI diagnostics) * Lack of outpatient capacity * Lack of treatment capacity **Effect** * Possible harm to Patients * Reputational damage * Regulatory concerns *Loss of STF	AO1: Patients. Help patients take control of their own health	I = 3 L = 4 Moderate (12)	Diagnostic capacity is reviewed at the KPI meeting and also within the Clinical Support Divisions **Control Owner:** Trish Hubbard	Limited	I = 3 L = 3 Moderate (9)	Agreement of the pathway for presentation of cancer of unknown primary **Person Responsible:** Trish Hubbard **To be implemented by:** 31 Aug 2017	High	**30 May 2017** The current route for the cancer of unknown primary is through the Upper GI MDT. This needs reviewing to ensure that timely review of these patients is being accomplished	I = 3 L = 2 Low (6)
						Increased endoscopy resource achieved through outsourcing using an agency contract which will run for 1 year whilst internal resource is being created **Control Owner:** Lisa Neal	Adequate		Achieve JAG accreditation of WHH endoscopy unit **Person Responsible:** Lisa Neal **To be implemented by:** 29 Sep 2017	High	**09 Jun 2017** Date for JAG inspection is set for September 2017 and therefore this action cannot be completed until then.	
						Process outlined for clinicians to complete initial screening of pathway delays **Control Owner:** Jane Ely	Adequate		Replacement of the MRI scanner in Canterbury **Person Responsible:** Mary Tunbridge **To be implemented by:** 29 Dec 2017	High	**25 Jul 2017** AERA 1.5T scanner commissioned. SKYRA 3T scanner on schedule for October 2017	
						Tracking system in place with an updated position disseminated weekly. **Control Owner:** Jane Ely	Adequate		Complete accredited training for surgeons undertaking endoscopy **Person Responsible:** Nicholas Goodger **To be implemented by:** 31 Dec 2017	High	**23 May 2017** 2 surgeons now reached their accreditation and 2 more being trained	
						Use of Datix incident reporting for all delayed cancer patients to improve visibility of patient affected. **Control Owner:** Helen Goodwin	Adequate					

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CRR 9	Inadequate Planned Preventative Maintenance of clinical equipment **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Julie Barton **Last Updated:** 18 May 2017 **Latest Review Date:** 03 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by delegated risk owner (Julie Barton). No change in risk scores. Progress updates added to actions.	22 Feb 2016	**Cause** * Lack of delivery of a servicing plan * Poor staff capacity to service equipment on a rolling basis * Lack of knowledge of equipment that need servicing **Effect** * Clinical equipment in direct Patient use will have passed their target date for PPM * Potential harm to Patients	AO3: Provision: Provide the services needed and do it well	I = 3 L = 4 Moderate (12)	All equipment previously managed by Estates are included in the PPM Programme **Control Owner:** David Attwell	Adequate	I = 3 L = 3 Moderate (9)	Recruitment to the additional staff outlined within the business case to enable the planned preventative maintenance of clinical equipment. **Person Responsible:** David Attwell **To be implemented by:** 31 Jul 2017	High	**03 Jul 2017** <3wte vacancies remain the same. However. redeployment from other teams/services due to be implemented in July.	I = 2 L = 2 Low (4)
						Each major site has access to an equipment library where items are cleaned and checked before re-use **Control Owner:** Paul Stevens	Adequate		Ensure Community Respiratory Equipment owned by the Trust are included in the PPM Programme **Person Responsible:** David Attwell **To be implemented by:** 31 Aug 2017	Medium	**03 Jul 2017** All devices previously managed by Estates are now with EME. Cardiology lung function equipment has been ordered. Implementation planned for August 2017. Co-located room for EME within respiratory clinics have been identified. Attention is focused on the patient pathway and integration of the CPAP and BiPAP equipment.	
						High risk clinical equipment is purchased with servicing and support arrangements as part of the contractual terms and maintained throughout the asset life of the equipment. **Control Owner:** Paul Stevens	Adequate					
						Monitoring of compliance formally by the Medical Devices Management Group and also informally by the Improvement Board Delivery Group **Control Owner:** Julie Barton	Adequate					
						The medical device co-ordinators have attended all clinical areas to raise awareness of this issue, and encourage ward / clinical staff to report overdue equipment to EME. **Control Owner:** Paul Stevens	Adequate					
						The Trust purchased a new database (F2) to identify, control and manage all equipment used in the care and management of patients. Wards and departments have access to the F2 database through the departmental device register link on all trust computers - this enables ward / dept managers to monitor and manage the maintenance of equipment in their areas. **Control Owner:** Paul Stevens	Adequate					

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CRR 8	Lack of timely mental health interventions for Patients with mental health problems **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 13 Jun 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** On track	22 Feb 2016	**Cause** *They are unable to recruit into their current vacancies and they have relied on agency cover to maintain their rotas. *There is a national shortage of in-patient mental health beds. **Effect** *Patients with recognised mental health disorders may not be treated in a timely way. *There are an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. *Other patients and staff are put at risk of harm from violent episodes. *Patients who require in-patient mental health care are managed in acute facilities which are not fit for this purpose.	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	Agency RMN used **Control Owner:** Jane Ely	Adequate	I = 3 L = 3 Moderate (9)	Seek CQC registration for the care of mental health patients in the ED. **Person Responsible:** Alison Fox **To be implemented by:** 31 Dec 2017	Low	**24 May 2017** In progress and in hand.	I = 3 L = 2 Low (6)
						Agreed SOP in place to order additional nursing staff when a mental health patient has attended or is admitted. RMN, then RN, the HCA if the others are not available. **Control Owner:** Sally Smith	Adequate		Plans being formulated to ensure 24 hour cover across the Trust by 2020. Mental Health Commissioner locally is leading the commissioning intentions up to this date. **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2020	Medium	**17 Jul 2017** On track	
						Increase in cover arrangements for a 12 hour period across all 3 sites in place **Control Owner:** Jane Ely	Adequate					
						Nominated consultant psychiatric cover for each site with Band 7 RMN and 5xBand 6 support to cover 08.00 to 20.00 hours. **Control Owner:** Jane Ely	Adequate					
						Regular escalation and meetings between the Trust COO and the COO of KMPT and the CCGs is in place. **Control Owner:** Jane Ely	Adequate					
						Single point of access for referrals for emergency and urgent patients from 01 April 2016 with a separate crisis team covering this area. Arrangements for other patients, including self-referrals and existing patients set up through GPs and NHS111. **Control Owner:** Jane Ely	Adequate					

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CRR 13	Inability to fund an adequate asset replacement programme for high cost and high risk medical equipment approaching the end of their asset life **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 18 May 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No change to risk scores. Only one outstanding action to implement - recruitment to agreed establishment for EME.	23 Feb 2016	**Cause** There has been a reduction in the capital allocation for replacement and updating of high cost essential clinical equipment. **Effect** Items of clinical equipment has reached the end of its asset life and requires increased maintenance and support in order to ensure that safety is maintained and reduce the likelihood of failure.	AO1: Patients. Help patients take control of their own health	I = 3 L = 4 Moderate (12)	Prioritised list of high cost medical equipment in place **Control Owner:** Fin Murray	Adequate	I = 3 L = 3 Moderate (9)	Recruitment up to new agreed establishment for EME **Person Responsible:** Julie Barton **To be implemented by:** 31 Jul 2017	High	**03 Jul 2017** <3wte vacancies remain the same. However. redeployment from other teams/services due to be implemented in July.	I = 3 L = 2 Low (6)
						Prioritised list of replacement equipment for 2017/18 in place **Control Owner:** Sarah Charman	Adequate					
						Risk based approach to re-prioritising the capital programme in place **Control Owner:** Elizabeth Shutler	Adequate					
						The Medical Devices Group prioritises the replacement programme using a risk-based model outlined in the Medical Devices Policy. **Control Owner:** Elizabeth Shutler	Adequate					
						The Planned Preventive Maintenance Programme identifies and manages equipment used in the care of patients **Control Owner:** Julie Barton	Adequate					
						There is an annual capital allocation, under the auspices of the Medical Devices Group that make decisions on the priorities for purchase and replacement. **Control Owner:** Fin Murray	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 36	Inadequate Adult Safeguarding training arrangements Trust-wide **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 10 May 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Reviewed - no changes	09 Sep 2016	**Cause** *Lack of access to current training data *Failure to prioritise training attendance **Effect** *Regulatory concerns *Legal challenge *Reputational loss	AO2: People: Identify, recruit and develop talented staff	I = 3 L = 4 Moderate (12)	Adult Safeguarding training delivered by e-Learning **Control Owner:** Helen Goodwin	Adequate	I = 3 L = 3 Moderate (9)	Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Heather Munro **To be implemented by:** 31 Mar 2018	High	**30 Jun 2017** 79% for May 17 - (with the trust Av of 77%) unfortunately we are below ULTC and CSSD whom are 84% this area of training is included within our CQC action plan and monitored via the old improvement board and EPR I assume we will continue to monitor via a group but it would be good to which one?	I = 3 L = 2 Low (6)
						Monthly training sessions on all sites **Control Owner:** Helen Goodwin	Limited					
						Safeguarding Team in place **Control Owner:** Sally Smith	Adequate		Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Elisa Steele **To be implemented by:** 31 Mar 2018	High	**18 Jul 2017** Level 2 compliance is at 83%.	
						Training needs analysis and Training Programme in place **Control Owner:** Helen Goodwin	Adequate		Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2018	High	**18 Jul 2017** Level 2 compliance is at 88%.	
									Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2018	High	**18 Jul 2017** Level 2 compliance is at 68%. Specific training sessions booked through the summer to address this.	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 20	Failure to send timely information to GPs on their patients who have had an outpatient appointment **Risk Owner:** Jane Ely **Delegated Risk Owner:** Mary Tunbridge **Last Updated:** 13 Jun 2017 **Latest Review Date:** 06 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jana e Ely. No change in risk scores.	24 Apr 2016	**Cause** * Lack of knowledge of performance standards * Lack of consistent monitoring of performance standards * Gaps in administration workforce e.g. ENT **Effect** * Failure to meet performance standard * Patients ongoing care is delayed * Reputational damage * Potential harm to Patients *Increased pressure on staff leading to low staff morale	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 2 L = 5 Moderate (10)	Deep-dives carried out with corresponding action plans in place **Control Owner:** Mary Tunbridge	Limited	I = 2 L = 4 Moderate (8)	Roll-out OpenEyes system to enable letters to Ophthalmology Patients be produced in a timely manner **Person Responsible:** Andrew Barker **To be implemented by:** 30 Jun 2017	High	**15 May 2017** Deadline not met. The first stage roll out takes it to June 2017. Revised deadline to be determined then. In the meantime, the Surgical Division are still working on improved letter generation in the normal way.	I = 2 L = 2 Low (4)
						Performance standards for response times agreed and monitored against the standards **Control Owner:** Mary Tunbridge	Limited					
						Regular feedback from GPs highlighting concerns **Control Owner:** Mary Tunbridge	Adequate		Trust-wide Administrative review to ensure design of new roles to focus on patients pathway (including ensuring correspondence are delivered in a timely way) - part of CIP programme **Person Responsible:** Christine Hudson **To be implemented by:** 31 Oct 2017	High		
						Typing of letters outsourced to an external provider with clear turnaround targets **Control Owner:** Mary Tunbridge	Adequate		Recruit into Administrative positions identified by Divisions as having an impact. **Person Responsible:** Jane Ely **To be implemented by:** 29 Dec 2017	High	**06 Jul 2017** Ongoing. Gaps are flagged at EPR.	
									Implement Divisional GP Letter Action Plans **Person Responsible:** Mark Dwyer **To be implemented by:** 30 Mar 2018	High	**13 Jun 2017** Progress reported at EPR monthly	
									Implement Divisional GP Letter Action Plans **Person Responsible:** Christine Hudson **To be implemented by:** 30 Mar 2018	High	**13 Jun 2017** Progress reported at EPR monthly	
									Implement Divisional GP Letter Action Plans **Person Responsible:** Lesley White **To be implemented by:** 30 Mar 2018	High	**13 Jun 2017** Progress reported at EPR monthly	
									Implement Divisional GP Letter Action Plans **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Mar 2018	High	**26 May 2017** All areas have actions plans and recovery trajectory. One area flagging red with detailed recovery plan	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 31	Exposure to Cyber Security Attacks **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Robert Nelson **Last Updated:** 08 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No change to risk scores. Actions progressing well and updated to reflect current position.	12 Aug 2016	**Cause** * External hacking *Staff non-compliance with internal processes * Unpatched or unsupported operating systems **Effect** * Loss to Trusts systems confidentiality and availability * Reputational damage * Potential financial and legislative penalties * Financial loss	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Home and Mobile working processes in place **Control Owner:** Robert Nelson	Limited	I = 4 L = 2 Moderate (8)	Review the removable media process/controls to ensure all access as some is required for clinical use. **Person Responsible:** Mark Williams **To be implemented by:** 31 Aug 2017	High	**17 Jul 2017** On review we cannot remove all access as some is required for clinical use. We are applying a more restrictive policy and this is currently under test.	I = 3 L = 1 Very Low (3)
						Incident management in place for reporting on cyber incidents **Control Owner:** Robert Nelson	Adequate		Complete the implementation of new network monitoring **Person Responsible:** Mark Williams **To be implemented by:** 31 Aug 2017	High	**17 Jul 2017** New solution procured and initial installation underway. Due complete phase in 2nd half on August 2017.	
						Information risk management regime in place **Control Owner:** Robert Nelson	Adequate		Install Application Delivery Controllers with application firewall **Person Responsible:** Mark Williams **To be implemented by:** 15 Sep 2017	High	**17 Jul 2017** ADC controllers are currently in procurement process. Due tocomplete mid August with rollout starting September 2017.	
						Information Sharing Agreements (ISAs) in place with some third parties for access to Trust information **Control Owner:** Michael Doherty	Adequate		Set up and migration of medical devices secure network overlay **Person Responsible:** Mark Williams **To be implemented by:** 29 Sep 2017	High	**17 Jul 2017** Medical devices network overlay is now complete and devices are in a migration to this.... Around 30% of devices already migrated and IT are working with EME and suppliers to migrate the rest. This is a significant task and likely to take up to a year to migrate the majority. Other trusts are looking to adopt our approach in this area.	
						IT Technical Security Assurance Group in Place **Control Owner:** Mark Williams	Adequate		Complete testing of the Disaster Recovery processes **Person Responsible:** Mark Williams **To be implemented by:** 29 Sep 2017	High	**17 Jul 2017** This issue is picked up in IT Risks 77 & 78 and as of 01/07/17 was making good progress.	
						Malware prevention in place **Control Owner:** Robert Nelson	Adequate		Complete the move of SSSP to electronic system **Person Responsible:** Mark Williams **To be implemented by:** 29 Sep 2017	High	**17 Jul 2017** The 6 main systems have now been migrated to DocIT and other systems in progress. This work is being led under the Resilience Group.	
						Management of user privileges in place **Control Owner:** Robert Nelson	Adequate					
						Network Security in place (e.g. Boundaries, firewalls and internet gateways) **Control Owner:** Robert Nelson	Adequate					
						Ongoing monitoring in place taking into account previous security incidents and attacks and other factors **Control Owner:** Robert Nelson	Limited					
						Regular audits of electronic access to systems **Control Owner:** Michael Doherty	Limited					
						Removable media controls in place **Control Owner:** Robert Nelson	Limited					
						Secure configuration in place for IT systems **Control Owner:** Mark Williams	Adequate					
						User education and awareness in place for Staff **Control Owner:** Michael Doherty	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 37	Potential negative impact of PAS system implementation on 18 weeks Referral to Treatment (RTT) **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 23 Jun 2017 **Latest Review Date:** 07 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change in risk scores. In preparation for the 31st October PAS implementation date, the first round of activity discussions with the divisions have been had including sharing of the work done last year. Follow up meetings have been scheduled. Thursday afternoons have been assigned to PAS operational implementation. Floor walkers/zones are being agreed and the first training session is planned soon.	04 Oct 2016	**Cause** *Potential reduction of clinics for outpatients for a three week period *Inability to accurately record timeliness from referral to treatment **Effect** *Potential harm to Patients *Reputational damage *Financial loss *Regulatory concerns (linked to Trust License)	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Detailed Information Database linking back to demand and capacity model that quantifies activity and the plans to bring the activity forward and any alternative provision if unable to do so **Control Owner:** Julia Bournes	Adequate	I = 4 L = 2 Moderate (8)	Ensure plans are reviewed at Speciality level to accommodate extended clinics instead of reducing them **Person Responsible:** Trish Hubbard **To be implemented by:** 31 Jul 2017	High	**07 Jul 2017** We have had the first round of activity discussions with the divisions and have shared the work done last year. Follow up meetings have been scheduled. Thursday's afternoons have been assigned to PAS operational implementation.	I = 4 L = 2 Moderate (8)
						Lessons learned/Advise received from other Trusts that have implemented PAS **Control Owner:** Julia Bournes	Adequate		Implementation of Staff Training plan to ensure no disruption in activities during go-live period **Person Responsible:** Debbie Lowes **To be implemented by:** 30 Sep 2017	High	**11 Jul 2017** Bookings for training coming in really slowly. Screensaver to promote further planned. First floorwalker session poorly attended - chase up email to ensure better coverage at next session.	
									Review existing controls in light of the new PAS Implementation date. **Person Responsible:** Jane Ely **To be implemented by:** 30 Sep 2017	High	**07 Jul 2017** This is in progress	
CRR 10	Lack of preparedness for the new European Data Protection Rules **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Michael Doherty **Last Updated:** 03 Jul 2017 **Latest Review Date:** 03 Jul 2017 **Latest Review By:** Michael Doherty **Latest Review Comments:** The anticipated NHS-specific national guidance programme NHS England announced to commence in April 2017 was delayed by election purdah. It was subsequently announced in late June that no such guidance yet exists and no dates for future publication have been announced. Michael Doherty (IG Manager) to draw up a strategy for compliance. md IG Manager	22 Feb 2016	**Cause** European Privacy Law is highly likely to become part of UK statute in 2018 placing specific responsibilities on all organisations for the use of personal data; this will affect patients in the main, but staff records will be included within the regulations. **Effect** The Trust may not have the necessary infrastructure in place to deliver against the following key areas: 1. Obtaining individual consent for disclosure 2. Privacy Impact Assessments to enable the organisation to understand the risks to personal data and privacy. 3. The Trust will need to establish systems to ensure that protection of personal data are included in all areas of business. 4. The Trust will need to be transparent in reporting externally all breaches of security and confidentiality to regulators and the persons affected. 5. A process is required to give individuals the right to be forgotten. 6. There is a financial penalty, up to 4% of turnover is possible, equivalent to £20million	AO1: Patients. Help patients take control of their own health	I = 5 L = 3 High (15)	Appointment of IAO for records containing personal information (primarily staff) **Control Owner:** Sandra Le Blanc	Adequate	I = 5 L = 1 Low (5)	Comprehensive review of the IG function and succession planning arrangements to identify core gaps internally. **Person Responsible:** Paul Stevens **To be implemented by:** 29 Sep 2017	Medium	**30 May 2017** This action's timeline has slipped due to competing priorities although in terms of identifying potential clinical leads in this area we already have clinicians performing IG actively in their other roles, especially those involved in research and in promoting integration of our information systems with commuinity and primary care	I = 4 L = 1 Low (4)
						Appointment of Information Asset Owner IAO for all clinical systems including health records. **Control Owner:** Paul Stevens	Substantial					
						IG Team actively engaging with national Information Governance Alliance, which is co-ordinating efforts to implement compliance as and when government guidance emerges. **Control Owner:** Michael Doherty	Limited		Appoint a formal Data Protection Officer **Person Responsible:** Michael Doherty **To be implemented by:** 31 Oct 2017	High	**06 Jul 2017** A paper was presented to the Information Governance Steering Group in June 2017. A further updated paper will be prepared for the IAGC October 2017. md IG Manager	
						The IG Manager is actively engaging nationally with peer and national leaders in order to assess accurately the impact of the proposed changes to legislation within the Trust. **Control Owner:** Michael Doherty	Adequate					
						The Trust has an Information Governance function within the corporate team to support the changes required **Control Owner:** Michael Doherty	Adequate					
						The Trust is registered with the Office of the Information Commissioner and reports IG breaches locally and nationally **Control Owner:** Michael Doherty	Substantial					

Principal Risks Report (Strategic Risk Register)

Report Date	03 Aug 2017
Comparison Date	In the past 60 Day(s)

Principal Risks Report (Strategic Risk Register)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 16	Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes **Risk Owner:** Matthew Kershaw **Delegated Risk Owner:** Elizabeth Shutler **Last Updated:** 17 Jul 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler and risk information strengthened. New actions added (including progress notes).	27 Feb 2017	**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 the change * Architecture / governance for change is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to delivery the transformation required to exit Financial special measures * Licence restrictions *Regulatory concerns * Reputational damage	AO3: Provision: Provide the services needed and do it well	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:** Matthew Kershaw	Substantial	I = 4 L = 4 High (16)	Implementation Team to deliver 8 point agenda (including reviewing programme, project and improvement methodology and ensuring a consistent process for the Transformation journey) **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Jul 2017	High	**04 Jul 2017** Membership of the implementation team has been agreed by EMT. Deputy CEO is leading - actions agreed - to be completed by 31st July.	I = 4 L = 2 Moderate (8)
						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:** Matthew Kershaw	Adequate		Approval for 2nd Phase of the Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Aug 2017	High	**17 Jul 2017** BC submitted to NHSI and EY Plum have presented to NHSI. Awaiting approval from NHSI.	
						Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Sandra Le Blanc	Adequate		Recruit into the Transformation Lead position **Person Responsible:** Matthew Kershaw **To be implemented by:** 31 Oct 2017	High	**17 Jul 2017** Advertisement out with expressions of interest.	
						Skills audit complete **Control Owner:** Sandra Le Blanc	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	Adequate					
						Time limited (until end July 2017) implementation team in place for the Transformation Programme **Control Owner:** Elizabeth Shutler	Limited					
						Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Matthew Kershaw	Adequate					

Principal Risks Report (Strategic Risk Register)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 5	Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 06 Jul 2017 **Latest Review Date:** 06 Jul 2017 **Latest Review By:** Nick Gerrard **Latest Review Comments:** Risk continues to be monitored at FIOG, FIC, FPC, EMT, MB, EPRs, Board and with NHSI	20 Jan 2016	**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 capability and 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 CCG's 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) **Effect** 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	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	Cash Committee in place **Control Owner:** Nick Gerrard	Adequate	I = 5 L = 3 High (15)	"Developing the Finance Team - Still Underpowered?" presented to FPC July 2016 setting out how the Leadership Development Programme would be deployed to support financial staff improvement **Person Responsible:** Nick Gerrard **To be implemented by:** 29 Sep 2017	High	**06 Jul 2017** Business case for EY/Plum leadership development programme was submitted to NHSI on 30 June 2017. Discussion at FSM Review Meeting 3 July. Awaiting response	I = 5 L = 2 Moderate (10)
						Clinical engagement in delivery of CIPs requiring Clinical Practice changes **Control Owner:** Paul Stevens	Limited					
						Cost Improvement Plan targets in place with workstream in support **Control Owner:** Nick Gerrard	Adequate					
						Financial Improvement Committee in place **Control Owner:** Nick Gerrard	Adequate		Ensure that the Trust Board and senior management team are fully informed of the Trust's financial position through regular updates, formal FPC papers, etc and that the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2018	High	**06 Jul 2017** Ongoing. Regular updates to Board and senior management.	
						Financial Improvement Director in place to provide support **Control Owner:** Matthew Kershaw	Substantial					
						Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Nick Gerrard	Adequate					
						Financial Recovery Plan in place **Control Owner:** Nick Gerrard	Limited		Deliver the Financial Recovery Plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2018	High	**06 Jul 2017** In progress. Progress reviewed at FIOG, FIC, FPC, EMT, MB, EPRs, Board and with NHSI.	
						Fortnightly confirm and challenge meetings with the Divisions (including Corporate) **Control Owner:** Nick Gerrard	Adequate					
						Monthly FSM review meetings with NHSI **Control Owner:** Nick Gerrard	Substantial					
						New approach to developing CIPs in place **Control Owner:** Nick Gerrard	Substantial		Ensure that the development of the Trust's clinical strategy, "Delivering Our Future" and that of the wider Kent & Medway STP, drive financial improvement and recovery in the Trust through to 2020/21. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**14 Jun 2017** First draft of the PCBC is due in July 2017	
						Payment by results infrastructure (coding and data quality) **Control Owner:** Nick Gerrard	Adequate					
						Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Nick Gerrard	Adequate					
						Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Nick Gerrard	Limited					
						Programme Support Office (PSO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Nick Gerrard	Adequate					

Principal Risks Report (Strategic Risk Register)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Robust plans in place for the delivery of operational performance targets **Control Owner:** Jane Ely	Limited					
						Vacancy Control Panel in place **Control Owner:** Elizabeth Shutler	Adequate					
						Workforce and Agency Control Group in place **Control Owner:** Sandra Le Blanc	Adequate					

Principal Risks Report (Strategic Risk Register)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
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:** 23 Jun 2017 **Latest Review Date:** 02 Aug 2017 **Latest Review By:** Andrea Ashman **Latest Review Comments:** The level of risk remains unchanged at this time. whilst there are actions being progressed the impact of these actions will not be realised immediately and require time to take effect.	23 Feb 2016	**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 (account for 75% of turnover figures) **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.	AO2: People: Identify, recruit and develop talented staff	I = 5 L = 4 Extreme (20)	The Trust has a plan in place that supports the retention of the majority of newly qualified nursing staff locally. **Control Owner:** Sally Smith	Adequate	I = 5 L = 3 High (15)	Finalise plan for recruitment to hard to fill roles **Person Responsible:** Jaz Mallan **To be implemented by:** 29 Jul 2016	High	**03 Jul 2017** Deadline for completion of hard to recruit plan has not been met. Revised deadline given to action of 10th July 2017	I = 5 L = 2 Moderate (10)
						Divisional Great Place to Work Action Plans in place **Control Owner:** Jane Waters	Adequate		Review and plan re: age profiling to form part of succession planning **Person Responsible:** Sandra Le Blanc **To be implemented by:** 30 Jun 2017	Medium	**02 Aug 2017** HRBPS are developing workforce plans to include age profiling as part of the broader measures to address shortfalls in workforce capacity. This was discussed at the workforce CIP meeting in July and is being progressed.	
						implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Adequate		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:** 31 Jul 2017	High	**10 Jul 2017** Outline metrics in place. Deadline unlikely to be met as it requires reviewing by the SWC. Will be presented at the end September 2017 SWC meeting.	
						New Appraisal Process in place **Control Owner:** Jane Waters	Limited					
						New People Strategy agreed by the Board incorporating attraction, retention, engagement and development of staff **Control Owner:** Sandra Le Blanc	Limited					
						Recruitment process in place **Control Owner:** Sandra Le Blanc	Limited		Report to Strategic Workforce Committee (SWC) on retention **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Jul 2017	High	**02 Aug 2017** Retention remains a concern for the Trust and in particular retention of new starters. The survey completed by Picker achieved a completion rate of 40% and will be presented to the next SWC meeting. Other initiatives are being reviewed as part of the Great Place to Work programme.	
						There is an agreed programme to recruit 50 nurses from the Philippines for 2017/18. **Control Owner:** Andrea Ashman	Limited		Devise & work towards implementing revised recruitment process **Person Responsible:** Andrea Ashman **To be implemented by:** 30 Sep 2017	High	**03 Jul 2017** Plans for implementation of changes are on Aspyre, with regular reporting to workforce CIP group on progress.	
						There is an agreed programme to recruit 90 nurses from EU / India for 2016/17. **Control Owner:** Andrea Ashman	Limited					
						Training plans in place in each division / corporate area that supports staff development. **Control Owner:** Andrea Ashman	Adequate		Implement Divisional Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2018	Medium	**10 Jul 2017** Ongoing review and update following key surveys etc	
						Working Group in place to review Consultant vacancies and recruitment **Control Owner:** Sandra Le Blanc	Adequate					

Principal Risks Report (Strategic Risk Register)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									Implement agreed programme to recruit 90 nurses from EU / India for 2016/17 **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2018	High	**02 Aug 2017** Overseas recruitment was presented at the workforce CIP meeting in July. Whilst initially this was thought to have been a successful project, offers to more than 100 nurses have not yielded new starts. The potential recruits have not been able to pass the IELTS exam whish is hindering our ability to recruit them in sufficient numbers quickly enough. there has been some success recruiting from European nations and it has been agreed that the focus on recruitment overseas should be from European countries where possible.	
									Implement agreed programme to recruit 50 nurses from the Philippines for 2017/18 **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2018	High	**03 Jul 2017** Philippine nurse campaign updated at workforce CIP group with first nurse arrived at end of June and more planned during the year. It is expected that we will reach our 50 target although delays in IELTS may mean some nurses arrive in 18/19.	
									Implementing a long term workforce plan that enables us to attract and retain high calibre staff **Person Responsible:** Andrea Ashman **To be implemented by:** 29 Jun 2018	High	**03 Jul 2017** Nick Gerrard and Sandra Le Blanc have produced a paper on improving workforce planning approach for 18/19. Initial meetings to discuss approach have yet to take place. JS followed up with Finance to get a meeting prior to her departure. Work is well underway led by Lindsey Shorter on behalf of JS to support the development of the workforce plan for the PCBC for consultation on the clinical strategy (STP).	
									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	High	**12 Jun 2017** Progress report to SWC in May 2017. Next progress report in six months.	

Principal Risks Report (Strategic Risk Register)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 10	Non-delivery of a timely Sustainability and Transformation Plan that can be resourced **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Rachel Jones **Last Updated:** 21 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No change in risk scores. Actions updated.	01 Jun 2016	**Cause** - STP timescales slip due to national management of the process - Parliamentary timing may not be conducive to timely implementation **Effect** - Delay to EKHUFT clinical strategy - Poor patient care - Emergency transfer of services will become necessary - Enforcement actions - Trust's provider licence (finance)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	Clinical standards reviewed **Control Owner:** Elizabeth Shutler	Substantial	I = 5 L = 3 High (15)	CCG sign off at Governance Boards of the Clinical Models Hurdle criteria, evaluation criteria and long list of options **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Aug 2017	High	**17 Jul 2017** In progress. On track for implementation by deadline	I = 5 L = 2 Moderate (10)
						East Kent Delivery Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Elizabeth Shutler	Substantial		Produce Financial Plan linked to delivery of the STP **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Oct 2017	High	**06 Jul 2017** This action is linked directly with the Pre-consultation Business Case (PCBC) and the Case for Change.	
						Internal Clinical Strategy Group in place **Control Owner:** Matthew Kershaw	Adequate		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:** 31 Oct 2017	High	**17 Jul 2017** In progress	
						Kent and Medway STP steering group in place **Control Owner:** Elizabeth Shutler	Substantial		Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**14 Jun 2017** Potential delay until April 2018	
						STP submission to NHS England **Control Owner:** Elizabeth Shutler	Substantial					

Emerging Risks Report (For New Risks)

Report Date	03 Aug 2017
Risk Register	2. Corporate Risk Register

Emerging Risks Report (For New Risks)

Risk Ref	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Target Risk Score
CRR 56	Inadequate critical care capacity **Risk Owner:** Sally Smith **Delegated Risk Owner:** Christine Hudson **Last Updated:** 03 Aug 2017	**Cause** *Historical chronic under-resourcing of critical care beds e.g. Nationally for every 100,000 head of population approx. 6.6 critical care beds and for EKHUFT it is 3.6 *Significant growth in emergency demand nationally for critical care beds insufficient to meet acuity *More people surviving with comorbidities * Increased activity of the PPCI service in WHH - out of hospital cardiac arrests who require increased length of stay **Effect** *Potential harm to patients/patient safety concerns *Cancellations of elective surgery *Nursing patients outside the foot print of the Critical Care Unit, theatre recovery and ED *Increase in non-medical transfers between sites *Inability to recruit and retain medical and nursing staff *Delays in admitting patients *Financial loss - no funding if patients are not in a critical care beds *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	Admissions, Discharge and Transfer policy in place	Limited	I = 5 L = 4 Extreme (20)	In-depth modelling and analysis regarding future planning (future projections) **Person Responsible:** James Bennell **To be implemented by:** 31 Aug 2017	I = 5 L = 2 Moderate (10)
					Movement of nursing staff across sites to support activity	Limited			
					The Critical Care Escalation plan (part of the Admission, Discharge and Transfer Policy) includes plans for a surge in demand for the 3 acute sites.	Limited		Business case to fund the current gaps **Person Responsible:** Deborah Higgs **To be implemented by:** 31 Aug 2017	
					Utilise critical outreach team to care for patients outside of the critical care unit	Limited			
					Utilise skilled staff to ensure patient safety	Limited			

Emerging Risks Report (For New Risks)

Risk Ref	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Target Risk Score
CRR 55	Inadequate sharing of Patients healthcare records with Community Trusts **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 02 Aug 2017	**Cause** *EKHUFT patient healthcare records (entire hard copy) are being sent to various locations within Kent Community Health NHS Foundation Trust (KCHFT) and other providers of continuing care across Kent, at the point of discharge * Historical practice - transferring the actual healthcare record, rather than a copy of the relevant sections of the healthcare record and an electronic discharge notification (eDN), has been in place for decades *Data protection concerns regarding EKHUFT as remaining the data controller and medicines governance issues as the Community Trust use the prescription chart from EKHUFT **Effect** *Potential data protection breach - As the data controller of the HCR, the Trust would be responsible and liable for any breach of the Data Protection Act 1998; the role of KCHFT would only be as a data processor. The DPA draws a distinction between a 'data controller' and a 'data processor' in order to recognise that not all organisations involved in the processing of personal data have the same degree of responsibility. It is the data controller that must exercise control over the processing and carry data protection responsibility for it. *Potential delays in releasing healthcare records by KCHFT - resulting in delays in completion of adult safeguarding reviews and sending records to HM Coroners *Potential patient safety concerns - The use of EKHUFT prescription charts for the on-going administration of medication. This process again places the total liability with this Trust for any error with the medication. This practice also places the individual prescriber at risk for any prescribing error even if the error is made within a location under the responsibility of KCHFT. There are associated professional implications. *There is a financial impact associated with potential missed income as the coding information is only obtained from the eDN and may not contain a complete history for diagnoses and procedures performed. The clinical coding team are therefore reliant only on the eDN. *There is a second financial impact associated with the storage of the Healthcare Records generated by KCHFT. These are currently stored with in the EKHUFT Healthcare Records rather than by KCHFT. *Legal challenge *Reputational damage to the Trust	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 4 L = 4 High (16)	Electronic Discharge Notification (eDN) in place and two weeks' supply of drugs Healthcare Records Standard Operating Procedures (SOPs) and Policy in place	Adequate Limited	I = 4 L = 3 Moderate (12)	Agree action plan with KCHFT and implement proposed changes to the sharing process **Person Responsible:** Helen Goodwin **To be implemented by:** 31 Oct 2017	I = 4 L = 2 Moderate (8)

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE **BoD/62/17**

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
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:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2017/18: QUARTER 1 REPORT** **APPENDIX 2: BOARD ASSURANCE FRAMEWORK** **APPENDIX 3: 2017/18 ANNUAL PRIORITIES**

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?

Positive assurance received in relation to:

- The Board Assurance Framework (BAF) and Annual Priorities 2017/18 quarter 1. There had been improved timeliness in relation to updating the BAF. Local priorities were at odds with the National priorities and Sustainability and Transformation Plan (STP) funding.
- A report was received and discussed regarding the positive lessons learnt exercise regarding Corporate Risk Register (CRR 49) – Negative impact of the implementation of the new HRMC – IR35 tax regime. This was around the risk register and how risks flowed up and down the organisation. There was a discussion about how the Trust might influence, around lobbies, with the Government on the impact that this tax regime was having on the organisation and the NHS as a whole.

Concerns in relation to assurance identified:

- The Committee discussed the report regarding the Highest Mitigated Risks and reviewed the strategic and corporate risk registers. The Emergency Department remained a high risk, in relation to staffing. The areas of significant risks would be picked up and discussed in detail at the relevant Board Committee. There had been improvements in the timeliness of providing progress updates on the risks.
- CRR 50 – Risks associated with the transfer of Healthcare Records (HCR) to Kent Community NHS Foundation Trust. This was identified as a significant risk and

needed to be added to the risk register. A letter would be sent from the IAGC Chair to the Chief Executive highlighting the importance of promptly resolving this risk.

Other reports discussed:

- The Committee received and discussed a Risk Appetite Alignment report.
- The Committee received and discussed a Freedom of Information Annual Report.
- A quarterly Freedom to Speak Up (FTSU) Guardian report was received. There was no take up of referrals. The IAGC Chair will be meeting with the FTSU Guardians for an informal update. The FTSU Guardians will be attending a future Board meeting to present their work and progress.
- The Committee received the Gifts and Hospitality Annual Report. There was a query regarding an item recorded in the register that would be followed up.
- A Single Tender Waiver (STW) report was received and discussed.
- A Progress Report was received from RSM Risk Assurance Services LLP (Internal Audit) and the good progress made during the year was noted. The Internal Audit Strategy and Plan for 2017-2020 was received and approved, it was agreed that transformation would be an area for an audit review over 10 days. The Internal Annual Report for 2016/17 was received.
- A Progress Report was received from KPMG (External Audit).
- An activity and progress report was received from TIAA (Local Counter Fraud).

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report.

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE **BoD/62/17**

REPORT TO:	**REPORT TO BOARD OF DIRECTORS AS RECEIVED BY INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
DATE:	**11 AUGUST 2017**
SUBJECT:	**BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2017/18: QUARTER 1**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**TRUST SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK** **APPENDIX 2: Q1 PERFORMANCE AGAINST THE ANNUAL PRIORITIES 2017/18**

BACKGROUND AND EXECUTIVE SUMMARY

The Board agreed its 2017/18 annual priorities at the April 2017 meeting. As part of good governance the Board Assurance Framework should be reviewed on a quarterly basis. The full Board Assurance Framework is provided as Appendix 1. As part of this review the following elements are highlighted and the detail is provided as Appendix 2 (colour coding relates to the appendix):

- Risk to the annual priorities – these are contained within the Strategic Risk Register with each risk being aligned with the annual priority it impacts;

- Assurance – there are two ways to look at assurance – the first relates to the level of information going to the Board for discussion so that Board members' are fully sighted on the topic; the second relates to what that assurance shows, for example and audit report may provide positive or negative assurance;

- Performance – each of the annual priorities have a number of objectives and associated metrics and quarterly reporting will show whether the quarter target was met or completed (blue); on track but there is no specific quarterly numeric target (green); delayed but still possible to deliver by the agreed date (amber); not met the quarterly numeric target (red); awaiting external input (grey).

- A separate paper on alignment of the risk appetite to the strategic risks is on the agenda and the Chairman of Integrated Audit and Governance Committee suggested that this could be widened to include alignment to the objectives, metrics and performance. The below table assimilates this information and this report will focus on what the BAF and Risk Appetite may indicate

This is the firstly quarterly report, this highlights the current performance, risks and assurance level. This report uses RAG rating to identify areas of concern from a risk, assurance and performance angle.

The IAGC's role is to discuss the assurance levels and possible gaps in assurance to provide feedback to the Executives on the additional evidence / assurance required. The meetings between the Executive lead, Trust Secretary and Risk Manager have met with the Executive Risk Leads.

Where possible the performance is taken from the Integrated Performance Report (IPR) and work is on-going with the Information Team to ensure this is no duplication and to ensure we can report consistently.

The table below provides an aggregated overview of the annual priorities as at quarter 1. The colour coding for "Performance" – "green" majority on-track; "amber" mixture of on-track / not met. The bracket in the Strategic Risk column indicates the Board's agreed risk appetite; more detail about the risk appetite is available in the papers.

STRATEGIC OBJECTIVE	PERFORMANCE Aggregated	STRATEGIC RISK Aggregated	ASSURANCE Aggregated
PATIENTS	**GREEN**	**MODERATE (HIGH)**	**ADEQUATE**
PEOPLE	**AMBER**	**HIGH (SIGNIFICANT)**	**ADEQUATE**
PARTNERSHIP	**GREEN**	**HIGH (SIGNIFICANT)**	**SUBSTANTIAL**
PROVISION	**GREEN**	**HIGH (MODERATELY HIGH)**	**ADEQUATE**

Patients:
Performance is green for all metrics except the Friends and Family test for Accident and Emergency, plans are in place to address this. Two of the objectives are on-track with delivery coming in the latter part of the year. Risk level is showing as moderate which is within the risk appetite agreed by the Board. Assurance level is adequate against all controls.

Questions / Consideration

- Risk appetite was agreed by the Board as "high" for "compliance / regulatory". Given that the significant majority of the metrics have been met in quarter 1 and assurance / information to the Quality Committee and Board is adequate and the residual risk is within appetite, does this indicate that less management time should be spent on mitigating this risk?
- Is the risk appetite for compliance / regulatory set at the correct level; implementing the outstanding actions will reduce the residual risk even further.
- If the risk appetite is set at "high" this gives the Board the ability to manage up to the risk appetite, giving the Board more flexibility to manage their risks.

People:
Performance is Amber due to two quarterly metrics not being met. These relate to:

- Improve the overall staff engagement score as measured by the staff survey and NHS staff friends and family test by March 2018. Recommend to work was 52.3% against an target of 58%; recommend to treat was 76.56% against a target of 78%; and
- Sustain the reduction in the number of staff leaving the Trust within their first year of employment (baseline 21.9%); the quarter 1 achievement was 24.3%. This appears slightly higher than last year (21.9%), which is largely attributable to the reduced number of joiners. There were 182 (WTE) new joiners and 44 (WTE) premature leavers in Q1. In real terms, the Trust has the lowest actual number of new starters leaving (14.79 WTE per calendar month) since the Retention Programme began.

The risk level is high which is in line with the Board risk appetite. Whilst there are a number of assurances showing as "limited" on the Board Assurance Framework, this is in relation to either on-going monitoring or controls that require strengthening, it is clear that the Strategic Workforce Committee receives adequate information and is aware of the challenges.

Questions / Considerations

Given "performance" is "amber" and the risks are managed in line with the agreed risk appetite there is a need to review how this is being managed to bring performance back to "green". Therefore, should consideration be given to

- reviewing the risk appetite in relation to "workforce / staff engagement" to bring it down from "significant" to "moderately high"?; or
- should there be focus on specific actions to reduce the residual risk? or
- are there unidentified risks that should be addressed in terms of the performance?

Partnership

Performance is "green", it should be noted that the objective on working with Kent Community Hospital NHSFT is showing as delayed as focussed work should enable this to progress and deliver by the end of the year as planned, an update requested from the Executive Lead. The risk the Trust is carrying against this objective is in line with the agreed risk appetite. The Board receives regular information and updates regarding the partnership work on the Sustainability and Transformation Plan and this is validated externally which leads to a "substantial" rating for assurance.

Questions / Consideration

- Risk appetite was agreed by the Board as "significant" for "innovation". The majority of the priorities in this area are being met and assurance is "significant" and the residual risk is within the appetite; does this indicate that less management time should be spent on mitigating this risk?
- Is the risk appetite for "innovation" set at the correct level – as the Trust is performing and managing the risk at a lower threshold, should the risk appetite be "high"?
- As above, leaving it might give the flexibility to the Board on how fully they treat a risk.

Provision

All metrics have either been met for the quarter or are on-track to deliver, giving a "green" performance for quarter 1. There are two risks against this annual priority one of which is within the agreed risk appetite, the other SRR5 Failure to achieve financial plans as agreed by NHS Improvement under the Financial Special Measures regime, with a residual score of "high" against a "moderately high" appetite. There is a mix of assurance levels and the majority of those that are "limited" relate to on-going monitoring and achievement rather than lack of information going to the Finance and Performance Committee. Nigel Mansley is currently reviewing the information that goes to the Board and it is anticipated that there will be a number of recommendations to enhance the reporting.

Questions / Consideration

Risk appetite was agreed by the Board as "moderately high" for "finance". A significant majority of the priorities in this area are being met and assurance is "adequate" and the residual risk is within appetite;

- does this indicate that more management time / resources should be spent on mitigating this risk to "moderately high"?
- As the Trust is achieving its metrics, gaining assurance, should the risk appetite be "high" rather than "moderately high" and
- Should the outstanding actions be reviewed to focus on the critical ones?

Committee action

The Committee should consider the overall picture and:

- Discuss how performance and assurance achievement relates to risk appetite and treatment and make recommendations to the Board
- review the performance against annual priorities;
- discuss what additional assurance is required in relation to future delivery /

mitigation of risks; and
- identify any additional risks.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The attached Board Assurance Framework reflects the strategic risks facing the Trust and the mitigating actions in place.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	As highlighted in the report
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Committee is invited to:
- Discuss how performance and assurance achievement relates to risk appetite and treatment and make recommendations to the Board;
- review the performance against annual priorities;
- discuss what additional assurance is required in relation to future delivery / mitigation of risks; and
- identify any additional risks.

Board Assurance Framework

Report Date	19 Jul 2017
Risk Status	Open
Risk Register	1. Strategic Risk Register
Control Status	Existing
Action Status	Outstanding

East Kent Hospitals University NHS Foundation Trust

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:** 24 Apr 2017 **Latest Review Date:** 17 Jul 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and updated including assurance levels.	**Cause** *The Trust recently came out of Quality Special Measures and needs to ensure the momentum for the improvement journey is sustained. **Effect** - Loss of autonomy; - Impact on staff morale; - Reputational damage; - Decline in pace and development of service; and - Regulatory concerns	I = 5 L = 4 Extreme (20)	Agreed Improvement Plan in place with supporting Divisional plans. **Control Owner:** Sally Smith	Emma Kelly manages the updates to the Improvement Plan on at least a monthly basis.	Improvement Board monitor progress (meets monthly) BoD receives exception and progress reports (bi-monthly)	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	Internal Audit on Risk Management / Improvement Plan (04/16)	I = 4 L = 3 Moderate (12)	Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2018	**17 Jul 2017** **Sally Smith** Q1 monitoring and reporting in progress.	I = 4 L = 2 Moderate (8)	Quality Committee
											Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2018	**17 Jul 2017** **Sally Smith** Monthly reviews in place. **12 Jun 2017** **Sally Smith** Plan on track. Monthly monitoring in place.		
				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)		Adequate						

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:** Liz Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 21 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No change in risk scores. Action progressing well and updated.	**Cause** - Backlog of work (£30million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** Resulting in poor patient and staff experience, potential breaches to health & safety standards and legislation, inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	I = 3 L = 5 High (15)	An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Liz Shutler	Deputy Director of Estates and Director of Capital receive information from all areas of the Trust regarding maintenance and undertake a first pass at prioritisation. Capital PLanning Group - review the prioritisation exercise	FPC receive reports about Backlog maintenance showing the risks.		Adequate		I = 3 L = 3 Moderate (9)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee **Person Responsible:** Liz Shutler **To be implemented by:** 31 Oct 2017	**17 Jul 2017** **Dorothy Otite** On track **14 Jun 2017** **Dorothy Otite** First draft of the PCBC due for July 2017	I = 3 L = 2 Low (6)	Quality Committee
				Interim Estates Strategy in place **Control Owner:** Fin Murray	*Approved by Management Board	- Strategy approved by the Trust Board - New NED in place to provide challenge		Adequate						
				Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Liz Shutler	Management Board receives reports from Director of Strategy and Capital Planning. Business cases are received on an ad-hoc basis - some of which require improvement to infrastructure	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:** Fin Murray	PEIC Action Plan available to view	*Plan approved by SIG in May 2017 *SIG monthly reviews progress of action plan		Adequate						
				Risk assessed condition survey carried out every 5 years (rolling interim plan every 18months) **Control Owner:** Fin Murray	Reviewed by Estates Managers Meeting (Chaired by Head of Engineering and Compliance)	Expenditure against plan reported to SIG	Stock Condition Survey by External Company Independent District Valuer reviews	Adequate						
				Statutory Compliance dashboard in place **Control Owner:** Fin Murray	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

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:** Jacqui Siggers **Last Updated:** 23 Jun 2017 **Latest Review Date:** 12 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Sandra Le Blanc. No change to risk scores. Progress notes have been added to the actions.	**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 (account for 75% of turnover figures) **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.	I = 5 L = 4 Extreme (20)	The Trust has a plan in place that supports the retention of the majority 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)	Finalise plan for recruitment to hard to fill roles **Person Responsible:** Jaz Mallan **To be implemented by:** 29 Jul 2016	**03 Jul 2017** **Jacqui Siggers** Deadline for completion of hard to recruit plan has not been met. Revised deadline given to action of 10th July 2017 **11 Apr 2017** **Jaz Mallan** Hard to recruit plan to be reviewed and updated by Mid May 2017.	I = 5 L = 2 Moderate (10)	Strategic Workforce Committee
				Divisional Great Place to Work Action Plans in place **Control Owner:** Jane Waters	- Plans available for all to access on Staff zone - Reviewed at the Divisional Management Boards	Progress of Plan reviewed annually at the SWC		Adequate			Review and plan re: age profiling to form part of succession planning **Person Responsible:** Sandra Le Blanc **To be implemented by:** 30 Jun 2017	**10 Jul 2017** **Dorothy Otite** Data is available. The plan is still outstanding. Progress will be reviewed at the next Workforce CIP meeting on 27 July 2017. **12 Jun 2017** **Dorothy Otite** In progress. HRBP to report back at the Workforce CIP meeting on 12 June 2017.		
				implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Jacqui Siggers	Discussed at the Workforce CIP meeting	Regularly reviewed at SWC		Adequate						
				New Appraisal Process in place **Control Owner:** Jane Waters	Trust-wide Communication HR BPs carried out audit on the process	- Regular monitoring through a number of routes - Divisional Governance Boards, EPR meetings and Strategic Workforce Committee - Report of audit to SWC	Annual staff survey results	Limited			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:** 31 Jul 2017	**10 Jul 2017** **Dorothy Otite** Outline metrics in place. Deadline unlikely to be met as it requires reviewing by the SWC. Will be presented at the end September 2017 SWC meeting.		
				New People Strategy agreed by the Board incorporating attraction, retention, engagement and development of staff **Control Owner:** Sandra Le Blanc	People strategy agreed by Board in October 2016	Implementation plan to be presented to SWC in January 2017		Limited	Not yet implemented - Ongoing monitoring by SWC. No KPIs					
				Recruitment process in place **Control Owner:** Sandra Le Blanc	Length of time to recruit is monitored monthly and provided as part of the IPR	Reviewed by the SWC at every meeting		Limited						
				There is an agreed programme to recruit 50 nurses from the Philippines for 2017/18. **Control Owner:** Jacqui Siggers	Head of HR leading on the programme with nominated leads at Divisional level	Strategic Workforce Group with formal strategy in place		Limited						

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
				There is an agreed programme to recruit 90 nurses from EU / India for 2016/17. **Control Owner:** Jacqui Siggers	Head of Strategic Resourcing and Acting Chief Nurse and Director of Quality leading programme with nominated leads at division level.	Strategic Workforce Group with formal strategy in place		Limited	Sustainability of model for overseas recruitment in the medium to long-term unclear		Report to Strategic Workforce Committee (SWC) on retention **Person Responsible:** Jacqui Siggers **To be implemented by:** 31 Jul 2017	**03 Jul 2017** **Jacqui Siggers** Turnover identified as an emerging risk at the SWC meeting at end of March - it is increasing and the Trust would not meet its target for 16/17. An analysis was reported of the turnover data and further work completed and reported in May 2017. This included the engagement of Picker to undertake exit interviews from April 2017 and first report will be available for Q1 - it is hoped this will be on July's SWC agenda. **09 May 2017** **Dorothy Otite** Will now be brought to the 31 July 2017 SWC meeting		
				Training plans in place in each division / corporate area that supports staff development. **Control Owner:** Jacqui Siggers	- Each Division agrees their training plan - HR BPs review the plans on an annual basis	- Annual review by the Divisions		Adequate	*Funding gap *Understanding of process and outcomes					
				Working Group in place to review Consultant vacancies and recruitment **Control Owner:** Sandra Le Blanc	- Monthly meeting led by HR Director and Deputy Medical Director - Action log in place to evidence this	- Report to Management Board, SWC and Board - gaps and improvement in process		Adequate						
											Devise & work towards implementing revised recruitment process **Person Responsible:** Jacqui Siggers **To be implemented by:** 30 Sep 2017	**03 Jul 2017** **Jacqui Siggers** Plans for implementation of changes are on Aspyre, with regular reporting to workforce CIP group on progress. **12 Jun 2017** **Dorothy Otite** Outline recruitment process has been agreed by the Management Board.		

East Kent Hospitals University NHS Foundation Trust

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
											Implement Divisional Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2018	**10 Jul 2017** **Dorothy Otite** Ongoing review and update following key surveys etc **09 May 2017** **Dorothy Otite** In progress and monitored by the SWC.		
											Implement agreed programme to recruit 50 nurses from the Philippines for 2017/18 **Person Responsible:** Jacqui Siggers **To be implemented by:** 31 Mar 2018	**03 Jul 2017** **Jacqui Siggers** Philippine nurse campaign updated at workforce CIP group with first nurse arrived at end of June and more planned during the year. It is expected that we will reach our 50 target although delays in IELTS may mean some nurses arrive in 18/19. **11 Apr 2017** **Sandra Le Blanc** 152 offers made with 8 completed International English Language Test (IELTS). Anticipated start dates from June 2017 onwards		

East Kent Hospitals University NHS Foundation Trust

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
											Implement agreed programme to recruit 90 nurses from EU / India for 2016/17 **Person Responsible:** Jacqui Siggers **To be implemented by:** 31 Mar 2018	**03 Jul 2017** **Jacqui Siggers** Draft paper produced on effectiveness of programme produced by Jaz Mallan. Needs to be updated with most recent information on Indian Nurses and is expected to be presented to Workforce CIP meeting in July 2017. **11 Apr 2017** **Sandra Le Blanc** 100 offers made and 2 have completed their International English Language Test (IELTS). Expected to commence in September 2017. A report on overseas recruitment in 2016/17 will be presented to the Strategic Workforce Committee in May 2017.		

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
											Implementing a long term workforce plan that enables us to attract and retain high calibre staff **Person Responsible:** Jacqui Siggers **To be implemented by:** 29 Jun 2018	**03 Jul 2017** **Jacqui Siggers** Nick Gerrard and Sandra Le Blanc have produced a paper on improving workforce planning approach for 18/19. Initial meetings to discuss approach have yet to take place. JS followed up with Finance to get a meeting prior to her departure. Work is well underway led by Lindsey Shorter on behalf of JS to support the development of the workforce plan for the PCBC for consultation on the clinical strategy (STP). **17 Feb 2017** **Jacqui Siggers** Actions identified following Mark Hackett's visit will improve approach and quality of workforce planning moving forward.		
											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	**12 Jun 2017** **Dorothy Otite** Progress report to SWC in May 2017. Next progress report in six months. **09 May 2017** **Dorothy Otite** On agenda for May 2017 SWC for monitoring of progress.		

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 Divisional Directors) to develop and deliver key strategies and recovery plans **Risk Owner:** Matthew Kershaw **Delegated Risk Owner:** Sandra Le Blanc **Last Updated:** 23 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Sandra Le Blanc . No change in risk scores. Progress notes added to actions. Phase 2 of the Leadership Development Programme has been sent to NHSI for approval.	**Cause** *Large number of complex priorities that need to be delivered including the sustainability and transformation plan, 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 *Current Director of Finance is stepping down in the Autumn - loss of focus on FRP *Governance structure fails to support the delivery of CIPs **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 = 3 L = 4 Moderate (12)	Business Partnering roles in place (finance, HR & Information) together with support from central governance team. They are an integral part of the Divisional Leadership Team (Capacity) **Control Owner:** Jane Ely	- BPs exist with clear job descriptions - Line Management appraisals in place	Support within divisions EPRs and overall process - meeting		Adequate	Vacancy in the BP team	I = 3 L = 3 Moderate (9)	Identify the leadership framework for Clinical staff (Nursing) **Person Responsible:** Sally Smith **To be implemented by:** 31 Jul 2017	**17 Jul 2017** **Sally Smith** Framework in place. **12 Jun 2017** **Sally Smith** Clinical leadership programme is in place for clinical staff of all disciplines. This reflects the shared purpose framework and Trust values, and the Quality Strategy. The Senior Leadership & Quality Forum meet every 6 weeks with the Chief Nurse. Work is in progress to refresh the fortnightly band 7 catch up forums.	I = 3 L = 2 Low (6)	Strategic Workforce Committee
				Communication plan in place to support delivery and emphasise the key priorities **Control Owner:** Natalie Yost				Adequate						
				Each Divisional Director is responsible for one of the national Performance Standards e.g. Cancer, ED, 18weeks (Capacity) **Control Owner:** Jane Ely	Reviewed at 121s	Reviewed at EPR monthly	*Regular contract performance meetings with the CCGs *NHSI single oversight/performance review meetings monthly	Limited	Some performance standards not being met					
				Executive Performance Reviews in place where delivery is challenged with EMT/DD meetings to support senior leadership team in prioritising and highlighting competing pressures **Control Owner:** Matthew Kershaw				Adequate			Identify the leadership framework for Clinical staff (medicine) **Person Responsible:** Paul Stevens **To be implemented by:** 31 Jul 2017	**12 Jun 2017** **Dorothy Otite** New Clinician Course in place for newly appointed Consultants. This course stimulates interest in Clinical leaderships. The 2nd part is the Kim Manly Clinical Leadership Course. Medical Staff forums are held regularly. Next step is to arrange a regular Clinical Lead forum with the Executives.		
				External Consultancy Support (ECIP, Financial Improvement Director, Ann Farrar) supporting Divisions and the Corporate Team to deliver transformation programmes (Capacity) **Control Owner:** Jane Ely	Regular reports through the Executive Team meetings and Management Board	Reviewing at Board Sub-Committees and Executive Performance Reviews (IPR)	Peer review and Benchmarking (Reports by Consultants include this)	Adequate						
				EY Plum alignment review completed and presented to the Exec Team. 3 areas for focus identified and these will be explored in more detail to lead to action at the 2 day EMT workshop at the end of February 2017 **Control Owner:** Sandra Le Blanc	Individual conversations between EKHUFT leaders and EY Plum	Review of the output with the Executive Team (1 February 2017)	External and independent review of current position in relation to leadership and development by both EY and Plum	Adequate			Transformation Implementation Team to address the priority gaps identified in the skills and capacity audit **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Jul 2017	**18 Jul 2017** **Dorothy Otite** Reviewed by the Transformation Board and any gaps to be picked up by Work stream leads **10 Jul 2017** **Dorothy Otite** On target.		
				Flexibility of current Director of Finance postholder to support transition **Control Owner:** Matthew Kershaw				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
				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	NHSI to review progress of the Leadership & Transformation Programme by EY Plum	Adequate	Fully populated succession plans to ensure short-term and long-term position is secure.		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:** 29 Sep 2017	**18 Jul 2017** **Dorothy Otite** BC submitted to NHSI and EY Plum have presented to NHSI. Awaiting approval from NHSI. **13 Jun 2017** **Dorothy Otite** Business case for Phase 2 to be sent to NHSI by end June 2017		
				Leadership Development Programmes in place for staff on the talent pipeline **Control Owner:** Jane Ely				Adequate			Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Sandra Le Blanc **To be implemented by:** 29 Sep 2017	**18 Jul 2017** **Dorothy Otite** BC submitted to NHSI and EY Plum have presented to NHSI. Awaiting approval from NHSI. **12 Jun 2017** **Dorothy Otite** Business case to be sent to NHSI by end June 2017		
				Outline Programme Plan in place for the Leadership Development Programme (Capability) **Control Owner:** Sandra Le Blanc	Reports to MB	Reports to SWC	NHSI review	Limited						
				Substantive staff in place for Executive and Divisional Directors (Capacity) **Control Owner:** Sandra Le Blanc	* Currently no vacancies exist for Executives and Divisional Directors			Adequate	Vacancies and capacity issues below the Executives and Divisional Directors that impact on capacity		Recruit to some key leadership posts below the Executive/Divisional Director levels **Person Responsible:** Jane Ely **To be implemented by:** 31 Oct 2017	**13 Jun 2017** **Dorothy Otite** All Divisional Directors in place. Interim Deputy for COO has been in post since April and will be leaving in June. Service Improvement Team have got two vacancies. Gaps in Ops Manager level and Cardiology. **12 Jun 2017** **Dorothy Otite** All Division al Directors in place. Interim Deputy for COO has been in post since April to June. Service Improvement Team have got two vacancies. Gaps in Ops Manager level and Cardiology.		
				Targeted resources into key CIP schemes in place e.g. patient flow, Cardiology **Control Owner:** Nick Gerrard				Limited						
				Transformation Programme in place (designed and resourced) **Control Owner:** Sandra Le Blanc	*Governance structure in place which links to Financial Special Measure s	Approved by the Trust Board on 10 April		Limited						

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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
											Design and deliver the Executive Development and Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Jul 2018	**10 Jul 2017** **Dorothy Otite** BP now with NHSI for consideration by the full NHSI Consultancy Approvals Panel (July/August 2017) **13 Jun 2017** **Dorothy Otite** Business case for Phase 2 to be sent to NHSI by end June 2017		

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

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:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 06 Jul 2017 **Latest Review Date:** 06 Jul 2017 **Latest Review By:** Nick Gerrard **Latest Review Comments:** Risk continues to be monitored at FIOG, FIC, FPC, EMT, MB, EPRs, Board and with NHSI	**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 capability and 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 CCG's 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) **Effect**	I = 5 L = 5 Extreme (25)	Cash Committee in place **Control Owner:** Nick Gerrard	*Led by the Director of Finance *Report on Daily and weekly cash balances	*Review by FIOG; and FPC		Adequate		I = 5 L = 3 High (15)	"Developing the Finance Team - Still Underpowered?" presented to FPC July 2016 setting out how the Leadership Development Programme would be deployed to support financial staff improvement **Person Responsible:** Nick Gerrard **To be implemented by:** 29 Sep 2017	**06 Jul 2017** **Nick Gerrard** Business case for EY/Plum leadership development programme was submitted to NHSI on 30 June 2017. Discussion at FSM Review Meeting 3 July. Awaiting response **14 Jun 2017** **Dorothy Otite** Business case for Phase 2 to be sent to NHSI by end June 2017	I = 5 L = 2 Moderate (10)	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	Feeds into BoD	Limited						
				Cost Improvement Plan targets in place with workstream in support **Control Owner:** Nick Gerrard	Monthly Executive Performance Review and Key Metric Reviews	* 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 2016/17, 2017/18 (including Governance)	Adequate						
				Financial Improvement Committee in place **Control Owner:** Nick Gerrard	*Governance structure & ToR in place *Chaired by the CEO	Reporting to the FPC monthly	NHSI attends FIC meetings	Adequate			Deliver the Financial Recovery Plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2018	**06 Jul 2017** **Dorothy Otite** In progress. Progress reviewed at FIOG, FIC, FPC, EMT, MB, EPRs, Board and with NHSI. **14 Jun 2017** **Dorothy Otite** In progress. Regular updates to Board.		
				Financial Improvement Director in place to provide support **Control Owner:** Matthew Kershaw	Reports to CEO	- Report to Executive Team and Board - Report to FPC	Report to NHSI	Substantial						
				Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Nick Gerrard	*Chaired by the Finance Director	*Reports to FIC	NHSI attends FIOG meetings	Adequate						
				Financial Recovery Plan in place **Control Owner:** Nick Gerrard	- Divisions, PSO and FID developed plans	*Board received plan on 10/04/17 - awaiting NED feedback *Reviewed at FPC on 3/4/17		Limited	Awaiting feedback from NHSI		Ensure that the Trust Board and senior management team are fully informed of the Trust's financial position through regular updates, formal FPC papers, etc and that the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2018	**06 Jul 2017** **Dorothy Otite** Ongoing. Regular updates to Board and senior management. **14 Jun 2017** **Dorothy Otite** Ongoing. Regular updates to Board and senior management.		
				Fortnightly confirm and challenge meetings with the Divisions (including Corporate) **Control Owner:** Nick Gerrard	*Chaired by the Financial Improvement Director	*Review by FIC		Adequate						
				Monthly FSM review meetings with NHSI **Control Owner:** Nick Gerrard	Internal review at Board prior to meeting with NHSI.		Feedback from NHSI after FSM Review meetings on 2 June 2017 and 3 July 2017 were positive	Substantial						
				New approach to developing CIPs in place **Control Owner:** Nick Gerrard	Led by Financial Improvement Director	Review of progress of CIP monthly by the FPC	NHSI to provide assurance once all agreed	Substantial						

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		Payment by results infrastructure (coding and data quality) **Control Owner:** Nick Gerrard	*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	Adequate	Clinical activity not consistently captured, coded and costed.		Ensure that the development of the Trust's clinical strategy, "Delivering Our Future" and that of the wider Kent & Medway STP, drive financial improvement and recovery in the Trust through to 2020/21. **Person Responsible:** Liz Shutler **To be implemented by:** 30 Apr 2018	**14 Jun 2017** **Dorothy Otite** First draft of the PCBC is due in July 2017 **08 May 2017** **Dorothy Otite** Assurance of this will be dealt with explicitly within the PCBC which we have commenced drafting.		
				Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Nick Gerrard	*Escalated through the FD to the CEO	*Escalate concerns to NHSI		Adequate						
				Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Nick Gerrard	Information and Income Teams to monitor and report on plan	Review by the FIOG; and FIC if escalation is required		Limited						
				Programme Support Office (PSO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Nick Gerrard	*Weekly CIP tracking *Direct line management by Director of Finance	*Monthly reports to MB, EPR and FPC	Regular contact with NHSI	Adequate						
				Robust plans in place for the delivery of operational performance targets **Control Owner:** Jane Ely	Divisional management of the standards through Governance and Business Boards	Compliance reports to Executive Performance Reviews Management Board Finance and Performance Committee Board of Directors Council of Governors	External review from: CCG's through monthly performance reviews NHSI through 6 weekly progress review meetings	Limited						
				Vacancy Control Panel in place **Control Owner:** Liz Shutler	Chaired by the Deputy Chief Executive			Adequate						
				Workforce and Agency Control Group in place **Control Owner:** Sandra Le Blanc	Chaired by Director of HR	Review by FIC		Adequate						

East Kent Hospitals University NHS Foundation Trust

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:** Matthew Kershaw **Delegated Risk Owner:** Liz Shutler **Last Updated:** 17 Jul 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler and risk information strengthened. New actions added (including progress notes).	**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 the change * Architecture / governance for change is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to delivery the transformation required to exit Financial special measures * 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:** Matthew Kershaw	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)	Implementation Team to deliver 8 point agenda (including reviewing programme, project and improvement methodology and ensuring a consistent process for the Transformation journey) **Person Responsible:** Liz Shutler **To be implemented by:** 31 Jul 2017	**04 Jul 2017** **Sandra Le Blanc** Membership of the implementation team has been agreed by EMT. Deputy CEO is leading - actions agreed - to be completed by 31st July.	I = 4 L = 2 Moderate (8)	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:** Matthew Kershaw	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			Approval for 2nd Phase of the Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Aug 2017	**17 Jul 2017** **Dorothy Otite** BC submitted to NHSI and EY Plum have presented to NHSI. Awaiting approval from NHSI.		
				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			Recruit into the Transformation Lead position **Person Responsible:** Matthew Kershaw **To be implemented by:** 31 Oct 2017	**17 Jul 2017** **Dorothy Otite** Advertisement out with expressions of interest.		
				Skills audit complete **Control Owner:** Sandra Le Blanc		*Reviewed by Board *Reviewed by the Transformation Board and any gaps picked up by Work stream leads	Reviewed by NHSI	Adequate						
				Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS and European / International hospitals **Control Owner:** Liz 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.					

East Kent Hospitals University NHS Foundation Trust

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 (until end July 2017) implementation team in place for the Transformation Programme **Control Owner:** Liz Shutler		Purpose agreed by EMT in June 2017 Reports to EMT and the Transformation Board	Review by NHSI	Limited						
				Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Matthew Kershaw	*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						

East Kent Hospitals University NHS Foundation Trust

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:** Liz Shutler **Delegated Risk Owner:** Rachel Jones **Last Updated:** 21 Jun 2017 **Latest Review Date:** 18 Jul 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No change in risk scores. Actions updated.	**Cause** - STP timescales slip due to national management of the process - Parliamentary timing may not be conducive to timely implementation **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:** Liz 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 = 3 High (15)	CCG sign off at Governance Boards of the Clinical Models Hurdle criteria, evaluation criteria and long list of options **Person Responsible:** Liz Shutler **To be implemented by:** 31 Aug 2017	**17 Jul 2017** **Dorothy Otite** In progress. On track for implementation by deadline	I = 5 L = 2 Moderate (10)	Finance & Performance Committee
				East Kent Delivery Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Liz Shutler	- 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		Substantial			Presentation of the capital requirements to the NHSE Investment Committee as part of the Pre-consultation Business Case **Person Responsible:** Liz Shutler **To be implemented by:** 31 Oct 2017	**17 Jul 2017** **Dorothy Otite** In progress **14 Jun 2017** **Dorothy Otite** Initial draft of PCBC due end July 2017		
				Internal Clinical Strategy Group in place **Control Owner:** Matthew Kershaw	Chaired by CEO			Adequate			Produce Financial Plan linked to delivery of the STP **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Oct 2017	**06 Jul 2017** **Dorothy Otite** This action is linked directly with the Pre-consultation Business Case (PCBC) and the Case for Change. **01 Mar 2017** **Nick Gerrard** Trust is carrying out a 're-set' of its 17/18 financial, activity and workforce plans that will provide the baseline for establishing medium and long term financial recovery plans onto which will be mapped STP plans and the impact of the clinical strategy.		
				Kent and Medway STP steering group in place **Control Owner:** Liz Shutler	*Trust CEO and Chair of East Kent Delivery Board attends to influence the programme. Liz attends in Matthew's absence *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 e.g Rachel Jones and Nick Gerrard Finance group lead for STP	PMO reviewed by NHSE and found to be adequate	Substantial						
				STP submission to NHS England **Control Owner:** Liz Shutler	Submitted in time	Reviewed by Board	NHSE positive feedback received in July and October 2016	Substantial			Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Liz Shutler **To be implemented by:** 30 Apr 2018	**14 Jun 2017** **Dorothy Otite** Potential delay until April 2018 **06 Mar 2017** **Dorothy Otite** Now delayed until October 2017		

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE **BoD/62/17**

PERFORMANCE AGAINST 2017-18 OBJECTIVES – QUARTER 1

PERFORMANCE AGAINST 2017-18 OBJECTIVES – QUARTER 1

PATIENTS. Enable all our patients (and clients who are not ill) to take control of all aspects of their **healthcare** by 2021

	RAG Q1	RAG Q2	RAG Q3	YEAR-END ESTIMATE
PERSON-CENTRED CARE: Work collaboratively with service users to improve the patient experience around accessing advice and support to enable self-care. Implement and evaluate virtual support services across 3 client groups. This will enable patients to access support and advice for greater self-care	ON TRACK			
PERSON-CENTRED CARE: Improve FFT satisfaction for inpatients, maternity, outpatients, day surgery and ED:				
Inpatients	MET			
Maternity	MET			
Outpatients	MET			
Accident and Emergency	NOT MET			
SAFE CARE: Reduce the number of falls with harm:				
Reduce the number of avoidable falls causing moderate or above harm by 5% (baseline 31)	MET			
Ensure the falls rate is below the national average – 5.63/1000 bed days				
EFFECTIVE CARE: Undertake 100 % of national audits / ensure data accuracy and action plans in place and implemented	ON TRACK			
EFFECTIVE WORKPLACE: Accredit at least 20 workplace teams against the 'Accrediting and Celebrating Excellence (ACE)' criteria. (This is a performance framework)	ON TRACK			

BLUE	MET QARTER / COMPLETED
GREEN	ON-TRACK TO DELIVER
AMBER	DELAYED
RED	NOT MET IN QUARTER
GREY	EXTERNAL DELAY

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE **BoD/62/17**

PERFORMANCE AGAINST 2017-18 OBJECTIVES – QUARTER 1

PEOPLE: Identify, recruit, educate and develop a talent pipeline of clinicians, healthcare professionals and broader teams of leaders, skilled at delivering integrated care and designing and implementing innovative solutions for performance improvement.

ANNUAL PRIORITY– PERFORMANCE OVERVIEW	RAG Q1	RAG Q2	RAG Q3	YEAR-END ESTIMATE
Improve the overall staff engagement score as measured by the staff survey and NHS staff friends and family test by March 2018	NOT MET			
Implement the Trust wide leadership and management development programme to 200 staff – subject to NHSI approval	AWAITING APPROVAL			
Implement talent management and succession planning process to create a pool of staff to fill key positions for Band 6 staff and above - March 2018	ON TRACK			
Reduce the number of vacancies of hard to fill roles	ON TRACK			
Reduce medical staff pay costs versus income				
Sustain the reduction in the number of staff leaving the Trust within their first year of employment (baseline 21.9%)	NOT MET			

BLUE	MET QARTER / COMPLETED
GREEN	ON-TRACK TO DELIVER
AMBER	DELAYED
RED	NOT MET IN QUARTER
GREY	EXTERNAL DELAY

PERFORMANCE AGAINST 2017-18 OBJECTIVES – QUARTER 1

PARTNERSHIPS: To define and deliver sustainable services and patient pathways together with our health and social care partners, by 2021.

ANNUAL PRIORITY– PERFORMANCE OVERVIEW	RAG Q1	RAG Q2	RAG Q3	YEAR-END ESTIMATE
As part of the K&M STP EKHUFT will (where applicable subject to agreed STP timetable): • support local CCGs to finalise consultation on the Trust Clinical Strategy (currently by October 2017); • complete the work required on the hospital elements of the plan (currently by August 2017); • publish a plan for productivity improvements across back-office services (currently by October 2017); • publish a plan to extend the sharing of information across the footprint (currently by October 2017); and continue to work with partners on a joint pathology project (currently by March 2018 but the progress will be dictated by the STP timeline).	ON TRACK			
Work with KCHFT through the MOU and with local Integrated Accountable Care Organisations to establish: • an agreed programme of work to respond to workforce pressures through, for example, joint appointments/rotations of staff by March 2018; • future plan for the use of community beds (subject to agreed STP timetable – currently October 2017); and • explore models of delivering integrated care that supports the establishment of IACOs within east Kent March 2018.	DELAYED			
Subject to the production of the pre-consultation business case and STP timetable, finalise a 5 year draft estates strategy (currently by March 2018).	ON TRACK			

BLUE	MET QARTER / COMPLETED
GREEN	ON-TRACK TO DELIVER
AMBER	DELAYED
RED	NOT MET IN QUARTER
GREY	EXTERNAL DELAY

PERFORMANCE AGAINST 2017-18 OBJECTIVES – QUARTER 1

Undertake business continuity planning to achieve operational sustainability for acute medical services across the Trust by June 2017.	COMPLETE			

PROVISION: Clearly identify 'what business we are in', 'what we want to be known for' and 'what our core services are'

ANNUAL PRIORITY– PERFORMANCE OVERVIEW	RAG Q1	RAG Q2	RAG Q3	YEAR-END ESTIMATE
Deliver the plan agreed with NHSI to make progress on exiting Financial Special Measures:				
Income	MET			
Expenditure	MET			
CIPs	MET			
Deliver the **locally agreed access standards** as shown in the Integrated Performance Report to ensure patients are seen in a timely way:				
Emergency Department 4 hour[1]	MET			
Referral to Treatment Times	MET			
Diagnostic waits	MET			
62 Day Cancer	MET			
Review the clinical sustainability, with a view to redesigning them in terms of effectiveness and efficiency, of: • Neurology - **complete** • Endoscopy - **Complete** • ENT/Audiology • Cardiology • Vascular • Obstetrics	ON TRACK			

[1] Overall the trajectory was met for quarter 1, however this was due to stronger performance in April and May, in June the Trust did not meet the trajectory.

BLUE	MET QARTER / COMPLETED
GREEN	ON-TRACK TO DELIVER
AMBER	DELAYED
RED	NOT MET IN QUARTER
GREY	EXTERNAL DELAY

REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE BoD/63/17

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE (SWC)**
BOARD SPONSOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX A: WARD ESTABLISHMENT REVIEW** **APPENDIX B: WORKFORCE RACE EQUALITY STANDARD**

BACKGROUND AND EXECUTIVE SUMMARY

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

This report presented reflects Committee activity for the July 2017 meeting.

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

- What went well over the period reported?
- What concerns were highlighted?
- What corrective action was sought?

MEETING HELD ON 31 JULY 2017

Issues from June 2017 Integrated Performance Report were discussed:

- The Trust turnover levels have reduced slightly and are returning to those at the beginning of the year. The first feedback from the Picker work on exit interviews shows an interest from staff in more flexible working possibilities.
- The Committee asked for a detailed review of the attraction retention and development of nurses given the national shortage.

The following concerns were highlighted:

- Ward Establishment Review
  - Vacancies across all wards in May are at 10.28% up from 9% in 2016, and turnover of nurses and midwives is up to 13% from 8.9% last year.
  - Active recruitment programmes are underway.
  - There is alignment between current funded establishments and the modelling tools used for most wards, however, the respiratory wards on each site need further assessment. Local management and the Heads of Nursing team will review whether some rebalancing of resource is needed.
  - SafeCare is being implemented which will help with the continuous monitoring of acuity and dependency.
- The Committee expressed disappointment that the consultant recruitment paper was not yet available. The Director of Human Resources gave assurances that she is monitoring processes and performance in this important area and extending the scope to recruitment of other medical staff.

The Committee received the following reports and assurances:

- People strategy

- The implementation plan was reviewed and some re-scheduling is required to line up with the Financial Special Measures (FSM) work and transformation plan.
- There has been National recognition of the Trust's work on reducing turnover in the first year of employment, and using the respect programme to reduce bullying/harassment.
- The most recent staff friends and family test shows 76% would recommend the Trust is a place to receive treatment (similar to previous scores) and 52% would recommend this as a place to work (down 2%) . Free text write in comments show some negative comments about management and trustworthiness, and the Executive Management Team (EMT) will be following this up.

- Medical Education Report
  - The Committee commended the Director of Medical Education for her leadership during the recent significant changes for trainee doctors, with clear signs that the doctors understand the rationale for the move and the long term benefits for their training. The General Medical Council (GMC) satisfaction survey showed improvement and reduction in the number of red flags.
- Workforce modelling
  - The Committee were presented with some encouraging work to support the clinical strategy and Sustainability and Transformation Plan (STP). Part of this is a business case to introduce 24 advanced clinical practitioners within emergency and acute medicine.
  - The Committee requested that a broader whole systems approach be taken to future career possibilities, and that the options for use of wearable devices, AI, and robotics be considered in improving patient care and modernising working practices.
- Impact of Agency Usage
  - A study showed no firm patterns where agency usage is relatively high. On balance people feel it is better to have staff in place than to have a shortage. Induction and training to meet local standards and practices is very important.
- Workforce Race Equality Standard (WRES)
  - East Kent Hospitals University NHS Foundation Trust (EKHUFT) has demonstrated improvement on all metrics over the last two years, and the diversity and inclusion steering group will be working with divisional leaders and HR business partner to produce more focused actions for further progress.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report from the Strategic Workforce Committee.

REPORT TO:	**REPORT TO BOARD OF DIRECTORS AS RECEIVED BY STRATEGIC WORKFORCE COMMITTEE**
DATE:	**11 AUGUST 2017**
SUBJECT:	**WARD ESTABLISHMENT REVIEW MAY 2017**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**ASSOCIATE CHIEF NURSE**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Annual staffing reviews are now required with six monthly updates to the Strategic Workforce Committee. It should be noted that this review took place in May-17 and therefore does not reflect the changes that took place with movement of services from Kent & Canterbury (K&C) from 19 June.

<u>The findings from the review are:</u>

1. The NHS Quality Board requirements in providing assurance on safe staffing are currently being met;
2. To improve alignment of staffing required to demand the implementation of Safe Care commenced in June-17;
3. The implementation of the Nurse Associate role to support safe staffing commenced in April-17 and candidates are progressing well;
4. The impact of previous investment into ward staffing has increased Whole Time Equivalent (WTE) per bed across most areas;
5. Average skill mix is similar to the previous review and close to 60/40 or more across most areas. The impact of associate practitioners is reflected in a slightly reduced skill mix over the last two years in most specialties where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies;
6. The vacancy rate across all wards is 10.28%, an increase from the previous review in May-16 (9.0%). Registered nurse vacancies in wards are 148 WTE, an increase from 91 WTE in the previous review, with the majority at band 5. Healthcare assistant vacancies have remained at 34 WTE, similar to the previous review (33 WTE);
7. Overall average sickness across all 49 wards is at 4.4% and has fallen from 4.47% in May-16.
8. The absence associated with maternity leave in May-17 across the 49 wards is significant, at 35 WTE (1.96%), similar to May-16 (2%). Ward managers are now able to recruit to posts and this has significantly reduced the impact of maternity leave;
9. Overall turnover of registered nurses and midwives has increased from 8.9% in 2015/16 to 13.0% during 2016/17. The turnover of healthcare assistants also increased, from 12.8% in 2016/17 to 13.2% in 2017/18 indicating a less stable workforce;
10. Improvement in roster quality has been sustained with the average

achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-17 at 78.7%, similar to May-16 (78%) from just 72% In Oct-15. Almost all (41 out of 49) wards achieved more than the optimum 75%;

11. Details and summary of planned and actual staffing on a shift-by-shift basis, continues to be published monthly. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in May-17 are near or over 100% on all three acute sites. The trend in performance over time reflects the national trend. Average hours filled during day shifts in May-17 were above 80% in all wards except Taylor (75%) which reflects the impact of planned and unplanned leave on small funded establishments.

    Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time. However, the bank line within ward budgets is not reflected in roster templates, which has the effect of slight over-inflation of %filled hours against planned. 45 out of the 49 wards have a bank line which represents 43.27WTE not included in roster templates.
12. Most ward managers reported an increased move from 7.5 to 12 hour shift patterns, thereby reducing staffing handover overlap times, to provide greater staffing numbers on each shift.
13. There is alignment between current funded establishments and modelling tools applied (Professional Judgement, Hurst and the Shelford SNCT for most wards. However, acuity and dependency appeared higher in May-17 than in Nov-16 for some wards not reflecting the expected variation in nursing workload between winter and spring.

Evaluation of the triangulation of the modelling methods is summarised as:

Clinical Decision Units (CDUs)	Current establishments show alignment to Shelford but less so to Professional Judgement. The K&C CDU was difficult to assess due to the combined establishment with Urgent Care Centre (UCC).
Medical wards	Alignment for most wards but establishments below that suggested by Shelford on CJ, Sandwich Bay, St Margarets, Deal, Invicta, Mount McMaster, St Augustines and CM1 where acuity and dependency has increased. Correlation of Shelford and Professional Judgement which suggest lower than required staffing establishments on CJ, Sandwich Bay, St Margarets, Invicta and CL which may require higher staffing levels and will require close monitoring. Acuity and dependency appear to have increased since May-16 particularly on Mount McMaster, St Augustines and CM1.
Stroke Units	Alignment for all wards (*SEC Network Stroke Model). Shelford does not capture stroke thrombolysis nursing work outside the ward.
Frailty	Increased acuity and dependency is seen on both wards but Professional Judgement does not indicate the requirement for more staff.

Coronary Care Units	Alignment with Professional Judgement and Hurst but Shelford does not capture intensity of pPCI nursing work.
Renal & Haematology	Alignment on both wards with Professional Judgement and Hurst but less so with Shelford.
Paediatrics	*RCN and Professional Judgement suggest higher establishments to cover day surgery & relocated outpatients particularly on Padua.
Surgery	Alignment for most wards except Rotary due to Shelford not capturing outpatient activity and Clarke & Kent not capturing trolley activity
Trauma and Orthopaedics	Alignment with Professional Judgement and Hurst but less so with Shelford on KC2 & Quex due to it not capturing high throughput on these wards. Acuity and dependency has increased on KC1 where Professional Judgement and Shelford both suggest a higher required establishment.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Continued vacancy factor and reliance on temporary staffing will require further innovative recruitment approaches to enable recruitment ahead of turnover.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR8 Ability to attract, recruit and retain high calibre staff to the Trust.
RESOURCE IMPLICATIONS:	Adequate staffing levels impact on the achievement of the required performance indicators, non-compliance with contractual obligations attract financial penalties. This includes 2017/18 CQUINs which are valued at 2.5% of actual outturn, or around £5.7M.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Divisional Heads of Nursing meeting.

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

RECOMMENDATIONS AND ACTION REQUIRED:

1. To review the impact of the movement of services from K&C to William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother (QEQM) on appropriateness of staffing;
2. Closely monitor acuity and dependency trends monthly particularly on medical wards where higher staffing levels may be required, to determine appropriateness of current staffing;
3. Support full implementation of Safecare during 2017/18 to enable alignment

of staffing to demand;

4. To continue phased recruitment to the investment approved into the Emergency Departments and Neonatal Intensive Care Unit (NICU). Further work to be undertaken to explore further investment required into Maternity;
5. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
6. Undertake further work to understand the complexity of evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation and report to the Strategic Investment Group.

WARD ESTABLISHMENT REVIEW MAY 2017

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WARD ESTABLISHMENT REVIEW MAY 2017

1. INTRODUCTION

Regular ward staffing reviews have been undertaken since 2007/08 to ensure that the ward nursing establishments provide an appropriate staffing level and skill-mix to support the delivery of safe and effective care to patients. Ward staffing reviews now take place annually, with a six monthly update, to fulfil the requirements set out by the NHS Quality Board.

In July 2016 the National Quality Board published updated guidance, building on the 2013 guidance, to provide an updated safe staffing improvement resource.

This report provides:

1. An overview of the updated guidance and a gap analysis on current Trust compliance;
2. A progress update on the recommendations from the previous ward staffing review update (Nov-17) reported to the Strategic Workforce Committee in January 2017;
3. The May 2017 review including all wards across the Trust including:

UC&LTC	Medicine
	Clinical Decision Units
	Coronary Care
	Stroke
	Health Care of the Older Person (HCOOP) / Frailty
Surgical Services	Surgery
	Trauma & Orthopaedics
	Critical Care
Specialist Services	Renal
	Haematology / Oncology
	Gynaecology
	Paediatrics
	Midwifery
	Neonatal Intensive Care (NICU)

This paper provides information on the findings of the review and outlines a number of recommendations to the Board of Directors.

2. NATIONAL QUALITY BOARD EXPECTATIONS ON WARD STAFFING

2.1 Recommendations for greater transparency of ward staffing levels has followed the Francis report on Mid Staffordshire (2013), the Keogh review (2013), the Berwick report on improving the safety of patients in England (2013) and the NHS England report on Hard Truths; The journey to putting patients first (2013).

As a result, in 2013 the NHS Quality Board published guidance ‘How to ensure the right people, with the right skills, are in the right place at the right time’ which

identified new requirements in providing assurance on safe staffing. The requirements were related to three main areas of action:

- To clearly display information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. Displays should be in an area visible to patients, families and carers and explain the planned and actual numbers of staff for each shift as well as who is in charge of the shift.

  Staffing boards have been in place since April 2014 in all inpatient wards.

- The board should receive monthly reports containing details and summary of planned and actual staffing on a shift-by-shift basis, is advised about those wards where staffing falls short of what is required to provide quality care, the reasons for the gap, the impact and the actions being taken to address the gap.

  Actual against planned staffing hours, by inpatient area, is reported to the Board as part of the monthly Integrated Performance report. This report is accessible to patients and the public on a dedicated area of the Trust website and is published on the relevant hospital profile on NHS Choices.

- The Board should receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in the National Quality Board guidance and reflects a realistic expectation of the impact of staffing on a range of factors.

2.2 In July 2016 the National Quality Board (NQB) published updated guidance 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' building on the 2013 guidance to provide an updated safe staffing improvement resource.

The priorities reflect the NQB expectations in three areas; Right staff, right skills and right place. A gap analysis has been undertaken (Appendix 1) against this recent guidance and the following key areas of work have been identified:

- Annual staffing reviews, using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans, should be reported to Trust Boards. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

  The previous requirement was six monthly full reviews. The last full review was undertaken in May 2016 and an update was reported to the Strategic Workforce Committee in January 2017.

- Care Hours Per Patient Day (CHPPD) should be included in the local quality dashboard. CHPPD are also included, by ward, and include registered nurse and care staff hours against the cumulative total of patients on the ward at 23.59 each day during the month, to relate actual staffing to patient numbers. This is reported every month to the Quality Committee and up to the Board of Directors. These data have been included in the Quality heatmap since February 2017.

- The current approach to improve alignment of staffing required to demand focusses on the further development and embedding of live capture, reporting and escalation of staffing status through the dedicated safer staffing tool within Qlikview which enables the capture of daily planned, actual and required staffing linked to acuity and dependency. However, this system is not sufficiently sophisticated to enable live view of patient acuity dependency and skill mix linked to the Healthroster to enable optimised deployment of staff. A business case aligned to the workforce CIP programme to implement Healthroster Safe Care was approved and implementation began on 26th June 2017.

3. PROGRESS IN IMPLEMENTING RECOMMENDATIONS FROM THE PREVIOUS REVIEW

1. Annual staffing reviews are now undertaken with six monthly updates to the Strategic Workforce Committee;
2. Care Hours Per Patient Day (CHPPD) are now included in the ward Quality Heatmap;
3. To improve alignment of staffing required to demand the business case aligned to the workforce CIP programme to implement Safe Care was approved and implementation commenced in June-17;
4. The 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme is being finalised;
5. Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation was reported to the Strategic Investment Group in February 2017. Further work is planned to understand the complexity of evaluating the impact of this investment;
6. The implementation of the Nurse Associate role to support safe staffing commenced in April-17 with 20 trainees. The Trust is leading the East Kent Partnership across EKHUFT and KCHFT;
7. Phased recruitment to the investment approved into Neonatal services and the investment into the Emergency Departments is progressing. Further work is to be undertaken to explore further investment required into Maternity.

4. CURRENT WARD ESTABLISHMENTS

A summary of current funded establishments and staff in post is provided in Appendix 2. This includes the detail, by ward, of funded registered nurse, support worker, administrative support posts and actual staff in post at May-17.

The structure of most (90%) ward budgets (44 out of the 49 reviewed) includes a separate bank line which provides a resource as part of the funded WTE to manage peaks and troughs in activity and flexible replacement for sickness. Most ward managers have chosen not to convert an element of this resource to substantive posts due to the flexibility it provides.
Converting this budget into WTE represents an additional 43.27 WTE across the 49 wards, and it is this 'uplifted' total funded establishment that has been used as the baseline when making comparisons with the modelling methods within this review. However, operationally this component of the budget is not included in the establishment for E-Rostering and is utilised by requesting additional shifts within the system to provide additional cover for long-term sick leave.

Additional average allowance or percentage headroom within funded establishments is 22% which includes a 3% allowance for sickness, 30 days annual leave plus bank holidays and study leave of around 4 days per year.

5. SKILL MIX AND WHOLE TIME EQUIVALENT PER BED (WTE)

Skill mix is similar to the previous review. The impact of associate practitioners is reflected in a slightly reduced skill mix in stroke, orthopaedic and some medical wards, over time, where the role has been implemented to support specific patient pathways and reduce the impact of registered nurse vacancies. Associate Practitioners are highly trained support staff who undertake a Foundation Degree, equivalent to diploma level, and are able to undertake much of the work previously within the domain of the registered nurse. Skill-mix is represented including those providing direct patient care only and excluding administrative staff (ward clerk and ward manager assistant roles) and close to 60/40 or more across most areas, seen in Figure 1.

Figure 1. Skill-mix including registered nurses / support staff

Skill-mix - Direct patient care						
Specialty	**Mar-14**	**Oct-14**	**Apr-15**	**Oct-15**	**May-16**	**May-17**
Medical	59/41	59/41	59/41	59/41	58/42	**59/41**
CDU	69/31	67/33	70/30	69/31	66/34	**66/34**
CCU	82/18	82/18	83/17	83/17	83/17	**83/17**
Stroke	63/37	59/41	57/43	58/42	58/42	**58/42**
Acute frailt	57/43	57/43	58/42	56/44	57/43	**56/44**
Surgery	60/40	59/41	59/41	59/41	60/40	**59/41**
T+O	58/42	57/43	57/43	57/43	57/43	**57/43**
Gynaecolo	65/35	65/35	65/35	63/37	67/33	**67/33**
Paediatrics	80/20	77/23	77/23	80/20	80/20	**80/20**

The impact of previous investment into ward staffing has increased WTE per bed across most areas, seen in Figure 2.

Figure 2. Average ward staffing WTE per bed from 2007 to 2017

Average WTE per bed											
Specialty	**2007/08**	**2008/09**	**2011/12**	**2012/13**	**Mar-14**	**Oct-14**	**Apr-15**	**Oct-15**	**May-16**	**May-17**	**Hurst**
Medical	1.14	1.19	1.28	1.33	1.29	1.29	1.34	1.36	**1.36**	**1.38 ↑**	1.38
CDU	NR	NR	NR	2.18	1.54	1.92	1.61	1.81	**1.87**	**1.75 ↓**	1.71
CCU	2.2	2.2	2.42	2.76	2.62	2.68	2.69	2.56	**2.54**	**2.54 ↔**	2.21
Stroke	1.19	1.52	1.57	1.75	1.79	1.84	1.85	1.84	**1.84**	**1.84 ↔**	1.9
Acute frailty	1.1	1.18	1.29	1.47	1.33	1.34	1.51	1.38	**1.46**	**1.45 ↓**	1.43
Surgery	1.09	1.28	1.46	1.38	1.45	1.5	1.57	1.53	**1.50**	**1.50 ↔**	1.43
T+O	1.12	1.17	1.21	1.32	1.36	1.37	1.40	1.41	**1.41**	**1.42 ↑**	1.42
Renal				1.5	1.81	1.81	1.83	1.91	**1.90**	**2.09 ↑**	1.71
Haematology				1.38	2.09	2.09	2.08	2.06	**2.03**	**2.20 ↑**	1.82
Gynaecology				1.96	1.93	1.93	2.02	1.97	**2.09**	**2.31 ↑**	1.53

6. WORKFORCE METRICS

The total budgeted establishment across the wards reviewed has increased over time, seen in Figure 5, following previous investment into ward staffing. The impact of current vacancy levels, sickness and maternity leave across the 49 wards is 16.75%, an increase from 15.5% in May-16, summarised in Figure 3.

Figure 3. Wards staffing vacancy, sickness and maternity leave May-17

Workforce indicators							
	Dec-12	Mar-14	Oct-14	Apr-15	Oct-15	May-16	May-17
Total budgeted establishment across 46 wards (WTE)	1514.90	1514.01	*1620.02	1680.86	1728.21	1746.45	1774.64
Registered Nursing vacancies (WTE)	44.00	73.88	37.66	124.71	120.58	91.43	148.06
HCA and other support staff vacancies (WTE)	28.00	5.13	36.44	12.55	38.72	32.90	34.48
Vacancy (%)	4.75	5.21	6.08	8.16	9.20	9.00	10.28
Sickness (%)	4.96	4.90	4.60	5.15	3.80	4.47	4.51
Maternity leave (%)	3.28	2.38	2.53	3.89	3.00	2.01	1.96
* includes 82.9 wte ECC/CDU which was not included in previous reviews							

The majority of maternity leave is recruited to, in accordance with guidance issued to ward managers, but further work is required to ensure that the process of recruitment is undertaken in a timely fashion to ensure availability of replacement staff to reduce gaps.

6.1 Vacancies

The vacancy rate across all wards is 10.28%, an increase from the previous review (9.0%). Registered nurse vacancies in wards are 148 WTE, an increase from 91 WTE in the previous review, with the majority at band 5. Healthcare assistant vacancies have remained at 34 WTE, similar to the previous review (33 WTE).

Several issues have contributed to the rise in vacancies:

- There is a national shortage of registered nurses;
- The shortage of candidates with the right skills and experience has created a competitive market and EKHUFT also suffers from a unique geographical position on a peninsula with 'fast transport links' into London;
- We compete with the London Healthcare Market and Private Healthcare Providers and other NHS providers in areas where the NHS High Cost Area Supplement (London Weighting) applies;
- NHS budget constraints led to reduced numbers of nurse training places from 2010 – 2013. Although a 10% increase in training places was agreed for 2015/16, a further increase for the 2016/17 academic year entry was not supported, following the 2015 Comprehensive Spending Review;
- There has been a gradual fall in % newly qualified nurses who take up their first post within EKHUFT since 2013 with only 55% of the Canterbury Christ Church University (CCCU) newly qualified cohort taking up a band 5 post within EKHUFT in Apr-17. This is due to many factors including relocation back to home and taking up posts in London. Feedback from students has led to cohort recruitment one year before qualifying and rotational opportunities being created to improve retention;
- There have been delays in the arrival of overseas nurses recruited in 2016/17 due to challenges in achieving the required IELTS level 7 English language qualification.

6.2 Sickness absence

ESR data demonstrates that average sickness absence rate across the wards has fallen slightly from 4.47% in May-16 to 4.4% in May-17. Average rates in excess of 5% were seen in some stroke, medical, frailty, surgical and orthopaedic wards with higher rates of HCA sickness in excess of 10% on two medical wards. This reflects the high physical and emotional demands of ward work in some areas and also significant opportunity for further improvement.

6.3 Maternity leave

The absence associated with maternity leave in May-17 across the 49 wards is significant, at 35 wte (1.96%), similar to May-16 (2%). Following investment into ward staffing this element of absence is now recruited to thus reducing the impact of maternity leave. The majority of maternity leave is recruited to, in accordance with guidance issued to ward managers, but further work is required to ensure that the process of recruitment is undertaken in a timely fashion to ensure availability of replacement staff to reduce gaps. Ward managers report that this has had a very positive impact.

6.4 Staff turnover

Turnover figures include only staff who have left the employment of the organisation and do not include staff who are internally promoted. ESR data (excluding TUPE staff) demonstrates that our overall turnover of registered nurses and midwives increased from 8.9% in 2015/16 to 13.0% during 2016/17, seen in Figure 4. The turnover of healthcare assistants also increased, from 12.8% in 2016/17 to 13.2% in 2017/18.

Figure 4. Average turnover of nursing, midwifery and care staff 2011 to 2017

Turnover (%)						
	2011	2012	2013/14	2014/15	2015/16	2016/17
Nursing & Midwifery	7.5	9.5	11.2	12.8	8.9	13
HCA and other support staff	12.6	10.6	10.6	14.2	12.8	13.2

7. Roster performance, actual against planned filled hours and Care Hours per Patient Day

7.1 Roster performance

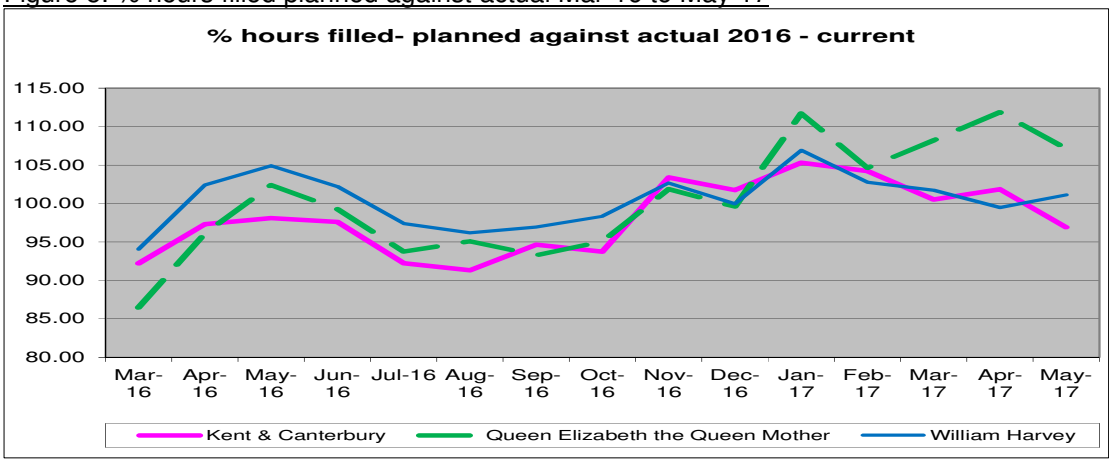
Improvement in roster quality has been sustained with the average achievement of % time clinically effective (% time worked) across all the wards reviewed, within E-Rostering for May-17 at 78.7%, similar to May-16 (78%) from just 72% In Oct-15. Almost all (41 out of 49) wards achieved more than the optimum 75%.

Meeting the 75% time worked measure requires effective annual leave planning to ensure it is evenly spread, effective sickness management, fair allocation of training days and effective use of management time. An annual leave wall planner to support ward managers in managing the spread of annual leave is in use in most wards.

7.2 Actual against planned filled hours

Revised National Quality Board guidance published in May 2014 outlined the requirement for % fill of planned and actual hours to be identified by registered nurse and care staff, by day and by night, and by individual hospital site. Reported data is derived from the E-Rostering and NHS-Professionals systems and aggregated fill rates in May-17 are near or over 100% on all three acute sites, shown in Figure 5.

Figure 5. % hours filled planned against actual Mar-16 to May-17



Average hours filled during day shifts in May-17 were above 80% in all wards except Taylor (75%) which reflects the impact of planned and unplanned leave on small funded establishments.

Low fill rates are also seen:

- In registered nurse shifts on Harvey and Fordwich wards due to vacancies, on Kingston due to high sickness and Kings C2 due to maternity leave;
- For support workers shifts in CCUs and Treble ward due to high levels of sickness;
- Other wards (Critical care units, Padua, Kennington, Braeborne, Maternity areas) show low fill rates for support worker shifts demonstrating the impact of sickness and parenting leave on % fill where small WTE exist within the ward establishment.

Actions in place include:

- Matrons and non ward-based staff often cover the shifts that are short of staff. This is not reflected in the filled hours as it is not captured on the E-Roster currently;
- The roll out of Safecare has commenced at WHH which will allow the live capture of patient acuity dependency and improved matching of staffing to demand;
- Skill-mix changes are made, such as using a healthcare assistant if a registered nurse is not available. This explains why some fill rates are high for 'Care Staff';
- Recruitment campaigns continue both locally and overseas;
- Retention is being addressed with wards and teams with support from the HR Business Partners.

Work to ensure that roster templates closely reflect the budgeted establishments and include shifts necessary for additional beds has supported the increased fill rates seen over time. However, the bank line within ward budgets is not reflected in roster templates, which has the effect of slight over-inflation of %filled hours against planned. 45 out of the 49 wards have a bank line which represents 43.27WTE not included in roster templates.

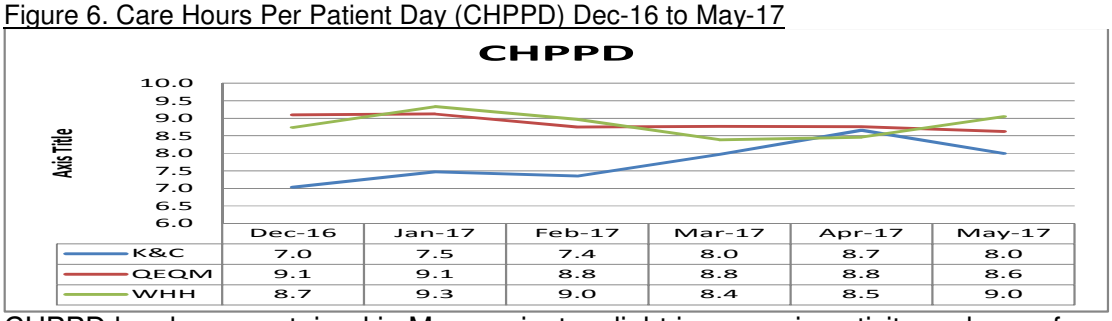
7.3 Care Hours Per Patient Day (CHPPD)

CHPPD have also been reported since May-16, to relate actual staffing to patient numbers and includes registered nurse and care staff hours against the cumulative total of patients on the ward at 23.59 each day during the month. The range is from around 5 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required. The trend in Figure 6 shows some

consistency by site and slightly higher CHPPD at QEQM and WHH reflecting the specialty of provision on those sites. CHPPD has been included in the Quality Heatmap, by ward, since Feb-17.

Comparative data within the Model Hospital dashboard for Jan-17 shows EKHUFT average of 8.8 against a peer median (based on both spend and clinical output) of 8.2 and a national median of 7.6 (all Acute Trusts, Mental Health Trusts and Community Trusts). Reasons for the variance against the peer value may be linked to the high numbers of patients requiring Specialling within our wards. The EKHUFT overall average CHPPD in May-17 is 8.4 (8.6 in April).

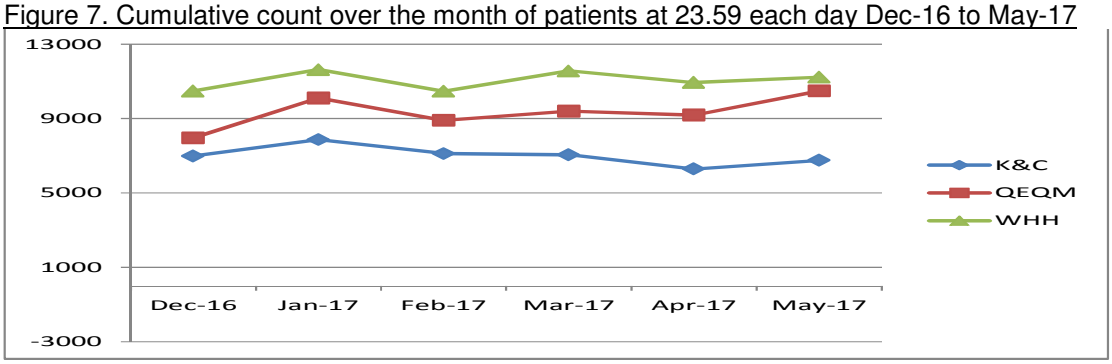
Figure 6. Care Hours Per Patient Day (CHPPD) Dec-16 to May-17



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
K&C	7.0	7.5	7.4	8.0	8.7	8.0
QEQM	9.1	9.1	8.8	8.8	8.8	8.6
WHH	8.7	9.3	9.0	8.4	8.5	9.0

CHPPD has been sustained in May against a slight increase in activity and use of contingency beds shown in Figure 7 and this has contributed to the continued rate of over 100% seen this month in %fill against budgeted establishments.

Figure 7. Cumulative count over the month of patients at 23.59 each day Dec-16 to May-17



8. Triangulation between evidence based tools and professional judgement and scrutiny

There is no single nursing staff to patient ratio that can be applied across all wards to safely or adequately meet the nursing care needs of patients. A range of tools, outlined in table 1 are available for use in evaluating individual specialties.

Table 1. Methodologies used to evaluate specialties

Area	**Methodology**
Wards	The Shelford Safer Nursing Care Tool (Shelford Group 2013), Professional Judgement, Hurst Nursing Workforce Planning Tool (2012 & 2014).
Stroke Units	SEC Cardiovascular Strategic Network Stroke and TIA Service & Quality Standards (2014)
Critical Care Units	British Association of Critical Care Nursing (2009)
Paediatrics	Royal College of Nursing (RCN 2012) guidelines
Emergency Departments	Baseline Emergency Staffing Tool (BEST - RCN)
Midwifery	Birthrate Plus (RCM)
NICU	Department of Health Toolkit for High Quality Neonatal Services 2009. British Association of Perinatal Medicine 2011.

There are advantages and disadvantages to the different methods and tools used to model staffing levels, and also a view that none of them capture the communication aspects of nursing work (nurse-patient, nurse-family, nurse-doctor, nurse-other healthcare professionals and departments, nurse-other agencies). Different systems applied to the same care environment can produce different results, and so combining two or more methods is recommended to improve reliability and validity.

8.1 Professional judgement

A component of the Hurst workforce planning tool includes a method of calculating required establishments using professional judgement. The feedback from ward managers on required staffing levels across the 24 hour period was utilised and there was a close correlation between calculated establishments and actual for most wards. Most ward managers (48 out of 49) reported an increased move from 7.5 to 12 hour shift patterns, thereby reducing staffing handover overlap times, to provide greater staffing numbers on each shift.

8.2 Hurst Workforce Planning Tool

The Hurst Nurse per Occupied Bed formulae (Hurst 2014) were applied to the main specialties. These formulas are unique because they are derived from data collected in same specialty wards. The wards providing these data (across the UK) passed a quality test, that is, none fell below a pre-determined quality standard to avoid projecting from inadequately staffed wards. Hurst formulae are available for a wide range of specialties and all wards were benchmarked against the most appropriate 'fit'. The tool provides a calculated establishment in relation to number of beds and NPOB guidance per specialty.

Calculation of establishments using the NPOB method suggested that most ward establishments are near recommended Hurst levels except Cambridge J and Kingston ward. However, the calculated establishments were significantly lower than current for Rotary, Birchington and Kennington wards as the tool does not enable capture of trolley, ward attender and outpatient activity.

8.3 Alignment of staffing required to demand though the Shelford Safer Nursing Care Tool

The Shelford Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care 2000). These classifications have been adapted to support measurement across a range of wards and specialties.
The dimensions of patient dependency and acuity are important variables in determining nursing workload and the SNCT was applied to study current nursing workload in all wards to calculate ward establishment. The updated Shelford SNCT (2013) reiterates the requirement for assessment over a longer period so this approach was used and quality control was provided by matrons who consistency checked submissions for all their wards. Further consistency checking was provided by a senior nurse to ensure common understanding and appropriate application of the criteria.

The capture of the dependency and acuity of patients has moved from paper-based to electronic with the development of a dedicated safer staffing tool within Qlikview in 2015. This enables live capture, reporting and escalation of staffing status with daily planned, actual and required staffing linked to acuity and dependency. . However, this system is not sufficiently sophisticated to be linked to Healthroster to readily allow reallocation to staff to areas of high demand.

Average March to May-17 calculation of establishments using the SNCT method taking account of nursing workload associated with patient acuity and dependency demonstrated some correlation between calculated and actual establishment for

most wards. However, Cambridge J, Sandwich Bay, St Margarets, Invicta and Cambridge L wards saw an increase in acuity and dependency of patients matched by professional judgement.

Some ward managers have reported some variation in interpretation of the levels within the SNCT tool particularly over the past year as the proportion of highly dependent and acutely ill patients has increased. Drivers of nursing workload related to acuity and dependency are outlined in table 2, but additional workload is presented with increased throughput of patients for example taking drug charts to pharmacy and collecting take home medications which can mean significant time away from the ward for nursing staff. Further experience in the use of the tool and continued consistency checking will lead to increased confidence in the use of the SNCT particularly as Safecare is rolled out across all adult wards during 2017/18. Safecare will provide more sophisticated information to enable staff to be available to meet patients' needs. An example of the reporting capability is included in Appendix 3.

Table 2. Drivers of nursing workload

Nursing workload is directly related to patient acuity and dependency. That is, the level of patient need in meeting activities of daily living combined with the complexity of treatment of the medical condition which necessitated admission to hospital. Examples of therapies and treatment which increase nursing workload include the care of patients requiring non-invasive respiratory support such as CPAP or BIPAP, caring for patients requiring enteral or parenteral nutrition, management of central venous lines, tracheostomy care, complex medication regimes including oral and intravenous therapy, neurological assessment, monitoring and observation for signs of deterioration and escalation of care. Nursing workload is further increased when supporting patients with complex nursing care needs including altered states of consciousness, patients with dementia, complex mental health needs or complex communication difficulties associated with learning disability. Increasing the throughput of patients and decreasing length of stay generates additional nursing work related to assessment on admission, and planning safe discharges to tight time-frames.

The Nursing and Midwifery Council (NMC), the regulator for nurses and midwives whose main purpose is to protect the public, have set standards for the supervision and assessment of students and learners in practice which produces another level of work which is conducted without additional resource to the budgeted ward establishments. Mentors with responsibility and accountability for making the final sign-off in practice must have the equivalent of an hour per student per week allocated during their final period of practice learning. With around 150 students alone undertaking this assessment within EKHUFT annually this represents a significant workload that is also absorbed at ward level.

The application of modelling methods (summarised in figure 8) has identified that:

- There is some alignment of current funded staffing budgets and the establishments derived from application of the modelling methods following previous investment into ward staffing;
- There is alignment between current funded establishments and modelling tools applied (Professional Judgement, Hurst and the Shelford SNCT) for most wards. However, acuity and dependency appeared higher in May-17 than in Nov-16 for some wards not reflecting the expected variation in nursing workload between winter and spring. There has been an increase in acuity dependency over time on some wards.

Evaluation of the triangulation of the modelling methods is summarised as:

CDUs	Current establishments show alignment to Shelford but less so to Professional Judgement. The K&C CDU was difficult to assess due to the combined establishment with UCC.
Medical wards	Alignment for most wards but establishments below that suggested by Shelford on CJ, Sandwich Bay, St Margarets, Deal, Invicta, Mount McMaster, St Augustines and CM1 where acuity and dependency has increased. Correlation of Shelford and Professional Judgement which suggest lower than required staffing establishments on CJ, Sandwich Bay, St Margarets, Invicta and CL which may require higher staffing levels and will require close monitoring. Acuity and dependency appear to have increased since May-16 particularly on Mount McMaster, St Augustines and CM1.
Stroke Units	Alignment for all wards (*SEC Network Stroke Model). Shelford does not capture stroke thrombolysis nursing work outside the ward.
Frailty	Increased acuity and dependency is seen on both wards but Professional Judgement does not indicate the requirement for more staff.
Coronary Care Units	Alignment with Professional Judgement and Hurst but Shelford does not capture intensity of pPCI nursing work.
Renal & Haematology	Alignment on both wards with Professional Judgement and Hurst but less so with Shelford.
Paediatrics	*RCN and Professional Judgement suggest higher establishments to cover day surgery & relocated outpatients particularly on Padua.
Surgery	Alignment for most wards except Rotary due to Shelford not capturing outpatient activity and Clarke & Kent not capturing trolley activity.
Trauma and Orthopaedics	Alignment with Professional Judgement and Hurst but less so with Shelford on KC2 & Quex due to it not capturing high throughput on these wards. Acuity and dependency has increased on KC1 where Professional Judgement and Shelford both suggest a higher required establishment.

Figure 8. Triangulation between professional judgement and evidence based tools.

WARD ESTABLISHMENT REVIEW MAY 2017

May-17

Specialty	Ward	Full Est (WTE)	Prof judgment (PJ)	Hurst NPOB or other appropriate model	Shelford May-16	Shelford Nov-16	Shelford May-17	CHPPD	Comments
CDUs	CDU WHH	63.47	56.69	76.2	58.14	68.57↑	66.09	13.3	Alignment to Shelford but less so to PJ. The K&C CDU is difficult to assess due to the combined establishment with UCC.
	CDU, QEQM	47.88	55.64	44.3	42.73	42.19	43.14	10.2	
	UCC (incl. CDU)	85.70	48.04	27.0					
Medical	Cambridge J	44.65	52.0	50.6	72.64 ↑	58.31	54.61	6.2	Alignment for most wards but establishments below that suggested by Shelford on CJ, Sandwich Bay, St Margarets, Deal, Invicta, Mount McMaster, St Augustines and CM1 where acuity and dependency has increased. PJ also suggests lower than required staffing establishments on CJ, Sandwich Bay, St Margrets, Invicta and CL. Acuity and dependency appear to have increased since May-16 on Mount McMaster, St Augustines and CM1.
	Cambridge K	34.70	32.9	37.0	32.39	32.33	33.83	5.6	
	Cambridge M2	27.09	31.6	28.3	29.66	29.19	27.53	6.2	
	Minster Ward	31.77	35.2	32.6	34.41	34.41	33.79	6.6	
	Oxford	23.91	25.5	20.9	23.34	23.71	24.01	8.0	
	Sandwich Bay	27.62	36.5	30.3	33.73	33.73	33.73	9.0	
	St Margarets	26.71	31.5	31.5	42.67 ↑	42.67	32.45	6.7	
	Deal	35.31	36.2	38.1	43.13 ↑	43.56	43.78	6.8	
	Harvey ward	27.96	30.3	24.6	27.37	27.37	27.37	6.7	
	Invicta	29.92	34.5	33.7	30.75	34.14	34.14	5.5	
	Treble ward	29.41	30.2	24.2	18.91	22.14	23.31	6.3	
	Mount McMaster	30.49	34.7	33.7	39.80 ↑	45.03↑	50.57	5.1	
	St Augustines	34.04	35.9	37.0	40.81	43.49↑	48.12	4.5	
	Cambridge M1	26.69	28.9	27.2	25.29	34.3↑	44.47	6.2	
Stroke	Fordwich Ward	39.22	44.8	38.0*	37.43	39.06	39.06	9.4	Alignment for all wards (*SEC Network Stroke Model. Shelford does not capture stroke thrombolysis nursing work outside the ward.
	Kingston	36.83	38.9	42.1*	31.76	36.57	36.82	6.2	
	Richard Stevens Unit	42.64	44.4	44.8*	41.55	39.44	39.95	7.0	
Frailty	Harbledown	34.59	35.5	32.1	54.45 ↑	55.76	64.87	5.9	Some alignment across both wards with PJ and Hurst. Increased acuity and dependency is seen on both wards but PJ does not indicate the requirement for more staff
	Cambridge L	38.22	41.2	34.1	43.10	43.62	43.84	6.4	
Coronary Care	Taylor KCH	14.07	13.4	10.8	7.78	8.57	8.79	7.0	Alignment with PJ and Hurst but Shelford does not capture intensity of pPCI nursing work.
	CCU QEQM	22.90	22.6	25.8	18.29	18.39	17.77	7.8	
	CCU WHH	31.75	30.2	32.7	17.33	17.36	16.45	13.5	
Renal & Haematology	Marlowe	60.84	61.8	54.7	27.67	34.61↑	30.19	9.4	Alignment on both wards with PJ and Hurst but less so with Shelford
	Brabourne	17.57	14.6	15.1	5.11	9.42	10.02	14.4	
Gynaecology	Birchington	33.81	36.8	23.9	17.10	18.15	17.20	6.4	Alignment on both wards with PJ but less so with Shelford and Hurst due to not capturing outpatient and day attender activity
	Kennington ward	26.27	22.3	19.7	9.56	10.45	10.45	9.8	
Paediatrics	Padua	48.45	53.5	50.3		54.4		10.3	*RCN and PJ suggest higher establishments to cover day surgery & relocated outpatients
	Rainbow	39.48	48.2	47.3		46.9		12.3	
Surgery	Rotary	35.34	34.4	19.9	16.44	17.04	17.62	9.0	Alignment for most wards except Rotary due to Shelford not capturing outpatient activity and Clarke & Kent not capturing trolley activity
	Cheerful Sp Female	36.02	34.4	38.7	30.15	29.54	29.98	5.8	
	Clarke	46.35	41.6	47.7	37.26	38.8	28.41	6.2	
	Cheerful Sp Male	40.65	38.4	38.7	31.04	28.89	28.89	6.7	
	Kent	33.30	30.2	32.6	20.20	23.36	22.95	7.7	
	Kings B	35.21	39.2	33.7	36.67	34.63	34.63	5.7	
	Kings A2	25.27	30.6	24.9	22.65	23.77	23.68	6.1	
Trauma & Orthopaedic	Kings C1	36.00	41.8	35.2	42.92 ↑	36.76	39.59	5.5	Alignment with PJ and Hurst but less so with Shelford on KC2 & Quex due to it not capturing high throughput on these wards. Acuity and dependency has increased on KC1 where PJ and Shelford both suggest a higher required establishment
	Kings C2	34.98	38.7	31.3	24.09	24.70	25.97	5.7	
	Kings D male(1)	62.21	65.6	66.4	57.08	59.09	57.64	5.7	
	Quex	25.33	25.4	25.9	19.49	21.35	18.94	5.4	
	Bishopstone	34.00	36.1	34.3	34.50	35.87	28.61	5.3	
	Seabathing	36.47	35.9	34.8	32.14	35.7	38.14	9.2	

9. PROGRESS IN IMPLEMENTATING RECOMMENDATIONS IN THE EMERGENCY DEPARTMENTS, NEONATAL INTENSIVE CARE AND MIDWIFERY

9.1 Emergency Departments

A business case was submitted to the Strategic Investment Group in December 2016 and the preferred option 2 was agreed in May 2017. The aim of the Business Case is to ensure a future proofed robust nursing workforce to enable a patient focussed safe service.

Emergency Department (ED) attendances have been rising every year since 2001/02, with an increase in conversion to admission. This coupled with overcrowding largely as a result of exit block and significant delays in ambulance handover have had a profound effect on the Emergency Departments and its ability to deliver a timely, safe quality service and maintain adequate flow.

Staffing concerns within the two Emergency Departments (ED) and the Minor injuries Units (MIU) have been highlighted by the Emergency Care Improvement Programme Team (ECIP) who advise that there should be a band 7 Nurse in Charge 24/7. This nurse works alongside the senior doctor to provide a safe quality service and a supervisory role for the nursing staff in all areas of the department.

Additionally they advise Emergency Nurse Practitioners (ENP) should be working at band 7 level and that there should be a stand-alone ENP service. This would provide a minor injuries service in the two EDs staffed by appropriately trained practitioners from 8am to midnight 7 days a week. The benefits of this service would be comparable to those at Kent and Canterbury and Buckland Hospitals minor injuries units.

In order to improve patient flow and streaming at the front door new ways of working are being introduced nationally and locally we have adopted improved assessment pathways for our patients. This is to ensure that they are seen in a timely manner by the most appropriate clinician. These new ways of working also require additional resources.

In order to deliver the above mentioned staffing resource the department relies heavily on agency staff, whilst it is understood the large financial impact of these additional staff it should be noted there are other issues in relying on agency staff in terms of quality, training and the constraints of a transient workforce.

The staffing review undertaken in 2016 highlighted the following:

- There is no national tool available to adequately determine appropriate staffing levels, therefore professional judgement and benchmarking with other Trusts was undertaken.
- A need to increase the establishment by 30 wte nurses during times of escalation. The UCLTC Division manage this risk by covering the EDs with additional temporary staff.
- The review showed that when benchmarked against similar Trusts we broadly have the correct establishment assuming a business as usual context in relation to nursing staff at bands 6 and below.
- The Review proposed that we need an uplift of the band 7 ENPs and nurse in charge roles in order to bring us in line with other similar Trusts.
- Overcrowding and flow issues are being actively managed internally and also externally through a number of improvement plans and mitigating actions including:
    - 3 times daily site meetings
    - Site situation and risk assessment monitoring

- Senior support by Site Operations Managers, Matrons, General Managers and a dedicated Head of Nursing for the EDs
- Roster changes to manage peak attendance patterns
- New models of ambulatory care led by consultant nurses
- Ensuring patient safety during overcrowding in the departments
- Monitoring quality and safety.

The preferred option 2 agreed is to:

1) Increase the establishments at QEQMH and WHH to ensure band 7 available 24/7, it is proposed that this be 6 wte who are able to undertake this role. This is a slight increase to the usual 5.69 wte required for 24/7 cover to take into account the increased training requirements that ED nurses require. This equates to an increase of:
    - Nurse in charge at QEQMH - 3.0 wte
    - Nurse in charge at WHH - 1.0 wte
2) Increase the banding of all ENPs Trust wide to band 7 provided they achieve the appropriate competencies. This will ensure that we are in line with national standards where ENPs are banded at band 7as a minimum and to increase the establishment of ENP posts at QEQMH and WHH only to provide a 8am to midnight service 7 days a week with 3 ENPs covering this time period in a staggered shift pattern. In addition a band 2 technician at BHD MIU to bring this in line with the other MIUs across the Trust. This equates to an increase of:
    - ENP at QEQMH (including increased service cover) increase 3.5 band 6 to band 7 and an additional 1.2 wte band 7
    - ENP at WHH (including increased service cover) increase 3.7 wte band 6 to band 7 and an additional 2.43 band 7 posts
    - ENP at K&CH increase 10.71 wte band 6 to band 7
    - ENP at BHD increase 3.48 wte band 6 to band 7
    - Band 2 technician at BHD 2.80 wte
3) Increased establishment to safely staff the increased demand on the ED service and to ensure appropriate streaming and assessment at the front door. This equates to an increase of :
    - Band 5 at QEQMH of 8.53wte
    - Band 2 at QEQMH of 5.69 wte
    - Band 5 at WHH of 8.53wte
    - Band 2 at WHH of 5.69 wte

The proposal was that the staffing for this option be managed in a phased approach as follows:

Phase 1:

- Ensure band 7 nurse in charge role to cover 24/7 period, likely to take 3-4 months to enable recruitment of new pots to take place. (WHH & QEQMH)

- Recruit to increased ENP posts at band 7 and increase existing band 6 posts to band 7 likely to take approximately 6 months for recruitment to pots and ensuring competencies met to upgrade staff. (All sites)

Phase 2

- Recruit to band 5 and band 2 posts at WHH & QEQMH in a phased way over a period of 1 year.

Phase 3

- Recruit to the band 2 posts at BHD minor injuries unit, this will make this come in line with equivalent staffing levels to the other minor injuries units across the Trust, also taking into account the increasing number of attendances there.

Due to the need to implement the business case ahead of winter it has been agreed that posts within all 3 phases be recruited to as soon as possible and recruitment is underway.

9.2 Neonatal Intensive Care

A comprehensive nurse staffing review was undertaken for Neonatal Services in East Kent and indicated that investment was required in the WHH NICU and the QEQM SCBU. A business case for phased investment was predicated on the fact that, within EKHUFT, neonatal staffing levels were inadequate in comparison to national recommendations (British Association of Perinatal Medicine) and national published guidelines (NICE, Department of Health (2009) Toolkit for High Quality Neonatal Services, Bliss (2011) The Bliss Baby Charter Standards) and was agreed in July-16.

The Phase 1 increase in the nursing establishment by 6.9 wte at WHH, 4.7 wte at QEQM and additional administrative support to compliment the nursing team and patient care and to enhance parental experience has been achieved . The Band 6 new posts were recruited to mainly by internal promotion however due to subsequent leavers and internal promotions to Band 7 a small vacancy remains. The band 4 and 5 posts are fully recruited to with almost 20 WTE staff recruited in the past year.

The Business Case recognised that there was a national shortage of Neonatal nurses and there would be a challenge to recruit, therefore plans to train and “grow our own” for the future have been implemented with 8 nurses undertaking training this coming year.

A further phased increment of staffing levels was approved over 2017/18 and 2018/19 dependent on a range of operational performance triggers based on unit activity, reduction in frequency of unit closures, reduction in the use of agency staff and improvements in staff sickness levels. A report to the Specialist Services Division and the Strategic Investment Group is being prepared outlining progress against the operational performance criteria in order for the second phase of the Business Case to be released.

Evaluation of appropriate staffing will be one of the clinical indicators included in benchmarking as part of the Neonatal services Peer review planned in autumn 2017.

9.3 Midwifery

A full Birthrate Plus assessment was reported in May-16 which indicated that current staffing levels meet or exceed recommended levels for clinical midwives and support staff. However, the outcome of the review suggests additional staff are required to provide a sustainable resource for specialist midwifery support roles e.g. Safeguarding, bereavement, obesity, ante-natal, per-natal care which were undertaken by clinical staff, at that time. Priorities are focused currently on up- skilling band 2 and 3 support workers to enable release of midwives to provide greater clinical contact time with women.

Engagement and discussion with midwifery staff was undertaken to seek suggestions and views on adjusting current working patterns and shift times to provide improved cover with the existing resource. A consultation was completed on working hours that resulted in releasing 2.9 WTE midwifery time across the acute sites with the change in hours that commenced on 1.4.17.

The shortfall that was identified in the Birthrate Plus in the additional resource required to sustain the specialist roles that were required that were being undertaken in clinical time has been resolved. Supervision of midwifery was removed from statute in April this year, 13 Supervisors of Midwives have transferred to the Professional Midwifery Advocate role and the remaining 11 Supervisors resigned from this role, opting to revert to a purely clinical role. The Midwifery Support Worker role (MSW) is being utilised in the community setting to provide support to the Community Midwife and a development programme to train further Midwifery Care Assistants (MCA) to the MSW role is awaiting sign off.

The average Midwife to birth ratio in May-17 was 1:30 but has reduced slightly in June-17 shown in Figure 9. Another important measure of safety, 1:1 care in active labour, has shown improvement with achievement of 93.9% in May-17 and 94% in June-17.

Figure 9. Monthly Midwife to birth ratio June-16 to June-17.

Midwife to Birth Ratio

June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
30.5	29.3	30.4	29.7	27.4	28.1	20.2	25.6	27.0	29.9	28.5	30.7	28.9

High levels of sickness has impacted on staffing over the last 3 months and continues to do so and all sickness is being managed appropriately. NHS Professionals is been used to supply temporary midwifery staffing. Agency staffing is no longer used due to lack of midwives registered with them and high costs. The use of registered general nurses is being explored and proposed as a viable option to support the postnatal wards in the absence of trained midwives so that the midwifery expertise can be utilised in other areas of the maternity unit.

Vacancy rate for June-17 was 8.1% compared to 4.7% at this time last year. Several members of staff have taken retirement, some have taken flexible retirement and others have left for personal reasons. It is encouraging that staff resignations are very different to that of 2 years ago when staff were leaving for reasons of work place stress and culture of the department. Active recruitment continues with midwifery open days, recruitment drives and the offer of observational placements to those on nursing/midwifery pathways to attract new members of staff.

10. Priorities identified from this review are:

1. To review the impact of the movement of services from K&C to WHH and QEQM on appropriateness of staffing;

2. Closely monitor acuity and dependency trends monthly particularly on medical wards where higher staffing levels may be required, to determine appropriateness of current staffing;

3. Support full implementation of Safecare during 2017/18 to enable alignment of staffing to demand;

4. To continue phased recruitment to the investment approved into the Emergency Departments and NICU. Further work to be undertaken to explore further investment required into Maternity;

5. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;

6. Undertake further work to understand the complexity of evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation and report to the Strategic Investment Group.

Appendix 1 – National Quality Board 2016 expectations on safe staffing

	Expectations		Compliance
1	Right staff ➢ Evidence based workforce planning ➢ Professional judgement ➢ Compare staffing with peers	➢ Annual strategic staffing review using a triangulated approach (evidence-based tool, professional judgement and comparison with peers) which takes account of all professional groups and is in line with financial plans. This should be followed by a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. ➢ Review of comparative data on actual staffing which provides context for differences in staffing requirements such as case mix, patient movement and acuity and dependency. ➢ Local quality dashboard for sustainable safe staffing which triangulates comparative data on staffing with other efficiency and quality metrics to include Care Hours per Patient Day (CHPPD).	The next full review based on April 2017 will be reported to the SWC July 2017. A triangulated approach will again be used including these methods. CHPPD was included in the Quality dashboard from February-17.
2	Right skills • Mandatory training, development and education • Working as a multi-professional team • Recruitment and retention	➢ Staffing establishments take account of the need for staff to undertake mandatory training and continuous professional development. ➢ Sufficient time allocated for team leaders to discharge supervisory responsibilities ➢ Commitment to investing in new roles and skill mix to enable nursing and midwifery staff to spend more time using their specialised training to focus on clinical duties and decisions about patient care. A strong multi-professional approach avoids placing demands solely on any one profession. ➢ Flexible and effective strategies to recruit, retain and develop staff as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Average 22% headroom is included in budgeted establishments currently. Investment in the ward manager assistant role has supported. Future Workforce Steering Group has been implemented to take forward standardisation of expectations and education preparation for Advanced Clinical Practice roles.

3	Right place and time • Productive working and eliminating waste • Effective deployment and flexibility • Efficient employment and minimising agency	➢ The organisation uses lean working principles such as the productive ward as a way of eliminating waste ➢ The organisation designs pathways to optimise patient flow ➢ Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs ➢ Systems for managing staff use responsive risk management processes, from frontline to board level, which clearly demonstrates how staffing risks are identified and managed. ➢ Clinical capacity and skill mix are aligned to the needs of patients thus making the best use of resources and facilitating effective patient flow ➢ Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs ➢ Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of steps to take where capacity problems cannot be resolved. Report, investigate and act on red flag incidents. ➢ Meaningful application of effective e-rostering policies is evident. ➢ The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. ➢ The organisation is working to reduce and eradicate the use of agency staff in line with NHS Improvement's nursing agency rules.	Productive ward principles are embedded within wards. Identification and management of staffing risks are part of the role of the matron. Current system does not enable live view of patient acuity dependency and skill mix to enable deployment of staff. A Business case aligned through workforce CIP programme to implement Safe Care has been approved and implementation commenced in June-17. Daily site situation and escalation report identifies patient flow, bed status and staffing appropriateness. Improvement required to the use of the NHSP interface. Service improvement team led project Smarter Agency Reduction

Appendix 2 - Current funded establishments and staff in post

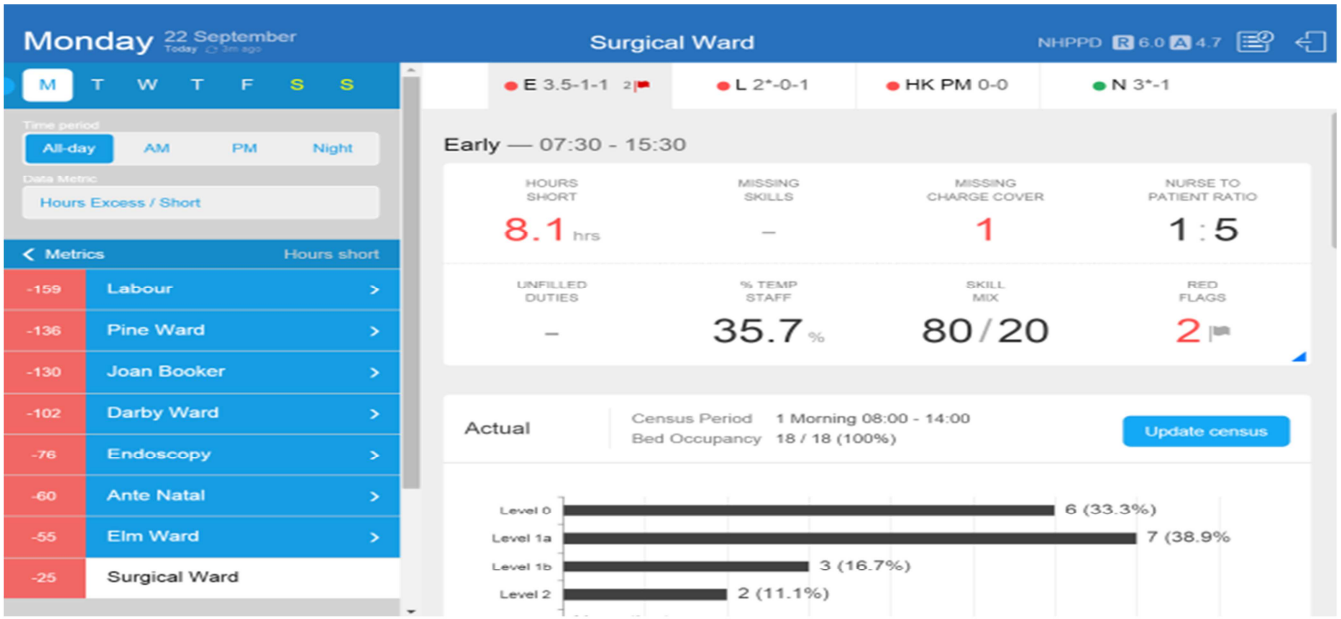
Review of ward staffing May-17

											Bank line					AP role	Attendance			Evaluation methods							Shift fill - DAY	
Ward	Beds Funded	Additional Capacity (Unfunded)	Funded Establishment (WTE)	RN Est (WTE)	RN in post (WTE)	Support worker Est (WTE)	Support worker in post (WTE)	Admin (WTE)	Admin in post (WTE)	Proportion staff in post (%)	Separate bank line (£000s)	RN Adjusted Bank (WTE)	SW Adjusted Bank (WTE)	Total Adjusted (WTE)	Full Establishment (WTE)	Band 4 AP (WTE)	Sickness May-17 (%)	Maternity leave (WTE at 31.05.17 WTE)	E-Rostering effectiveness (%time worked)	Skill mix	WTE/Bed	Prof judgment (clinical)	Prof judgment (total)	Hurst NPOB	Shelford acuity & dependency	CHPPD	Average filled hours DAY - May-17 (%)	Average filled hours NIGHT- May-17 (%)
Cambridge J	34	0	44.04	24.64	19.23	17.90	13.15	1.50	1.53	77.0%	19.0	0.61	0.00	0.61	44.65	0.00	10.1%	0.00	81.4%	60/40	1.31	50.5	52.0	50.6	54.61	6.2	120	109
Cambridge K	27	0	34.13	19.96	18.83	12.67	11.22	1.50	1.50	92.4%	17.7	0.57	0.00	0.57	34.70	1.00	4.6%	0.00	82.1%	61/39	1.29	31.4	32.9	37.0	33.83	5.6	104	114
Cambridge M2	19	0	26.61	15.18	15.04	9.93	8.68	1.50	1.50	94.8%	14.9	0.48	0.00	0.48	27.09	0.00	7.8%	0.64	77.4%	60/40	1.43	30.1	31.6	28.3	27.53	6.2	105	113
Taylor KCH	5	2	14.07	12.90	11.46	0.00	0.00	1.20	0.50	85.0%	0.0	0.00	0.00	0.00	14.07	0.00	2.7%	0.00	78.4%	100/0	2.81	12.2	13.4	10.8	8.79	7	75	100
CCU QEQM	12	0	22.75	14.50	12.87	7.22	6.51	1.00	1.00	89.7%	4.8	0.15	0.00	0.15	22.90	1.80	6.0%	0.00	78.0%	66/34	1.91	21.6	22.6	25.8	17.77	7.8	91	102
CCU WHH	11	0	31.62	25.62	22.67	4.50	3.50	1.50	1.50	87.5%	4.0	0.13	0.00	0.13	31.75	0.50	2.0%	0.00	83.9%	85/15	2.89	28.7	30.2	32.7	16.45	13.5	102	83
Minster Ward	23	0	31.37	15.00	15.98	14.87	12.60	1.50	1.50	95.9%	12.5	0.40	0.00	0.40	31.77	1.80	2.4%	0.00	83.5%	50/50	1.38	33.7	35.2	32.6	33.79	6.6	105	112
Oxford	14	0	23.61	14.36	13.19	7.75	6.51	1.50	1.30	88.8%	9.3	0.30	0.00	0.30	23.91	0.00	1.9%	0.00	81.4%	65/35	1.71	24.0	25.5	20.9	24.01	8	113	113
Sandwich Bay	21	0	27.31	15.97	16.80	9.54	7.88	1.80	2.80	100.6%	9.7	0.31	0.00	0.31	27.62	0.00	6.3%	1.60	79.5%	63/37	1.32	34.7	36.5	30.3	33.73	9	161	210
St Margarets	22	3	26.24	14.98	10.20	10.26	10.66	1.00	1.00	83.3%	14.8	0.47	0.00	0.47	26.71	0.80	7.6%	0.00	77.5%	59/41	1.21	30.5	31.5	31.5	32.45	6.7	124	150
Deal	28	0	34.93	19.61	15.60	13.72	12.13	1.60	1.60	84.0%	11.9	0.38	0.00	0.38	35.31	1.00	1.2%	3.00	78.2%	59/41	1.26	34.6	36.2	38.1	43.78	6.8	112	136
Harvey ward	19	0	27.50	13.80	12.00	12.20	10.24	1.50	1.00	84.5%	14.2	0.46	0.00	0.46	27.96	0.00	1.0%	0.00	84.8%	53/47	1.47	28.8	30.3	24.6	27.37	6.7	106	142
Invicta	24	0	29.56	16.35	14.26	11.50	9.88	1.70	1.20	85.8%	11.4	0.36	0.00	0.36	29.92	0.00	12.7%	0.00	75.0%	59/41	1.25	32.8	34.5	33.7	34.14	5.5	92	134
Cambridge L	26	0	37.64	20.11	18.70	16.03	16.44	1.50	1.50	97.3%	18.2	0.58	0.00	0.58	38.22	0.00	10.7%	0.00	71.5%	56/44	1.47	39.7	41.2	34.1	43.84	6.4	101	129
Treble ward	18	0	29.08	15.44	11.76	12.23	11.50	1.41	0.99	83.4%	10.4	0.33	0.00	0.33	29.41	1.00	7.8%	0.92	72.9%	56/44	1.63	28.8	30.2	24.2	23.31	6.3	80	132
Mount McMaster	24	2	29.97	16.50	7.80	11.57	10.59	1.90	1.90	67.7%	16.4	0.52	0.00	0.52	30.49	0.00	9.6%	0.00	79.4%	59/41	1.27	32.8	34.7	33.7	50.57	5.1	93	127
Fordwich Ward	19	5	38.51	21.79	19.60	15.22	12.31	1.50	1.49	86.7%	22.1	0.71	0.00	0.71	39.22	1.52	3.7%	2.32	76.8%	59/41	2.06	43.3	44.8	38.0*	39.06	9.4	114	121
Kingston	22	5	36.34	20.17	23.03	14.87	12.14	1.30	1.29	100.3%	15.2	0.49	0.00	0.49	36.83	1.00	10.2%	0.00	72.6%	58/42	1.67	37.6	38.9	42.1*	36.82	6.2	92	110
Richard Stevens Unit	24	0	42.19	22.87	18.50	17.82	14.91	1.50	1.86	83.6%	13.9	0.45	0.00	0.45	42.64	2.00	4.8%	1.43	72.3%	56/44	1.78	42.9	44.4	44.8*	39.95	7	96	88
Harbledown	24	2	34.17	18.09	13.24	14.26	13.63	1.82	1.50	83.0%	13.0	0.42	0.00	0.42	34.59	0.00	5.1%	0.00	82.3%	56/44	1.44	33.7	35.5	32.1	64.87	5.9	92	109
St Augustines	27	2	33.06	18.56	13.40	13.00	17.80	1.50	1.50	98.9%	30.7	0.98	0.00	0.98	34.04	1.00	3.3%	0.00	77.8%	59/41	1.26	34.4	35.9	37.0	48.12	4.5	104	111
Cambridge M1	18	0	26.69	15.23	7.80	9.96	8.61	1.50	1.50	67.1%	0.00	0.00	0.00	0.00	26.69	0.00	7.8%	0.64	77.4%	60/40	1.48	27.4	28.9	27.2	44.47	6.2	105	113
CDU, QEQM	24	0	46.89	29.28	21.20	15.37	21.38	2.24	2.84	96.9%	30.9	0.99	0.00	0.99	47.88	0.00	4.5%	1.00	78.9%	66/34	2.00	53.4	55.6	44.3	43.14	10.2	118	165
CDU WHH	42	0	61.87	39.21	35.24	19.07	18.04	3.59	3.51	91.8%	50.0	1.60	0.00	1.60	63.47	1.00	5.2%	0.00	73.9%	67/33	1.51	53.1	56.7	76.2	66.09	13.3	99	107
UCC (incl. CDU)	18	0	83.44	55.46	48.44	17.24	16.81	10.74	10.41	90.7%	70.5	2.26	0.00	2.26	85.70	*0.00*	9.9%	0.48	72.1%	76/24		37.3	48.0	27.0				
Rotary	16	0	35.06	16.70	16.00	12.71	10.11	5.65	4.65	87.7%	8.8	0.28	0.00	0.28	35.34	2.40	3.3%	0.00	82.8%	57/43	2.21	28.7	34.4	19.9	17.62	9.00	101	107
Cheerful Sp Female	27	0	35.75	20.69	10.99	15.06	15.19	0.00	0.00	73.2%	8.2	0.25	0.03	0.27	36.02	0.00	7.3%	0.00	77.5%	58/42	1.33	34.4	34.4	38.7	29.98	5.80	93	89
Clarke	36+6	2	44.87	27.87	21.96	14.50	12.80	2.50	2.50	83.0%	28.4	0.00	1.48	1.48	46.35	0.60	9.0%	0.00	78.3%	66/34	1.29	39.1	41.6	47.7	28.41	6.20	89	90
Cheerful Sp Male	27	0	40.40	17.67	13.12	18.73	15.53	4.00	4.00	80.8%	7.7	0.25	0.00	0.25	40.65	2.00	8.4%	0.60	74.8%	49/51	1.51	34.4	38.4	38.7	28.89	6.70	91	99
Kent	20+6	2	32.03	19.80	18.95	9.73	9.32	2.50	2.00	94.5%	24.3	0.00	1.27	1.27	33.30	0.00	1.9%	0.92	82.4%	67/33	1.66	27.7	30.2	32.6	22.95	7.70	102	93
Kings B	27	0	33.81	17.89	15.02	13.39	14.55	2.53	1.61	92.2%	26.8	0.00	1.40	1.40	35.21	0.00	2.8%	1.00	79.1%	57/43	1.30	36.7	39.2	33.7	34.63	5.70	97	118
Kings A2	20	0	24.78	13.93	12.39	9.85	8.73	1.00	1.00	89.3%	9.4	0.00	0.49	0.49	25.27	0.00	7.2%	0.00	82.0%	58/42	1.26	29.6	30.6	24.9	23.68	6.10	97	110
Kings C1	27	0	34.53	17.57	14.57	14.46	15.44	2.50	1.50	91.3%	28.2	0.00	1.47	1.47	36.00	0.00	4.6%	0.96	85.9%	55/45	1.33	39.3	41.8	35.2	39.59	5.50	112	100
Kings C2	24	0	33.51	17.41	14.13	14.60	13.14	1.50	1.50	85.9%	28.3	0.00	1.47	1.47	34.98	1.00	1.6%	1.00	80.0%	54/46	1.46	37.2	38.7	31.3	25.97	5.70	83	94
Kings D	43		60.22	32.30	31.34	23.84	21.98	4.08	4.07	95.3%	38.1	0	1.99	1.99	62.21	1.00	3.0%	3.40	83.8%	57/43	1.44	61.5	65.6	66.4	57.64	5.65	105	122
Quex	19	1	24.65	15.66	14.94	6.96	7.16	2.03	1.91	97.4%	13.0	0.00	0.68	0.68	25.33	0.00	8.8%	0.43	81.3%	69/31	1.33	23.4	25.4	25.9	18.94	5.40	101	98
Bishopstone	22	0	32.50	17.34	14.60	13.44	11.88	1.72	1.64	86.5%	28.9	0.00	1.50	1.50	34.00	0.00	4.5%	0.00	84.1%	56/44	1.55	34.4	36.1	34.3	28.61	5.30	87	102
Seabathing	26	0	34.98	18.00	13.73	15.48	14.84	1.50	1.47	85.9%	28.7	0.00	1.49	1.49	36.47	0.00	4.5%	0	84.1%	54/46	1.40	34.4	35.9	34.8	38.14	9.20		
ITU WHH	11	0	63.60	56.52	56.37	5.41	5.41	1.67	1.59	99.6%	0.0	0.00	0.00	0.00	63.60	1.00	6.4%	3.83	73.8%	91/9	5.78					33.2		
ITU QE	8	0	46.52	42.72	37.86	2.80	2.80	1.00	1.00	89.6%	5.5	0.00	0.29	0.29	46.81	0.00	4.7%	1.80	77.7%	94/6	5.85					26.8	91	113
ITU KCH	4 + 4	0	39.06	37.13	35.90	1.00	1.00	0.93	0.93	96.9%	0.0	0.00	0.00	0.00	39.06	0.00	1.9%	3.28	75.6%	97/3	4.88					28.7	91	102
Marlowe	29 +6	4	54.88	35.01	28.23	17.27	15.12	2.60	2.60	83.7%	152.3	3.17	2.79	5.96	60.84	0.00	7.1%	1.00	78.4%	67/33	2.09	59.2	61.8	54.7	30.19	9.4	94	96
Neonatal ITU	7	0	72.74	66.74	63.27	3.60	4.00	2.40	1.00	93.9%	19.0	0.61	0.00	0.61	73.35	0.00	4.6%	1.00	76.8%	95/5	10.48					9.3	101	101
Padua	28	0	45.67	35.61	29.80	7.76	10.43	2.30	1.80	92.0%	86.8	2.78	0.00	2.78	48.45	0.00	6.9%	2.61	67.9%	80/20	1.73	51.2	53.5	50.3		10.3	92	96
Rainbow	20	0	38.58	30.28	27.61	7.30	8.36	1.00	1.00	95.8%	25.4	0.68	0.22	0.90	39.48	0.00	3.4%	1.00	76.5%	80/20	1.97	47.2	48.2	47.3		12.3	102	114
Birchington	15	4	33.12	19.50	18.75	10.05	8.99	3.57	3.57	94.5%	14.0	0.07	0.61	0.69	33.81	1.00	0.6%	0.00	87.8%	66/34	2.25	33.2	36.8	23.9	17.2	6.4	102	99
Kennington ward	11+2	0	23.88	14.78	12.27	6.60	5.53	2.50	2.49	85.0%	65.6	1.65	0.74	2.39	26.27	0.00	4.4%	0.00	80.4%	69/31	2.38	19.8	22.3	19.7	10.45	9.8	87	97
Brabourne	8	0	15.91	12.84	12.84	2.67	2.00	0.40	0.93	99.1%	50.3	1.53	0.14	1.66	17.57	0.00	6.7%	0.00	79.2%	83/17	2.20	14.2	14.6	15.1	10.02	14.4	81	104
		34	1774.64	1119.54	971.48	555.91	521.43	99.18	92.98	89.4%	1133.23	25.22	18.06	43.27	1817.91	23.42		34.86	78.7%									

Appendix 3 – Example of Safecare reporting capability

Sunburst SafeCare

Selecting a unit will then display metrics for that individual unit:



REPORT TO:	**REPORT TO BOARD OF DIRECTORS AS RECEIVED BY STRATEGIC WORKFORCE COMMITTEE**
DATE:	**11 AUGUST 2017**
SUBJECT:	**WORKFORCE RACE EQUALITY STANDARD (WRES)**
BOARD SPONSOR:	**DIRECTOR HR**
PAPER AUTHOR:	**HEAD OF DIVERSITY & INCLUSION**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The WRES came into being in April 2015.

The NHS Standard Contract requires all NHS provider organisations to publish WRES metrics year on year by 31 July. This is the second year the Trust has had to report and publish our findings.

The attached 2016/17 Report demonstrates that whilst there is room for EKHUFT to develop and improve we able to demonstrate improvement over the last two years.

Whilst the overall workforce data shows improvement, there are indications of pockets within the Trust where significant development is possible. The Diversity & Inclusion team will provide a detailed analysis of the WRES data to HR Business Partners and Senior Leaders and support them in the development of targeted action plans. To be published as soon as possible.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to comply with the mandatory requirements
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

PRIVACY IMPACT ASSESSMENT:	**EQUALITY IMPACT ASSESSMENT:**
No	No

RECOMMENDATIONS AND ACTION REQUIRED:

1. That the Committee agree the approach outlined in this report.
2. That the Committee agree to the publication of the WRES EKHUFT Reporting Template.
3. That the Committee agree to the submission of WRES data through the Unify2 system to NHS England.

Contents

1 Introduction

1.1 The Workforce Race Equality Standard (WRES) has been in place for 24 months, the main aims are:

- To improve workplace experiences and employment opportunities for Black Asian & Minority Ethnic (BAME) people in the NHS
- The WRES also applies to BAME people who want to work in the NHS. This can be achieved by taking positive action to help address race equalities in the application process.

1.2 The Equality Diversity Council [EDC NHS] placed a priority on the development of the WRES to tackle race equalities.

1.3 The EDC NHS prioritised the development of the WRES to tackle race equalities - the WRES was identified as the best means to achieve this by helping the NHS to improve by:

- BAME representation at Senior Management and Board level.
- To provide better working environments for the BAME workforce.

1.4 The WRES is a tool to identify gaps between BAME & White staff experiences in the workplace this is measured through a set of Metrics. Closing the gaps will achieve:

- Tangible progress in tackling discrimination
- Promoting a positive culture.
- Valuing all staff for their contribution to the NHS

1.5 This will provide an environment in the NHS whereby all staff are valued and supported across its entire diverse workforce. The result will be high quality patient care and improved health outcomes for all.

1.6 The WRES supports EDS2 goals in relation to a representative workforce and is already embedded in the Trust;

- Better Health outcomes
- Improved patient access and experience.
- Representative and supported workforce
- To provide better working environments for the BAME workforce.

2 Links between Equality Delivery System 2 [EDS2] & Workforce Race Equality Standard

2.1 EDS2 will help NHS organisations through discussions with staff and local stakeholders. This will allow all parties to review and improve performance for patients, communities and staff in respect of all Protected Characteristics under the Equality Act 2010. The WRES tackles one particular aspect of equality which has consistently been evidenced receiving less favourable treatment in relation to BAME workforce. The WRES and EDS2 are complimentary but distinct.

2.2 The WRES and EDS2 complement each other although reporting will be via separate reports for each. The data published for the WRES will align in particular to outcomes 3 and 4.

Outcome 3
A representative and supported workforce

Outcome 4
Inclusive leadership

3 Metrics

The method of measuring progress and action plans is through nine WRES metrics which cover the following areas:

1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:
    - Non-Clinical staff
    - Clinical staff - of which
        - Non-Medical staff
        - Medical and Dental staff
2. Relative likelihood of staff being appointed from shortlisting across all posts.
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of staff accessing non-mandatory training and CPD.
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage believing that trust provides equal opportunities for career progression or promotion.
7. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
8. In the last 12 months have you personally experienced discrimination at work from Manager/team leader or other colleagues
9. Percentage difference between the organisations' Board membership and its overall workforce disaggregated:
    - By voting membership of the Board
    - By executive membership of the Board

4 NHS Standard Contract

4.1 The NHS standard contract April 2016 includes the WRES, which requires all NHS providers of NHS services to start to address the issue. It states at Service condition 13: (See Appendix C)

"The provider must implement EDS2 and implement the national Workforce Race Equality Standard and submit an annual report to the co-ordinating commissioner on its progress implementing the standard."

4.2 The CQC will also consider the WRES in their assessments of how "Well Led" NHS providers are from April 2016 which will now be current.

5 Business Benefits to the Trust

5.1 Simon Stevens says that,

"We want an NHS of the people, by the people, for the people. That's because care is far more likely to meet the needs of patients we are here to serve when NHS Leadership is drawn from diverse communities."

5.2 There are numerous benefits for the Trust through the implementation of the WRES – which all make good business sense:

5.2.1 Recruitment – this would open up access to a young BAME labour market.

5.2.2 Would add value to the Trust as a "diverse employer", raising awareness of different cultures, traditions and religious beliefs. Which in turn would provide greater understanding when delivering patient care, particularly in relation to dignity and respect.

5.2.3 This would enhance and empower mutual respect from all staff and from our communities.

5.2.4 The WRES will demonstrate our commitment as a Trust to deliver a diverse workforce, representative of the communities we serve.

5.2.5 It would demonstrate to our own BAME staff the Trust commitment to ensure staff are treated equitably and appropriately free from discriminatory practices.

5.2.6 The WRES will provide a transparency of what the Trust is delivering and evidence to prove progress.

6 Leadership

6.1 The composition of the Board will be under scrutiny in comparison with the demographics of our staff.

6.2 A key message is that real and sustained changes will only be made by determined senior leadership and commitment. This requires a shift beyond over reliance on Diversity Managers and HR Directors to drive change.

6.3 The Diversity & Inclusion Steering Group (DISG) leading by example of championing race equality and not just to comply with a newly imposed standard. This should be viewed as a strategic opportunity to demonstrate commitment to diversity and to leverage improvements in patient care.

7 Legal Duties

The Trust needs to fulfil its legal duties regarding other Protected Characteristics as detailed in the Equality Act 2010 in particular relating to the General Duty as follows:

7.1 Eliminate unlawful discrimination, harassment and victimisation

The Trust has in place policies and process to eliminate discrimination and harassment of all staff and continues to take legal responsibility for all Protected Characteristics.

7.2 Advance equality of opportunity between different groups.

To mitigate risk the Trust may want to consider developing a baseline assessment of current resources and initiatives for all staff support across Protected Characteristics.

7.3 Foster good relations between different groups

1. Reduce any negative impact by positive market communication. It is critical to make sure staff teams are engaged and understand the rationale and see the value of the work.
2. Clarity about what positive action is, it's not about giving BAME staff an unfair advantage but addressing inequalities.

8 EKHUFT WRES Metrics 2017

8.1 Action Plan 2016

8.1.1 EKHUFT implemented a Trust-wide generalised action plan (See Appendix D) put forward by the Head of Diversity & Inclusion in August 2016. The WRES data for 2017 (See Appendix A) have shown across the board improvements during the last year. However, the large scale and generalised action plan has resulted in the Trust not being able to establish categorically which aspects of the plan were successful.

8.1.2 The Diversity & Inclusion Steering Group has decided to use the TRUSTED model (See Appendix B) to deliver improvements to the EKHUFT WRES data and for BAME staff.

8.2 Recruitment and promotion

8.2.1 Recruitment and promotion affect many of the metrics of the WRES and in particular those areas of greatest concern to the DISG.

- Percentage of staff in each of the AfC Bands. (Metric 1)
- Relative likelihood of staff being appointed
- Relative likelihood of staff accessing non-mandatory training
- Percentage believing that trust provides equal opportunities for career progression or promotion
- discrimination at work from manager/team leader or other colleagues
- Percentage difference between the organisations' Board voting membership and its overall workforce.

8.2.2 In recruitment and promotion, bias impacts on every stage of the process from how the job description and person specification are written, through how jobs are advertised, how acting up opportunities are filled, how tests and interviews are designed and conducted, and how selection is undertaken.

8.2.3 There are a number of ways in which accountability can be reinforced. When individuals know they will need to justify their decisions on appointments to a more senior manager, they are likely to undertake more complex thought processes before doing so, and doing so may undermine bias when making decisions. When members of appointment panels know they will have to justify their decisions to a higher authority, they tend to engage in more complex decision-making processes. Holding individuals accountable for their personnel decisions is one way to reduce bias in recruiting and promotion.

8.2.4 The DISG will:

- Identify specific areas where there is clearly a failure to recruit BME staff – often at more senior grades.
- Set their own goals for recruitment, with clear milestones.
- Expect regular reports on progress, analysed by department, service, or occupation, on the ethnicity gap relating to WRES.
- Expect to hold the relevant department or profession to account for interview outcomes whilst considering what continuous improvement methods might assist in improving changing patterns of appointment and promotion
- Asking shortlisting panels to be cautious when using "previous experience" as a criteria – in other words to recognise that BME staff will tend to have gained more qualifications to compensate for the likelihood of having had less opportunity to gain experience at a higher level e.g. through acting up.

8.2.5 The attached WRES reporting template and TRUSTED Plan detail the approach of the DISG towards addressing improvements in WRES metrics.

8.2.6 These documents provide a framework upon which to build a more detailed action plan to address specific issues identified by the deeper investigation into WRES data

9 Conclusion

9.1 The overall trust-wide data for 2016/7 shows definite improvement but the trust is not able to specify which aspects of last year's action plan implementation if any have resulted in this positive development.

9.2 All future action plans will be targeted and capable of evaluation.

9.3 Whilst the Trust has shown definite improvement over the last year it must be recognised that in comparison to peer organisation there is still plenty of room for improvement. (see appendix E)

10 Appendix A WRES Data 2017

	2015	2016	2017
Relative likelihood of White staff being appointed from shortlisting compared to BAME staff:	1.59	1.54	1.17
Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff:	1.35	0.56	0.35
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff:	1.16	1.25	1.21
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White 33.54% BAME 31.21%	White 32.19% BAME 31.77%	White 32.68% BAME 30.89%
% of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 41.82% BAME 38.35%	White 42.22% BAME 39.43%	White 35.94% BAME 34.59%
"% staff believing that trust provides equal opportunities for career progression or promotion"	White 77.44% BAME 67.60%	White 82.48% BAME 67.38%	White 83.69% BAME 74.67%
% staff personally experienced discrimination at work from Manager/team leader or other colleague	White 10.49% BAME 19.64%	White 9.01% BAME 20.58%	White 8.13% BAME 16.62%
Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board	Voting White 23.07% BAME -14.27% Executive White 23.07% BAME -14.27%	Voting White 6.21% BAME 5.84% Executive White 9.54% BAME 5.84%	Voting White 6.06% BAME 7.12% Executive White 13.20% BAME -0.02%

11 Appendix B TRUSTED Model

	TRUSTED	Start date	Milestones	RAG
1.1	**Take Stock**			
	The Diversity & Inclusion (D&I) Team will request and obtain data to enable the publication of WRES metrics.	1/4/17	Complete	B
	The D&I team will produce WRES data demonstrating the Trust wide situation breaking down to divisional level.	1/5/17	24/7/17 DISG	G
1.2	**Respect the findings**			
	The D&I team will produce disaggregated WRES data showing the situation in Divisions, Departments, localities, occupational groups, etc. Human Resources Business Partners (HRBP) in discussion with Senior Leaders and with support from the D&I team will investigate further and identify those areas where there is evidence of good practice or practice that requires development.	31/7/17	31/8/17 Publish action Plan	G
1.3	**Unite around finding a solution**			
	Trust wide and Divisional engagement with Employees, staff-side and employee networks to examine data and explore solutions. Support provided from Communications, Patient and Public Engagement (PPE) Manager, D&I Team, BAME Network, Healthwatch Kent, and HRBPs.	31/7/17 Ongoing	DISG discuss data	G
1.4	**Support**			
	EKHUFT has excellent working relationships with NHS Leadership Academy and Kent Surrey & Sussex (KSS) Leadership Collaborative			G
	EKHUFT is NHS Employers Diversity and Inclusion Partners Alumni member.			G
	EKHUFT chairs the KSS Diversity Leads group.			G
1.5	**Talk, train and develop**			
	The EKHUFT Cultural Change Programme is already well established and there is an opportunity to address issues identified by WRES data as part of Trust wide and Divisional Cultural Change Action Plans. These activities will be carried out under scrutiny from the Diversity & Inclusion Steering Group (DISG) and subsequently by the Strategic Workforce Committee.	31/8/17	31/3/18 Publication of WRES data 2018	G
1.6	**Design**			
	Evaluation and redesign are important to establish which activities undertaken have been most effective at bringing about positive change. These activities can then be further developed to address issues identified in other areas. It is recommended that EKHUFT should work with key stakeholders to determine what worked well, what could be improved and what are useful components to building the TRUSTED process into all aspects of the organisation's business.	1/4/18	WRES Action Plan 2018	G

12 Appendix C NHS STANDARD CONTRACT 2016/17

12.1 SERVICE CONDITIONS SC13 Equity of Access, Equality and Non-Discrimination

13.1	The Parties must not discriminate between or against Service Users, Carers or Legal Guardians on the grounds of age, disability, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, gender reassignment, or any other non-medical characteristics, except as permitted by Law.	All
13.2	The Provider must provide appropriate assistance and make reasonable adjustments for Service Users, Carers and Legal Guardians who do not speak, read or write English or who have communication difficulties (including hearing, oral or learning impairments). The Provider must carry out an annual audit of its compliance with this obligation and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result.	All
13.3	In performing its obligations under this Contract the Provider must comply with the obligations contained in section 149 of the Equality Act 2010, the Equality Act 2010 (Specific Duties) Regulations and section 6 of the HRA. If the Provider is not a public authority for the purposes of those sections it must comply with them as if it were.	All
13.4	In consultation with the Co-ordinating Commissioner, and on reasonable request, the Provider must provide a plan setting out how it will comply with its obligations under SC13.3. If the Provider has already produced such a plan in order to comply with the Law, the Provider may submit that plan to the Coordinating Commissioner in order to comply with this SC13.4.	All
13.5	The Provider must implement EDS2.	NHS Trusts/ FTs
13.6	The Provider must implement the National Workforce Race Equality Standard and submit an annual report to the Co-ordinating Commissioner on its progress in implementing that standard.	All

13 Appendix D WRES Action Plan August 2016. Activities.

1. Recruiting Managers training will be enhanced to include bias/prejudice
2. Bias/prejudice training to be made available to all staff and managers
3. Cultural Change programme will continue to address bullying and harassment but will include additional attention to bullying and harassment from patients, relatives and the public.
4. New Junior managers training will include fairness and bias inputs
5. Leadership training will include awareness raising of bias/prejudice
6. Continue to investigate where the discrepancies in the recruitment process result in inequality
7. Staff Friends and Family Test to include equality data for more detailed analysis and heatmap investigation.
8. Continued investigation and development of additional means to record non-mandatory training in particular external delivery.
9. Introduce the Golden thread principal for all training courses including for doctors and nurses.
10. Mandatory Equality & Diversity Training requirement changed to require all managers above Grade 7 to complete Professionalism in Equality & Diversity a more comprehensive program ideal for managers.
11. BAME Staff Conference
12. New Diversity and Inclusion Steering Group Chaired by CEO Deputy Chair NED. Will direct and review WRES Action Plan & report progress to SWC
13. Programme to increase reporting of ethnicity.

14 Appendix E WRES Peer Organisation Comparison.

		In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager / team leader or other colleagues	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage of staff believing that trust provides equal opportunities for career progression or promotion
Trust Name	**Ethnic Group**	**Yes**	**%**	**%**	**%**
Royal Surrey County Hospital NHS Foundation Trust	BAME	14.0%	30.2%	21.7%	81.3%
Bedford Hospital NHS Trust	BAME	18.8%	24.0%	25.3%	71.0%
Frimley Health NHS Foundation Trust	BAME	12.2%	24.7%	21.8%	77.7%
Hampshire Hospitals NHS Foundation Trust	BAME	13.9%	25.0%	25.3%	79.2%
Dartford And Gravesham NHS Trust	BAME	12.5%	31.7%	30.6%	81.7%
Medway NHS Foundation Trust	BAME	13.0%	26.0%	27.7%	76.3%
Queen Victoria Hospital NHS Foundation Trust	BAME	11.8%	26.4%	25.5%	86.5%
Ashford and St Peter's Hospitals NHS Foundation Trust	BAME	12.8%	26.7%	28.9%	78.9%
East Kent Hospitals University NHS Foundation Trust	BAME	16.6%	30.9%	34.6%	74.7%
Maidstone And Tunbridge Wells NHS Trust	BAME	4.6%	22.1%	21.2%	90.9%
Brighton And Sussex University Hospitals NHS Trust	BAME	20.8%	34.3%	36.9%	64.0%
Western Sussex Hospitals NHS Foundation Trust	BAME	11.5%	32.2%	23.3%	84.3%

15 Appendix F WRES reporting template

Submitted on 2017-07-24 10:12:29

1 Name of organisation

East Kent Hospitals University NHS Foundation Trust

2 Date of report

July 2017

3 Name and title of Board lead for the Workforce Race Equality Standard

Sandra Le Blanc, Director Human Resources

4 Name and contact details of lead manager compiling this report

Bruce Campion-Smith,
Head of Diversity and Inclusion,
bruce.campion-smith@nhs.net
01227 864077,
07826890938

5 Names of commissioners this report has been sent to

Ashford CCG,
Canterbury and Coastal CCG,
Dartford, Gravesham And Swanley CCG,
NHS Medway CCG,
West Kent CCG,
South Kent Coast CCG,
Thanet CCG, SWA

6 Name and contact details of co-ordinating commissioner this report has been sent to

Co-ordinating Commissioner for the East Kent CCG Contract:
Simon Perks,
Accountable Officer
NHS Canterbury and Coastal Clinical Commissioning Group

7 Unique URL link on which this report and associated Action Plan will be found

http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/diversity-and-inclusion/

8 This report has been signed off by on behalf of the board on

Sandra Le Blanc, Director of Human Resources
Date:
31 July 2017
Background narrative

9 Any issues of completeness of data

86.84% of our staff have declared their ethnicity compared with 87.95% last year.

10 Any matters relating to reliability of comparisons with previous years

None

11 Total number of staff employed within this organisation at the date of the report:

7904

12 Proportion of BME staff employed within this organisation at the date of the report?

14.31%

13 The proportion of total staff who have self reporting their ethnicity?

86.84%

14 Have any steps been taken in the last reporting period to improve the level of self reporting by ethnicity?

The development of our new people portal provides easier access to the Electronic Staff Record Self Service Feature.
Staff are able to access and submit Protected Characteristic Data.

15 Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity?

Working with the new Black Asian and Minority Ethnic (BAME) Staff Network we plan to encourage greater levels of recording
Workforce data

16 What period does the organisation's workforce data refer to?

01/04/15 - 31/03/16

17 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

17.1 Data for reporting year:

Band	Non Clinical	Clinical
Apprentice	0.00%	11.11%
Band 1	38.64%	0.00%
Band 2	3.61%	11.93%
Band 3	2.53%	5.48%
Band 4	2.66%	8.91%
Band 5	4.42%	18.88%
Band 6	2.52%	11.91%
Band 7	1.27%	8.75%

Band 8A	10.00%	2.56%
Band 8B	4.55%	3.45%
Band 8C	12.50%	0.00%
Band 8D	0.00%	0.00%
Band	9 0.00%	0.00%
Exec	25.00%	0.00%
VSM	11.11%	0.00%
Medical Staff	0.00%	45.00%
Total	4.26%	17.70%
Trust	14.31%	14.31%

17.2 Data for previous year:

Band	Non Clinical	Clinical
Apprentice	0.00%	0.00%
Band 1	39.13%	0.00%
Band 2	3.46%	9.26%
Band 3	3.21%	5.14%
Band 4	2.57%	8.99%
Band 5	4.55%	19.29%
Band 6	3.85%	10.49%
Band 7	1.28%	8.67%
Band 8A	7.27%	1.59%
Band 8B	5.26%	3.33%
Band 8C	5.26%	0.00%
Band 8D	0.00%	0.00%
Band 9	0.00%	0.00%
Medical Staff	0.00%	49.08%
Total	4.23%	17.62%
Trust	14.23%	14.23%

17.3 The implications of the data and any additional background explanatory narrative:

There are 288 members of staff in bands 8A to 9. Fifteen (5%) of whom are BAME.
14.3% of all staff are BAME.
41.4% of Band 1 staff are BAME

17.4 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

This area will be addressed by actions taken to reduce disproportionalities in recruiting, promotion, access to training and reduction in discrimination.
This indicator links to EDS2 Outcomes 3.1, 3.3, 3.5 and 3.6
This indicator also links to Corporate Equality Objective 3. Reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions

18 18 Relative likelihood of staff being appointed from shortlisting across all posts.

18.1 Data for reporting year:

1.17

18.2 Data for previous year:

1.54

18.3 The implications of the data and any additional background explanatory narrative:

This indicator shows significant improvement since last year.
Factors impacting on this indicator during the last year include:
1. Recruiting Managers training was enhanced to include bias/prejudice.
2. Bias/prejudice training was made available to all staff and managers

18.4 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

An in-depth exploration into recruitment data will identify performance against this indicator across the trust. Targeted actions will address those areas where changes will have the greatest impact.
This indicator is linked to EDS2 Outcome 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.
This indicator is linked to corporate Equality Objective 3. Reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions.

19 Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.

19.1 Data for reporting year:

0.35

19.2 Data for previous year:

0.56

19.3 The implications of the data and any additional background explanatory narrative:

A figure below “1” would indicate that BME staff members are less likely than white staff to enter the formal disciplinary process.
This indicator was not identified requiring any remedial actions.

19.4 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

No Actions are planned in regard to this indicator.

20 Relative likelihood of staff accessing non-mandatory training and CPD.

20.1 Data for reporting year:

1.21

20.2 Data for previous year:

1.25

20.3 The implications of the data and any additional background explanatory narrative:

There has been a small improvement over the last year.

20.4 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

An in-depth exploration into non-mandatory training data will identify performance against this indicator across the trust. Targeted actions will address those areas where changes will have the greatest impact.

This indicator is linked to EDS2 Outcome 3.3 Training and development opportunities are taken up and positively evaluated by all staff.

This indicator is linked to corporate Equality Objective 3. Reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions.

Workforce Race Equality Indicators

21 KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

White:
32.68%
BME:
30.89%
White:
32.19%
BME:
31.77%

21.1 The implications of the data and any additional background explanatory narrative:

There has been some improvement during the last year.

This indicator is addressed by our Great Place to Work Programme for both white and BAME staff. This indicator was not identified as requiring action under a separate WRES action plan.

21.2 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

Our great place to work programme continues and this indicator was not identified as requiring action under a separate WRES action plan for 2017.

This indicator links to:

Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.

Corporate Equality Objectives.

1. To support the development of leadership at all levels in a way that values and promotes equality, diversity and inclusion.

3. Reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions.

22 KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.

White:
83.69%
BME:
74.67%
White:
82.48%

BME:
67.38%

22.1 The implications of the data and any additional background explanatory narrative:

There has been a significant improvement in the level of BAME staff believing that trust provides equal opportunities for career progression or promotion.
Factors impacting on this indicator during the last year include:
1. Recruiting Managers training was enhanced to include bias/prejudice.
2. Bias/prejudice training was made available to all staff and managers
3. Development of a BAME Staff Network following the BAME conference arranged in November last year by the Diversity & Inclusion team.

22.2 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

The trust will carry out an in depth analysis and examine those areas where level of staff believing the trust provides equal opportunities for career progression or promotion are of greatest concern and develop targeted action plans to address this issue.
EDS2 Outcomes
3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.3 Training and development opportunities are taken up and positively evaluated by all staff
3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.
3.6 Staff report positive experiences of their membership of the workforce
Corporate Equality Objectives.
1. To support the development of leadership at all levels in a way that values and promotes equality, diversity and inclusion.
3. Reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions.

23 Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.

White:
8.13%
BME:
16.62%
White:
9.01%
BME:
20.58%

23.1 The implications of the data and any additional background explanatory narrative:

Once again there is a significant improvement over last year but there remains a significant disparity between white and BAME staff. Factors impacting on this indicator during the last year include:
1. Recruiting Managers training was enhanced to include bias/prejudice.
2. Bias/prejudice training was made available to all staff and managers

3. Development of a BAME Staff Network following the BAME conference arranged in November last year by the Diversity & Inclusion team.

23.2 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

The trust will carry out an in depth analysis and examine those areas where levels of reported discrimination are of greatest concern and develop targeted action plans to address this issue.

EDS2 Outcomes

3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

3.3 Training and development opportunities are taken up and positively evaluated by all staff

3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.

3.6 Staff report positive experiences of their membership of the workforce

Corporate Equality Objectives.

1. To support the development of leadership at all levels in a way that values and promotes equality, diversity and inclusion.

3. Reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions.

24 22 KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

White:
35.94%
BME:
34.59%
White:
42.22%
BME:
39.43%

24.1 The implications of the data and any additional background explanatory narrative:

There has been some improvement during the last year.

This indicator is addressed by our Great Place to Work Programme for both white and BAME staff. This indicator was not identified as requiring action under a separate WRES action plan.

24.2 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

EDS Outcome 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source.

Corporate Equality Objectives.

1.To support the development of leadership at all levels in a way that values and promotes equality, diversity and inclusion.

3. Reduce discrimination experienced by Disabled and BME staff and applicants and Increase the percentage of BME staff in senior positions.

Workforce Race Equality Indicators

25 Percentage difference between the organisations' Board voting membership and its overall workforce.

White:
Board 78.6%
Overall Workforce 83.5%
Difference -4.9%
BME:
Board 21.4%
Overall Workforce 16.5%
Difference 4.9%
White:
Board 80.0%
Overall Workforce 83.9%
Difference -3.9%
BME:
Board 20.0%
Overall Workforce 16.21
Difference 3.9%

25.1 The implications of the data and any additional background explanatory narrative:

These figures do not take account of those staff who have not declared their ethnicity and are therefore not strictly comparable as all voting members of the board have declared their ethnicity. In addition at the time of reporting there were fewer board members than last year.

25.2 Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective:

This data shows that the ethnic breakdown of voting members of the board of directors very closely matches the overall workforce. Therefore there is no requirement for any further action.

26 Are there any other factors or data that should be taken into consideration in assessing progress?

None

27 27 Organisations should produce a detailed WRES action plan, agreed by its board. It is good practice for this action plan to be published on the organisation's website, alongside their WRES data. Such a plan would elaborate on the actions summarised in this report, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at board level, such as EDS2. You are asked to provide a link to your WRES action plan in the space below.

28 Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.:

A detailed action plan will be developed in response to these metrics and published at
http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/diversity-and-inclusion/

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**CHARITABLE FUNDS COMMITTEE CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF CHARITABLE FUNDS COMMITTEE**
PAPER AUTHOR:	**CHAIR OF CHARITABLE FUNDS COMMITTEE**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Charitable Funds Committee remit is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy.

Chair's summary of the key issues highlighted at the Charitable Funds Committee meeting held on 3 August 2017.

1 <u>Applications for funding</u>

Echocardiograms for Queen Elizabeth the Queen Mother Hospital (QEQM) and the Kent and Canterbury Hospital (K&CH) plus TOE imaging software. £323,323.07

- A presentation was made by the Consultant Cardiologist, highlighting the needs and benefits for this new equipment which can be summarised as follows:
  - This new equipment at both QEQM and K&CH will bring all sites up to comparable standards with William Harvey Hospital (WHH) cardiac ultrasonic machines.
  - This equipment will bring better and quicker diagnosis for patients including the highest imaging quality with new technology which includes "speckle tracking" which is important in the diagnosis and follow up of heart failure, post cancer chemotherapy and 3D technology.
  - The benefits for staff are that the equipment provides better ergonomics and will help in staff recruitment and retention and departmental excellence.
- The Committee felt strongly that this kind of request that delivered great benefits to both patients and staff was exactly what the Charity wanted to support.

Decision:

The Committee approved the grant for funding and recommend that the Board supports this grant.

2 <u>Cazenove Capital – Charity Portfolio Performance</u>

- Cazenove Capital made a presentation to the Committee giving details of the Charity's portfolio performance over the last twelve months which delivered a gross yield of 3.4% (£110K), which was favourable against other balanced funds.
- In addition Cazenove gave a comprehensive presentation about asset class returns, UK and global trends and equity markets.
- The Committee outlined to Cazenove the agreed strategy to diminish its portfolio to £1M over the next 2-3 years in a controlled way.
- Cazenove confirmed that they are happy to continue managing the Charity's portfolio with this brief and offered their help in working with the Committee in

undertaking this reduction in the best and most advantageous way.

Decision:

The Committee agreed that Cazenove would continue to manage its portfolio.

3 Charity Strategy Review Options

- The charity membership and administration function is facing a time of significant change and it was discussed if it was timely to consider whether an external appraisal of the delivery of the Charity strategy is required, the timing and the scope if recommended.
- A paper was reviewed that outlined three options:
  - Commission an external review immediately
  - Do not undertake external consultancy review
  - Allow new Finance resources (Director of Finance and Performance and Finance Charity lead, who are due to start in October and September) to settle in and consider if a review would be appropriate in 6-12 months time.

Decision

The Committee agreed with the third option above and will review this in 6-12 months.

4 Finance Report

- A current finance report was submitted to the Committee showing the following key elements:
  - Financial position @ 30/6/17 - £3.82M
  - Cash position @ 30/6/17 - £0.55M
  - Investments (portfolio) @ 30/6/17 - £3.2M
  - Income April – June 2017 - £0.073M
- A detailed cash availability was tabled showing that with current commitments there will be a shortfall of £340K.
- The current holdings in the Charity's investment portfolio exceeds the recommendation in the Governance Policy (Investments) to not exceed a percentage of 60% of the total assets to reduce the risk. The current percentage is 81.9%.
- Due to the shortfall in cash availability and to meet the recommendation in the Governance Policy the Committee were asked to approve a request to Cazenove to release £1M from the investment portfolio.

Decision

The Committee agreed to request Cazenove to release £1M from the investment portfolio.

4 Charitable Property

- The Charity and Margate Civic Society were named as beneficiaries of the capital and any residual income, following the death of the son. The son currently resides at the property in question, and the beneficiaries are deemed to be Landlord of the property.
- As Landlords we are required to provide the following:
  - Provide an annual Landlords Gas Safety record.
  - Electrical fixed wiring test – every 5 years.
  - Insurance for our property – annually.
- The Trust's Estates and Facilities Department has undertaken an inspection of the property and the following works have been identified:
  - The main gas boiler has been serviced and passed the safety check.

However, the Gas Engineer has indicated that the boiler is quite old and inefficient and will require to be replaced in the very near future.
    - The gas cooker in the kitchen has been serviced and although it passed the safety check it is old and has no safety device on each burner, which would protect the resident in the event that the flame was blown out. The Gas Engineer recommends that this is replaced as soon as possible.
    - The gas fire in the lounge has been serviced and passed the safety check. However, there is a significant amount of "clutter" in the room. The resident informed the Gas Engineer that he does not use the fire, however should he at any time decide to do so whilst the "clutter" remains in close proximity to the fire there would be a significant fire risk.
- Advise has been sought from the Trust's Deputy Director of Estates and Facilities regarding further areas that would fall within our remit as Landlords and he has suggested that the following be addressed in the next 3 months;
    - Survey property to ascertain any underlying issues with regards to windows, roof, movement/settlement etc.
    - Health and safety survey to be carried out and engagement with tenant regarding "clutter" in the property.
    - Recommend removal of gas fire.
    - Replace gas cooker.
    - Investigate costs of replacing gas boiler.
- The Committee expressed their grave concerns about these issues and agreed with all of the recommendations mentioned above and that Trust's Estate and Facilities Department should provide a quotation for all of these items.
- In addition the Committee agreed that a meeting should take place as soon as possible with Margate Civic Society to seek urgent agreement for these works.

Decision

The Committee agreed to all of the recommendations made by the Trust's Estates and Facilities Department and that these works should be completed as soon as possible together with the discussions with Margate Civic Society.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Charity has to remain financially stable and cannot over commit to projects that could lead to an overreach of funding capacity. The Committee oversees the financial position and activities to ensure the Charity achieves its strategies and objectives.
LINKS TO STRATEGIC OBJECTIVES:	The broad objectives of the Charity link to all the strategic objectives of the Trust. **Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	No
RESOURCE IMPLICATIONS:	Not applicable
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

PRIVACY IMPACT ASSESSMENT: No	**EQUALITY IMPACT ASSESSMENT:** No

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is being asked to:-

1. Approve the grant of £323,323.07 for the Echocardiograms for QEQM and K&CH plus TOE imaging software
2. Discuss and note the report.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**TRANSFORMATION BOARD**
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER**
PURPOSE:	**TO NOTE**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Board of Directors received a report at its last meeting a report outlining plans for reporting to Board progress against the Trust's Transformation Programme.

The Trust has established a Transformation Board to oversee the Transformation Programme and to drive delivery of the projects that address improved outcomes and better performance standards and once implemented, will help drive improve quality and efficiencies.

Below is a summary of agenda items discussed at the last meeting held on 21 July 2017.

Update from the Implementation Team

The Trust's Implementation Team will be undertaking a review of all leadership programmes undertaken across the organisation, through the Trust's Integrated Education Board and will coordinate a central transformation leadership programme with agreed content against an established framework. A skills gap was finalised and will be presented to the next Transformation Board.

The Transformation Board received updates from the following workstreams:

Getting to Good

To date this work stream has:

- Identified a Non-Executive Director to support the programme
- Arranged our first programme management meeting for Thursday 20 July
- Identified the leads for each strand
- Ascertained the resources we have to deliver the programme.

Further work includes:

- Agreeing Terms of Reference
- Gathering assurance at our first meeting regarding progress and any challenges
- Agreeing timelines and developing milestones for delivery

The Transformation Board discussed the need for assurance that the whole organisation had visibility of compliance requirements with CQC and Divisional progress to date.

Healthy Finances

The Transformation Board received the Month 3 finance report (as per the Integrated Performance Report to Board). Quarter 1 performance was £1.6m ahead of plan and the majority of the individual elements of the work stream were progressing well.

Delivering Our Future

A report was received on progress made with other organisations across Kent and Medway to progress the Kent and Medway Sustainability and Transformation Programme. Regular progress reports to Board are reported to through the Chief Executives Report.

The Transformation Board received an update on the work supporting development of a social movement surrounding transformation programme. A communication plan would be presented to the next Implementation Team.

General discussion points

The following work streams would report in more detail at the next meeting:

- Higher Standards for Patients;
- Right skills, right time, right place; and
- Great Place to Work

The Transformation Board discussed the importance of ensuring the emergency pathway had visibility within the Higher Standards for Patients work stream.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	SRR 12 - Insufficient capacity and capability of the leadership team (Executive and Divisional Directors) to develop and deliver key strategies and recovery plans
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 12 - Insufficient capacity and capability of the leadership team (Executive and Divisional Directors) to develop and deliver key strategies and recovery plans SRR 16 - Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes
RESOURCE IMPLICATIONS:	Will be identified through project plans
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None – Finance and Performance Committee will receive an update at their April meeting

PRIVACY IMPACT ASSESSMENT: No	**EQUALITY IMPACT ASSESSMENT:** No

RECOMMENDATIONS AND ACTION REQUIRED:

(a) **Note the update from the Transformation Board.**

East Kent Hospitals University NHS
NHS Foundation Trust

JUNE 2017

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
NHS Foundation Trust

Chief Executive's Summary

I am pleased to report that our caring domain is demonstrating continued positive patient experience levels to those reported in my previous report. Our focused work continues in improving patient experience in our Emergency Departments where there have been significant challenges. There is also more to do with our complaints response time and focussed work continues with our Divisions to bring this back in line.

Referral to treatment (18 weeks) has remained static reporting at 85%. As reported last month, this is positive particularly as the Trust continues to see an increase in referrals and additions to our admitted waiting list but further work is required to make improvements in compliance. I am pleased to report that the number of patients treated beyond 52 weeks has reported a decrease in June compared to the previous month. Work on this continues as a priority.

Cancer 2 week wait performance continues to report a compliant position. Unfortunately, breast symptomatic 2 week wait performance reported a non-compliant position in June at 89.87% and work is underway to address that for the future. Cancer 62 day performance remains a challenge in particular specialties and focussed work continues as we work to achieve compliance from September 2017 data.

We have seen a slight improvement in our A&E 4 hour performance for June 2017 reporting at 78.59% compared to the position in May 2017 which reported at 76.78% but this remains well below the expected level and following the Canterbury changes to the acute medical take in June, our focus is now on embedding the model and improving 4 hour performance. This will take time and one of the key drivers for this continues to be staffing issues across our emergency departments and this and other issues are currently being examined and solutions being identified to help improve performance ahead of the winter.

Harm free care (new harms which we can influence) continues to report higher than the national average with a further improvement in June 2017 compared to May 2017.

As reported last month, infection control is an area of increased focus as this is a key area of patient safety. The current year to date total (as at 21/07/2017) for C.difficile is 14 cases against an annual objective of 46 cases which is just below trajectory.

Although there were no cases of MRSA in May and June 2017, there have been 2 as yet unassigned MRSA bacteraemias in July 2017 to date. A validated position will be reported in our next report to Board.

Mercia Spare, Head of Quality, NHSI, has agreed to undertake a critical friend review of our Infection Prevention and Control together with a review of the Trust's action plan. This review is scheduled for August 2017.

Whilst the rate of falls within the Trust remains lower than the national average, inpatient falls remain a challenge in our hospitals and for the NHS as a whole. However, the number of falls decreased significantly in June 2017 with a total of 138 compared to 174 in May 2017. The Falls Team continue to work hard to implement the "Fallstop" programme across the Trust.

Performance around Category 2 pressure ulcers compares well with other Trusts and a decrease was reported in June compared to May 2017. One category 3 pressure ulcer was reported in June 2017 which was avoidable. During June 2017, the TV team continue to reinforce the 'react-to-red' message throughout the Trust.

The Trust's I&E deficit in June (month 3) was £1.1m (consolidated position excluding Sustainability and Transformation Funds and after technical adjustment) against a plan of £1.5m.

The year to date I&E deficit is £6.6m against a plan of £8.2m (£1.6m better than plan).

Pay costs in the month of £28.7m were £0.2m up on May but also £0.2m better than plan. Permanent staff reduced by £0.3m, bank staff was unchanged, but overtime increased by £0.1m and agency/locum staff by £0.4m. The move of Kent and Canterbury medical trainees to WHH and QEQM took place on 19 June necessitating additional costs. Invoicing from NHSP continues to be investigated. Temporary staff spend in month is a concern and will need to see a reduction in future months if workforce CIPS are to be delivered. Waiting list payments continued to be depressed at £0.16m, a small increase on May. Pay is now £1.5m better than plan year to date.

Activity/income was £1.2m better than plan in month with total income now £0.9m better than plan YTD.

Against the £32m CIPS target, including income, £1.79m was reported in month against a target of £1.97m. Year to date £5.2m is reported against a plan of £4.7m. Of the reported position, £1.3m (25%) is non-recurrent and steps are being taken to ensure that this is made up recurrently.

The cash balance as at the end of May was £7.9m. No new borrowings were required.

No agreement on the 2016/17 contract value outturn or CQUIN has yet been reached with East Kent CCG commissioners. A proposal has been forwarded to them and further discussions are planned before the end of July. Total risks net of opportunities of £11.4m have been identified.

The Trust's Financial Recovery Plan has been received and accepted by NHSI. This is for an £18.9m deficit target (excluding Sustainability and Transformation Funds). The third review meeting took place on 3 July and was a constructive and positive discussion. The Trust remains in Financial Special Measures.

The turnover rate has reported a slight reduction in June 2017 at 12.6%. The vacancy rate increased marginally from 11.6% to 11.9%. Continued action is being taken for roles which have been identified as hard to recruit either because of repeated difficulty in recruiting to EKHUFT posts or because of shortages in labour supply nationally. Some posts are agreed as 'on hold' as part of cost improvement plans.

The proportion of temporary staff engaged by the Trust increased in April and May (this despite the fact the wte temporary staff used in month reduced). This has largely resulted from an increased supply of bank staff in the reporting period. Percentage agency supply showed a marginal increase. Agency costs are controlled by the Agency Taskforce and are a key part of controlling staffing costs. Greater efficiencies are being sought in the use of E-Roster aimed at maximising use of substantive staff, for example, using net hours owed before booking overtime or agency cover. Breaches in pay caps continue to be reported and monitored. Divisions are all now monitoring Agency use on a post by post basis through the agency reduction plans in Aspyre with support from HR and Improvement Delivery Teams. These plans identify detailed and specific actions to eliminate where possible spend on agency.

Local induction compliance continues to be an area of concern and focus for the executive team. Statutory training compliance remained steady at 89%. This remains above the target of 85%. Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements. There remains an on-going issue with the recording of Information Governance training, so this is being sent manually in some cases.

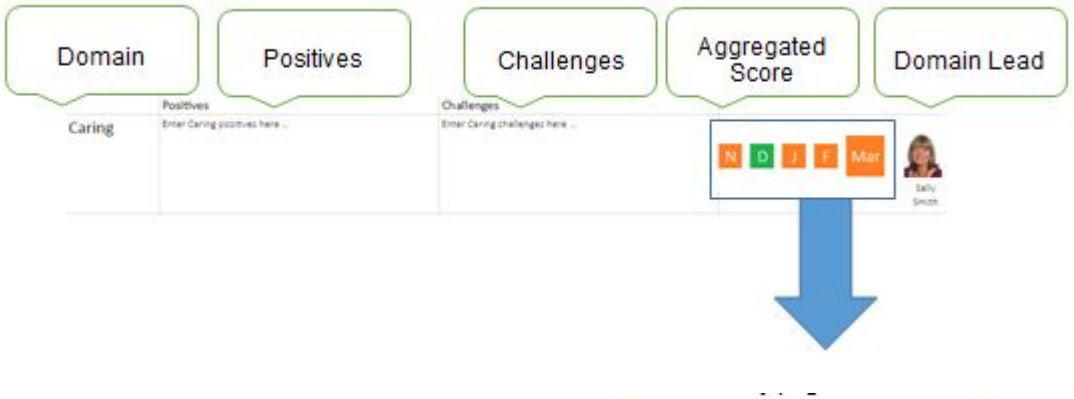
The Trust staff appraisal rate decreased to 81.1%, below the 90% target. Divisions are working on plans to complete appraisals due in (traditionally high volumes are due in April/May) to avoid a further drop in appraisal rates.

Time to recruit has decreased in the last two months and it is hoped that this will be further supported by the recruitment process mapping plans in place for implementation by the end of June 2017.

East Kent Hospitals University NHS
NHS Foundation Trust

Understanding the IPR

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

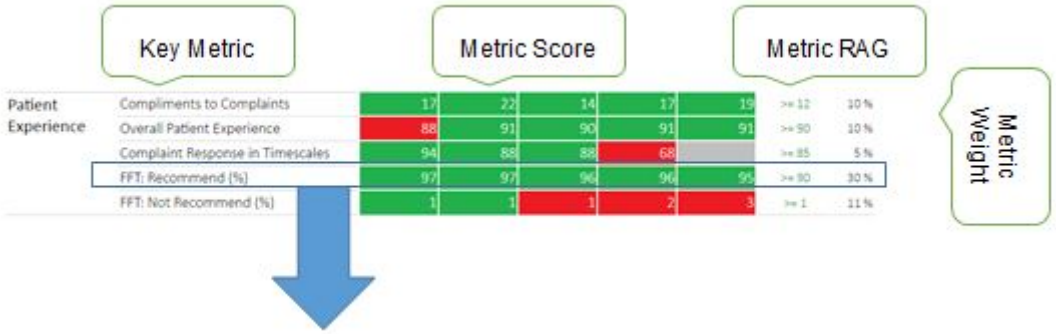


2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall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

East Kent Hospitals University NHS
NHS Foundation Trust

Understanding the IPR

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



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

All RAGs are banded as Green, Amber and Red. A grey cell indicates that data is not yet available. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Priorities

East Kent Hospitals University NHS
NHS Foundation Trust

Contents

East Kent Hospitals University NHS
NHS Foundation Trust

Headlines

	Positives	Challenges	
Caring	Friends and Family Test for inpatients remains at 97% registering green. The percentage of patients not recommending the Trust reduced again and is registering the lowest level of dissatisfaction since January 17. Overall patient experience as recorded by the real-time survey is similar to last month. Satisfaction with 'Care that matters to you' is showing an improvement compared to last month as is patients' reported satisfaction with hospital food. The complaints:compliments ratio is registering green in June	We are still reporting mixed sex breaches in our Clinical Decision Units and in June the occurrences increased Our complaint responses within 30 working days is registering amber.	F M A M Jun  Sally Smith
Effective	Bed Occupancy improved in June to a monthly figure of 94% with a reduced non-elective length of stay. This follows the work undertaken to prepare the sites for the moves of medical services from the Kent and Canterbury Hospital site. An increase in the number of patients discharged before midday and also a reduction in the number of reportable delayed transfers of Care (DTOC), balanced by slight reductions in the readmissions rates.		F M A M Jun  Jane Ely
Responsive	Cancer 2 week wait performance remained compliant Diagnostic performance remained compliant and continues to perform well. Referral to Treatments (18 weeks RTT) performance has remained steady at 85%, however referrals, total waiting list and additions to the admitted waiting list have all increased significantly. The number of patients treated beyond 52 weeks has decreased slightly and an improvement trajectory at specialty level is now in place. The A&E 4 hour performance has improved to 78.59%.	Improving the A&E 4 hour performance remains a challenge due to the doctor cover across the Emergency departments. The high number of attendances have put pressure on departments and found to be related to the hot weather. Cancer 62 day performance is a challenge in a number or tumour sites – Colorectal, Lung, Head and Neck and Urology. Daily performance meetings are now in place to work towards September compliance. RTT performance will be a challenge to maintain with the increasing in the waiting list	F M A M Jun  Jane Ely

Safe	Harm free care (New harms, that we can influence) remains better than the national average and improved in June compared to May. The falls rate is registering green in June and is below the national average. The incidence of category 2 pressure ulcers has improved in June. There were no avoidable deep ulcers reported in June. The infection prevention and control team is virtually back to establishment. Clinical incident reporting has increased this month compared to last month. We see this as a positive indication of a culture of openness and transparency with regard to safety and quality. The % of patients screening positive for sepsis and receiving antibiotics within an hour of arriving in A&E has risen to 81% this month, similarly 80% of inpatients screened received intravenous antibiotics within the golden hour.	VTE risk assessment recording remains sub-standard but has improved to above 90%. A stop before you block never event occurred in the QEQMH operating theatre despite work done previously with the anaesthetic teams to prevent this from happening. Hip fracture 30 day mortality at the WHH Ashford has flagged negatively having risen from 6.4% in April 2016 (cf. 6.8% nationally) to 10.4% in February 2017 and 9.9% in March 2017 (latest data). This compares to national figures of 6.6% and 6.5% and to the QEQMH figures of 7.1% and 6.1%. This is being actively investigated with individual case note review. Infection prevention and control remains an area of concern	F M A M Jun	 Paul Stevens
Well Led	I&E £1.6m ahead of plan at month 3 Permanent staff spend reduced by £0.3m Sickness rates stable (3.7%) Cash balance as at 31 March on plan £7.9m) Nursing shifts filled CIPS of £5.2m reported against a plan of £4.7m year to date	Vacancies increase for 5th month in a row (11.9% from 11.7%) Turnover stable (12.6%) Appraisal rate reducing for 3rd month (81.1% to 75.8%) Temporary staff spend increased by £0.5m (agency, locum, overtime) High number of medical staff vacancies Non recurrent CIPS at £1.2m year to date (25%)	F M A M Jun	 Matthew Kershaw

East Kent Hospitals University NHS
NHS Foundation Trust

Caring

	F	M	A	M	Jun	
OVERALL DOMAIN SCORE						Weight
Patient Experience	F	M	A	M	Jun	90 %

East Kent Hospitals University NHS
NHS Foundation Trust

Caring

		Feb	Mar	Apr	May	Jun	Green	Weight
Patient Experience	Compliments to Complaints (#/1)	39	20	40	32	27	>= 12	10 %
	Mixed Sex Breaches	6	17	10	7	17	< 1	10 %
	Overall Patient Experience %	91	92	92	92	92	>= 90	10 %
	Complaint Response in Timescales %	79	84	86	86	79	>= 85	5 %
	FFT: Recommend (%)	95	95	96	97	97	>= 90	30 %
	FFT: Not Recommend (%)	2.7	2.4	1.8	1.4	1.3	>= 1	10 %

East Kent Hospitals University NHS
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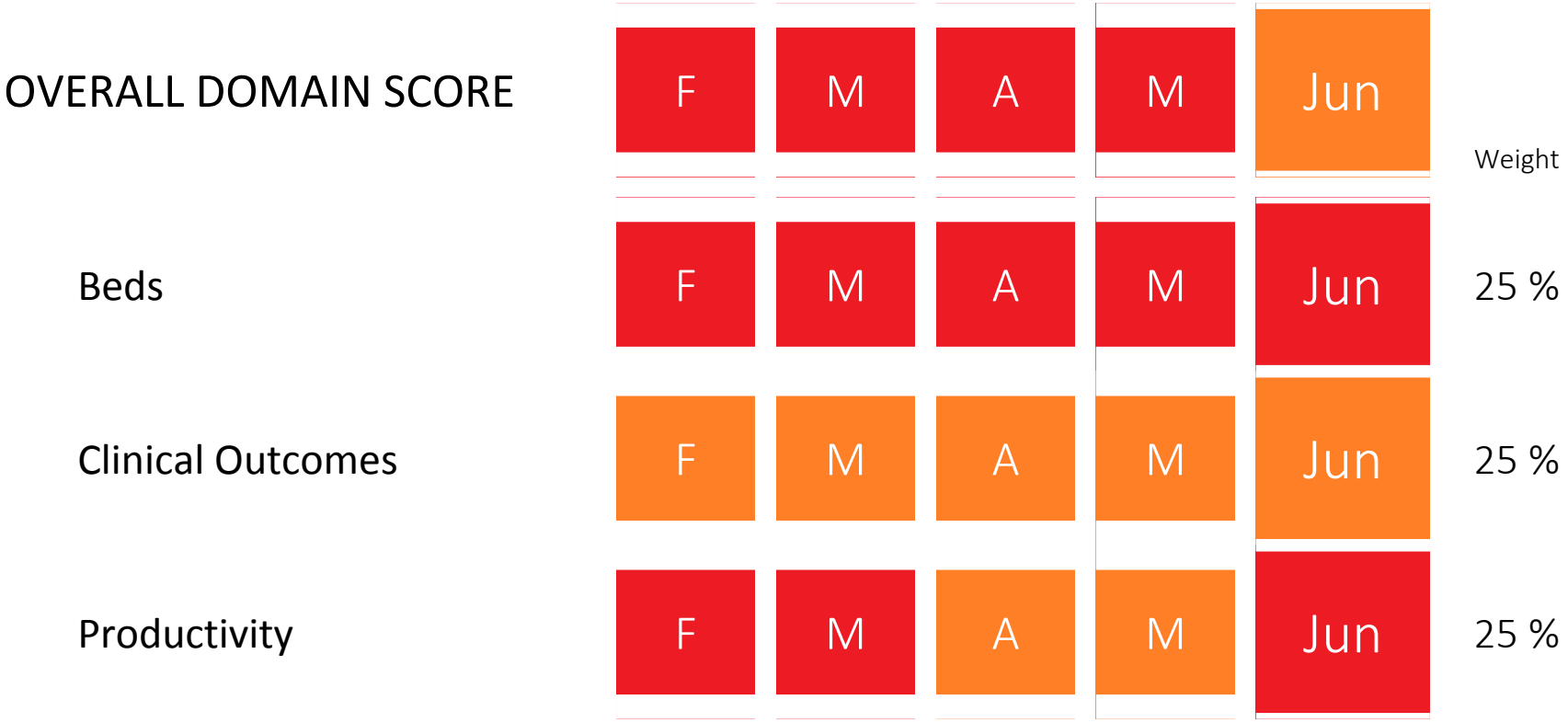
Effective



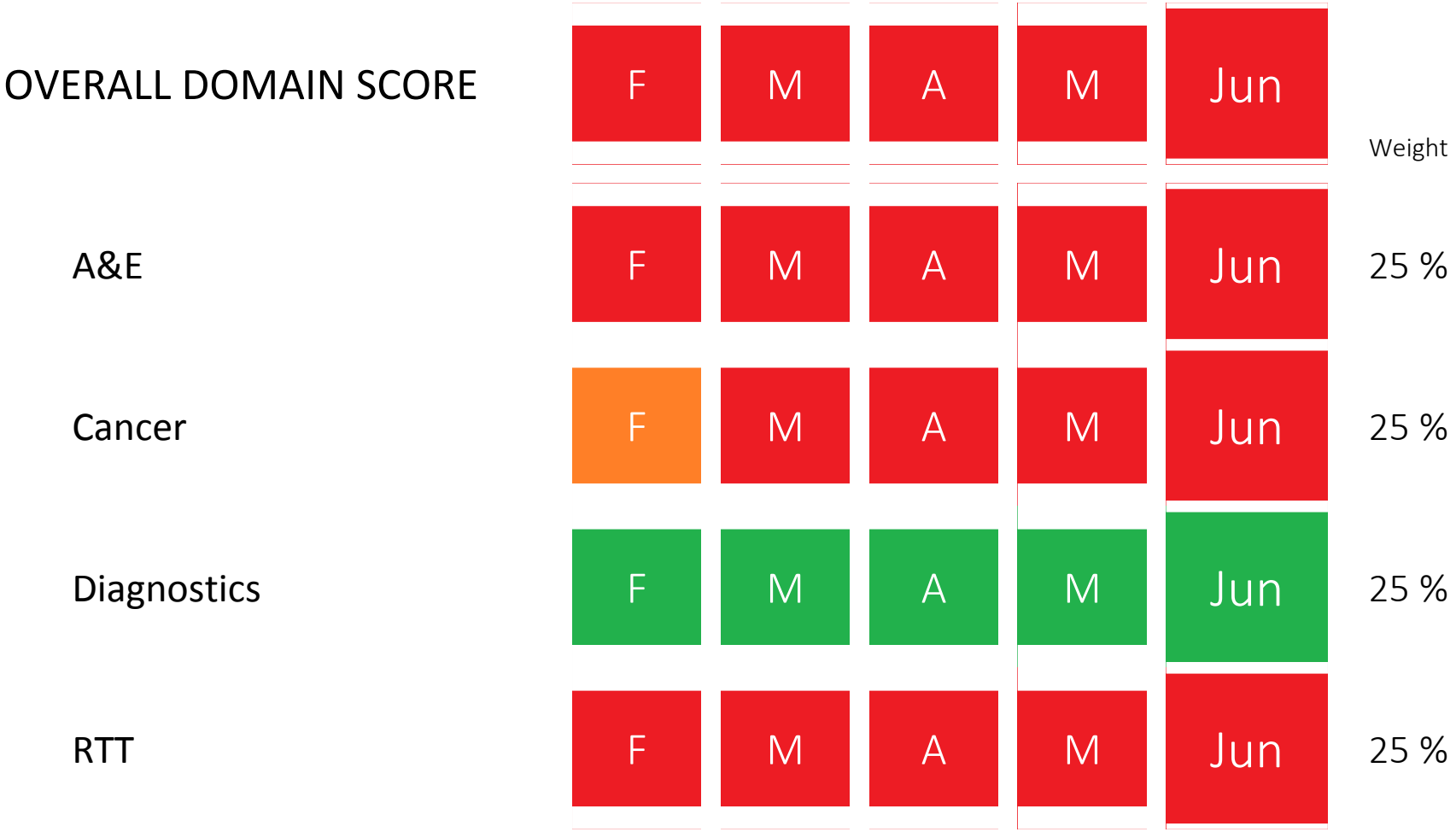
East Kent Hospitals University NHS
NHS Foundation Trust

Effective

		Feb	Mar	Apr	May	Jun	Green	Weight
Beds	Bed Occupancy (%)	104	101	97	99	94	<= 90	60 %
	IP - Discharges Before Midday (%)	15	14	15	15	13	>= 35	10 %
	DToCs (Average per Day)	56	59	49	62	56	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3.4	3.4	3.4	3.4	3.4	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	16.2	16.1	16.0	15.9	15.8	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	99	100	100	100	100	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	6.5	6.7	6.7	6.8	6.9	< 7	
	DNA Rate: Fup %	6.1	5.7	6.4	6.2	6.9	< 7	
	New:FUp Ratio (1:#)	0.7	0.7	0.6	0.7	0.6		
Productivity	LoS: Elective (Days)	2.7	2.9	3.3	3.0	3.1		
	LoS: Non-Elective (Days)	6.6	6.2	6.1	6.7	6.5		
	Theatres: Session Utilisation (%)	81	81	78	82	82	>= 85	25 %
	Theatres: On Time Start (% 30min)	78	80	80	77	78	>= 90	10 %
	Non-Clinical Cancellations (%)	1.6	1.7	1.2	1.3	0.8	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	11	15	9	12	25	< 5	10 %
	EME PPE Compliance %	73	76	76	75	77	>= 90	20 %

East Kent Hospitals University NHS
NHS Foundation Trust

Responsive



East Kent Hospitals University NHS
NHS Foundation Trust

Responsive

		Feb	Mar	Apr	May	Jun	Green	Weight
A&E	ED - 4hr Compliance (%)	76.24	80.45	78.57	76.48	78.15	>= 95	100 %
Cancer	Cancer: 2ww (All) %	96.08	97.41	93.59	95.67	96.76	>= 93	10 %
	Cancer: 2ww (Breast) %	94.81	93.57	90.91	90.71	89.87	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	96.96	97.42	95.68	94.81	95.91	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	94.12	90.24	89.29	92.00	85.45	>= 94	5 %
	Cancer: 31d (Drug) %	95.77	97.50	97.06	95.24	95.35	>= 98	5 %
	Cancer: 62d (GP Ref) %	70.45	77.30	72.40	70.19	74.47	>= 85	50 %
	Cancer: 62d (Screening Ref) %	76.47	89.23	92.00	95.00	95.74	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	92.59	69.77	66.67	80.56	76.09	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.67	99.78	99.06	99.36	99.46	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	99.67	100.00	100.00	>= 99	
RTT	RTT: Incompletes (%)	84.35	85.40	84.85	85.82	85.07	>= 92	100 %
	RTT: 52 Week Waits (Number)	24	28	29	36	30	< 1	

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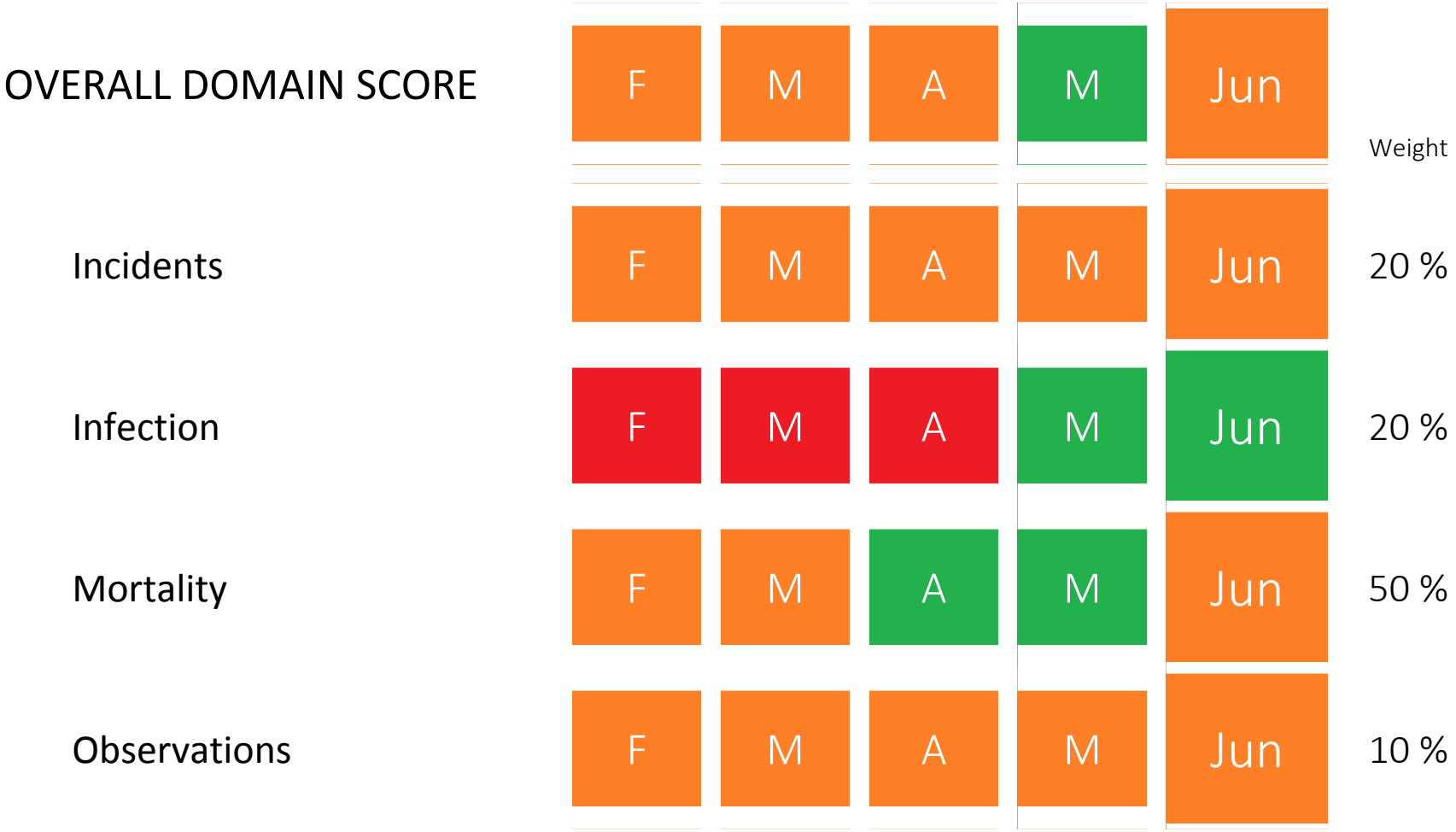
Safe



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Safe

		Feb	Mar	Apr	May	Jun	Green	Weight
Incidents	Serious Incidents (STEIS)	6	9	5	6	8		
	Harm Free Care: New Harms (%)	99.1	99.0	99.2	98.5	99.4	>= 98	20 %
	Falls (per 1,000 bed days)	5.51	5.07	5.12	5.25	4.75	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.48	0.30	0.38	0.30	0.17	<= 0.15	10 %
	Clinical Incidents: Total (#)	1,337	1,391	1,255	1,372	1,356		
Infection	Cases of C.Diff (Cumulative)	45	53	5	8	11	<= Traj	40 %
	Cases of MRSA (per month)	2	2	1	0	0	< 1	40 %
Mortality	HSMR (Index)	83	81				< 90	35 %
	Crude Mortality EL (per 1,000)	0.5	0.1	0.5	0.3	0.5	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	34	30	31	35	28	< 27.1	10 %
	RAMI (Index)	91	89	87	87		< 87.45	30 %
Observations	Cannula: Daily Check (%)	75.4	77.2	76.3	77.5	76.3	>= 50	10 %
	Catheter: Daily Check (%)	49.3	49.5	46.9	47.8	47.3	>= 50	10 %
	Central Line: Daily Check (%)	65.4	68.0	67.8	68.5	67.7	>= 50	10 %
	VTE: Risk Assessment %	91	90	89	89	90	>= 95	20 %
	Obs. On Time - 8pm-8am (%)	92	92	92	92	91	>= 90	25 %
	Obs. On Time - 8am-8pm (%)	90	90	90	90	89	>= 90	25 %

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Well Led

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Well Led

		Feb	Mar	Apr	May	Jun	Green	Weight
Culture	Staff FFT - Treatment (%)	76	76	77	77	77	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	0.5	0.4	0.3	0.3	0.8	< 4	25 %
	Valid NHS Number %	100	100	100	100	100	>= 99.5	40 %
	Uncoded Spells %	0.0	0.0	3.3	0.1	0.1	< 0.25	25 %
Finance	I&E £m	-3.3	-8.8	-2.8	-1.8	-0.7	>= Plan	30 %
	Cash Balance £m	8.2	5.1	8.9	13.0	7.9	>= Plan	20 %
	Total Cost £m	-46.8	-55.3	-47.3	-48.5	-49.7	>= Plan	20 %
	Forecast I&E £m	-27.7	-31.4	-19.0	-19.0	-19.0	>= Plan	20 %
	Normalised Forecast £m	-31.8	-30.7	-19.0	-19.0	-19.0	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	1	1	0	0	1	<= 3	20 %
	Formal Notices	0	0	0	0	0	< 1	15 %
Staffing	Sickness (%)	4.1	4.1	3.6	3.7	3.7	< 3.6	10 %
	Staff Turnover (%)	12.6	12.7	12.9	12.9	12.6	<= 10	15 %
	Vacancy (%)	9.4	9.8	11.4	11.7	11.9	<= 7	15 %
	Total Staff In Post (SiP)	6989	6967	6921	6913	6900		1 %
	Temp Staff (WTE)	265	260	234	226	240	< 182	1 %
	Shifts Filled - Day (%)	100	100	101	99	98	>= 80	15 %
	Shifts Filled - Night (%)	111	111	110	106	107	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	11	11	10	10	12		
	Local Induction Compliance %	15.0	21.8	16.3	20.8	23.5	>= 85	
	Agency %	19.2	21.9	18.5	18.9	20.5	<= 10	
Training	Appraisal Rate (%)	83.6	84.6	84.9	81.1	75.8	>= 90	50 %
	Statutory Training (%)	88	89	89	89	89	>= 85	50 %

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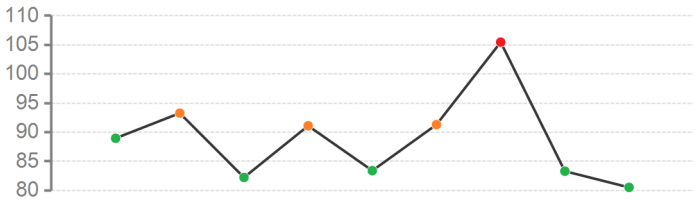
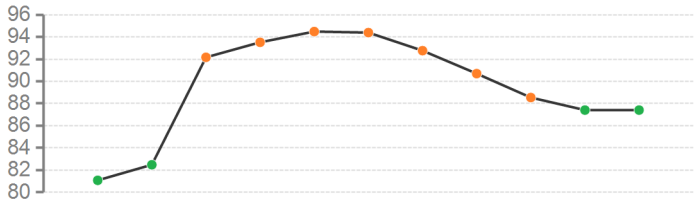
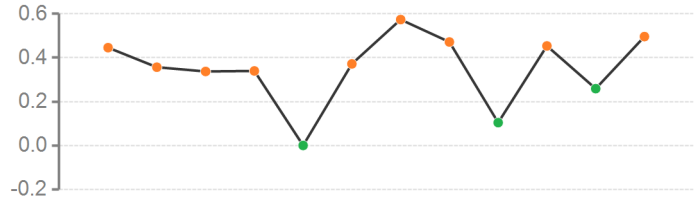
Strategic Theme: Patient Safety

Mortality

Jun	HSMR (Index)	89 (6.1%)		Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.
Jun	RAMI (Index)	89 (-1.8%)		Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	Crude Mortality EL (per 1,000)	0.3 (-8.8%)		The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

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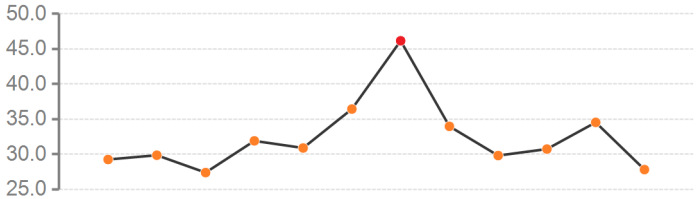
Strategic Theme: Patient Safety

Jun

Crude Mortality NEL (per 1,000)

32 (12.9%)



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

Comments:

The Trust crude mortality rate continues at 1.4% and is within the peer 25th to 75th percentile. HSMR for the current period of reporting (April 2016 to March 2017) was 88.8%, below the peer 25th percentile of 89.6%. There continues to be a site variation and the rolling 12 months chart continues to show highest indices at WHH followed by QEQMH and then K&CH. In the previous report septicaemia was alerting on red and abdominal pain alerting on amber. In this reporting period these 2 conditions continue to alert and also with the addition of 154 non infectious gastroenteritis.

1. Septicaemia

The Trust continues to monitor this group. It is expected that with the introduction of new coding rules nationally that this CCS group will continue to alert. In this reporting period the number of cases was 392 compared to 367 in the previous report covering March 2016 to February 2017.

2. 154 Non-infectious gastroenteritis

The cusum illustrates that the alerting period was in the earlier months of the reporting period followed by a decrease in the following months. There was one death in March 2017, 91 years of age with a length of stay of 7 days, the patient had extensive secondary diagnoses including acute lower respiratory infection, acute renal failure.

3. 251 Abdominal pain

The cusum illustrates that the alerting period was in the earlier months of the reporting period followed by a decrease in the following months. The amber alert was triggered by a death in February 2017 which was an 87 year old with secondary diagnoses including malignant neoplasm of the caecum. Following a length of stay of 7 days the patient was discharged to another provider and under the HSMR methodology the death was attributed to the Trust.

An additional area that has not been picked up by the routine mortality alert monitoring is 30 day hip fracture mortality. Hip fracture 30 day mortality had previously alerted at the WHH Ashford back in 2013 when the mortality was 13.7% compared with national mortality of 8.5%. Following investigation an improvement programme was established which saw the 30 day mortality at WHH progressively fall to 6.4% in April 2016 compared to a national figure of 6.8%. Since April 2016 the 30 day hip fracture mortality has progressively risen again to 10.4% in February 2017 and 9.9% in March 2017 (latest data). This compares to national figures of 6.6% and 6.5% and to the QEQMH figures of 7.1% and 6.1%. This is being actively investigated with individual case note review.

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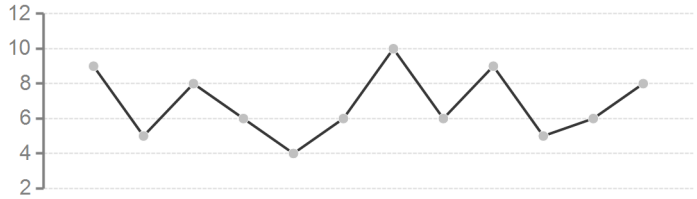
Strategic Theme: Patient Safety

Serious Incidents

Jun	Serious Incidents (STEIS)	82 (2.5%)		Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Jun	Never Events (STEIS)	2 (-60.0%)		Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

Total open SIs on STEIS June 2017: 68 (including 8 new)
SIs under investigation: 38
Breaches: 18
Non-breaches: 20

SIs awaiting closure: 30
Waiting CCG response: 22
Waiting EKHUFT non-closure response: 8

Supporting Narrative:
The number of breached cases is 18. Breaches are mainly due to the quality of analysis. This is being managed by the Root Cause Analysis Group and at the Executive Performance Reviews each month.

Work continues on clearing the longest breached cases and further progress is predicted. The Clinical Incident Manager and Head of Patient Safety have been working with the divisions to progress these cases and are now attending many of the RCA meetings, and supporting the writing of the investigations.

The eight new SIs related to:

- one never event relating to wrong site block
- three treatment delays relating to a trauma patient with a haemothorax and fractures, a patient who required earlier escalation when he deteriorated and an ophthalmology case
- one diagnostic delay relating to a patient with discitis
- one surgical procedure relating to dentistry
- one fall
- one obstetric incident regarding a post-partum haemorrhage.

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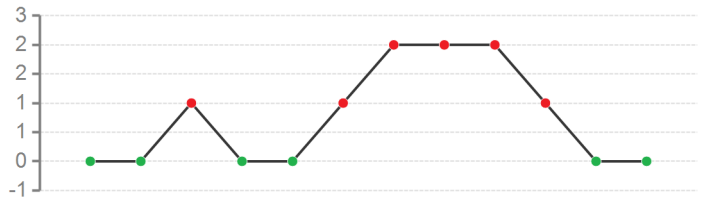
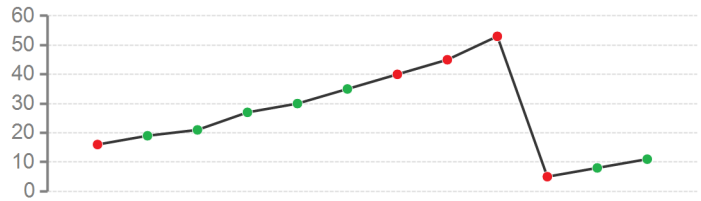
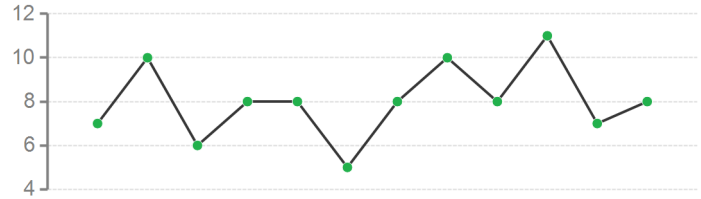
Strategic Theme: Patient Safety

Infection Control

Jun	Cases of MRSA (per month)	9 (200.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Jun	Cases of C.Diff (Cumulative)	11 (37.5%)		Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month.
Jun	E. Coli	96 (23.1%)		The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

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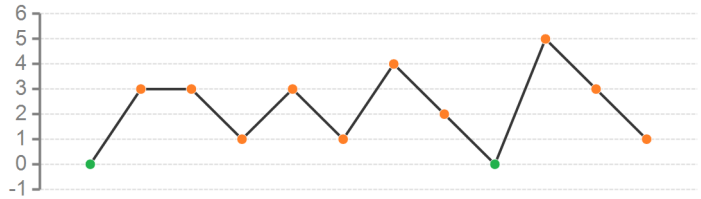
Strategic Theme: Patient Safety

Jun

MSSA

26
(-3.7%)



The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

C.difficile
The current year to date total (as at 21/07/2017) is 14 cases against an annual objective of 46 cases which is just below trajectory. Performance is driven down by medicine who are above trajectory.
MRSA
Although there were no cases of MRSA bacteraemia in May and June there have been 2 as yet unassigned MRSA bacteraemias in July to date.
Anti-microbial Stewardship (AMS)
The employment of a Band 8a Pharmacist in intensive care with focus on antimicrobials will pick up issues around sepsis and critical care AMS. That individual comes into post in August 2017. A further band 8a pharmacist will be in post in the autumn as AMS lead and they will take the lead in training of staff, alongside other members of the clinical microbiology team. Dr Graeme Calver has taken on the microbiological lead for this area with effect from now.

Critical Friend Review
Mercia Spare (NHS Head of Quality) has kindly agreed to undertake a critical friend review of our Infection Prevention and Control together with a review of the IPC action plan, this review is scheduled for August 8/9.

There have been no further infection control incidents.

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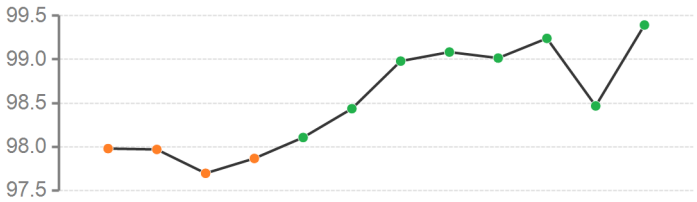
Strategic Theme: Patient Safety

Harm Free Care

Jun	Harm Free Care: New Harms (%)	98.5 (0.5%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.

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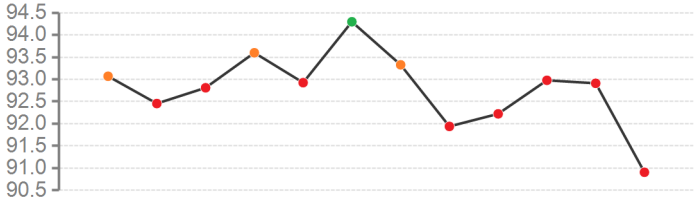
Strategic Theme: Patient Safety

Jun

Harm Free Care: All Harms (%)

92.8
(0.5%)



Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.

Comments:

Overall Harm Free Care (HFC) relates to the Harms patients are admitted with as well as those they acquire in our care. HFC in June-17 was 90.91% compared to 92.91% in May-17. A wide variation, as expected, is seen across the divisions with specialist achieving 95.42%, surgical 88.98% (a reduction from 94.18% in May-17) and UCLTC 89.96%.
The prevalence of pressure ulcers (admitted with) has increased in June to 7.5% from 5% in May-17. A review of old harms (patients admitted with) during Q1 has been undertaken and reveals no particular themes in admission source. A review of the 240 Datix reported incidents of patients admitted with pressure ulcers is underway to identify any trends and drive improved work with our partners.

Harm Free Care experienced in our care (New Harms only) has significantly improved to 99.39% in June compared to 98.4 in May-17.

WHH New Harms Only HFC had a slight increase to 99.30% in June compared to 99.13% in May.
QEQM New Harms Only HFC also had an increase to 99.42% in June compared to 98.01% in May.
K&C New Harms Only HFC also had an increase 99.54% in June compared to 97.84% in May.

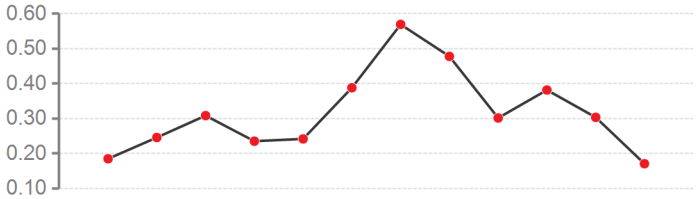
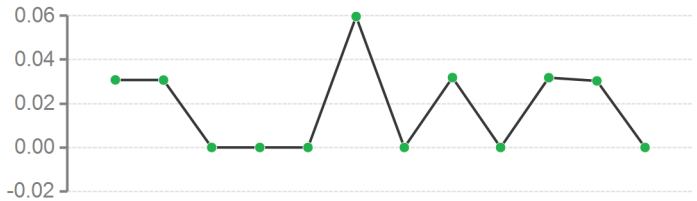
HFC (new harms only) for all four individual harms have fallen this month. No national comparison data was available at the time of reporting due to a technical issue. The Safety Thermometer for June-17 demonstrates:

- Lower levels of catheters & New UTIs (0.10%) compared to 0.57% in May-17.
- Lower levels of New Pressure Ulcers (0.20%) compared to 0.38% in May-17.
- Lower prevalence of falls with harm (0.20%) compared to 0.29% in May-17.
- Lower prevalence of new VTEs (0.10%) compared to 0.29% in May-17.

Rigorous work will continue to ensure validation is carried out correctly and focus work continues to be carried out to reduce the number of falls to ensure patient safety.

Strategic Theme: Patient Safety

Pressure Damage

Jun	Pressure Ulcers Cat 2 (per 1,000)	0.32 (-69.0%)		Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Pressure Ulcers Cat 3/4 (per 1,000)	0.02 (-75.9%)		Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

In June 2017 a total of 27 category two pressure ulcers were reported, a reduction of 7 from last month. Of these incidents, 5 were confirmed as avoidable, a decrease of 50%. Four incidents affected the sacrum/buttock area. These occurred on CL, CDU/WHH, Maternity/QEQM and Bishopstone. Learning issues identified were insufficient repositioning; lack of reacting to red skin; delay in equipment and laying on a plastic device. The other incident affected the abdomen resulting from incorrect incontinence pad application (Kingston).
Of the 22 unavoidable superficial ulcers, 15 affected the sacrum/buttocks and one the thigh. The remaining 6 were related to medical devices affecting the nose x 1, ears x 2, mouth/chin x 2 (optiflow and ET tube fastenings) and one brace affecting the arm.
In June 2017, there was one confirmed category 3 pressure ulcer (CM2) which was unavoidable. There were 9 potential deep ulcers, a reduction of 10 from last month. Five were confirmed as avoidable. Two heel ulcers occurred on CM1 and CL with lack of preventative heel offloading found. The patient is being monitored and it is hoped that this discolouration will resolve without depth of skin loss. The remaining 3 patients sustained pressure damage at QEQM, all T & O. Two occurred on Bishopstone affecting the sacrum (one DTI and one unstageable) with lack of repositioning and delay in active mattress cited as key factors. The other was an unstageable ulcer which developed under hip protectors on Quex ward where lack of skin monitoring was identified.
In total, 4 ulcers affected the foot/heel, 2 avoidable. 23 affected the sacrum/buttock, 6 avoidable. 10 affected other body sites with 6 being medical device related.
During June 2017, the TV team continue to reinforce the 'react-to-red' message throughout the Trust. Joint team meetings have been held with the TV team and EME to address and improve any equipment issues. Bespoke drop in training sessions have taken place on the trauma floor at QEQM to deal with recurrent themes in avoidable ulceration.

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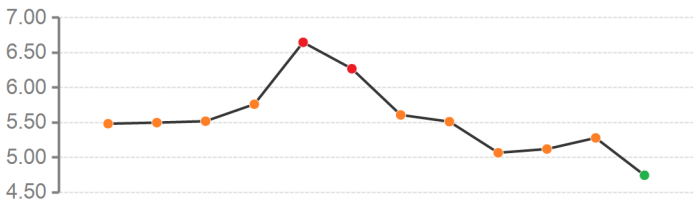
Strategic Theme: Patient Safety

Falls

Jun	Falls (per 1,000 bed days)	5.55 (-74.5%)		Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

While the rate of falls within the Trust remains lower than the national average, inpatient falls remain a great challenge in our hospitals and for the NHS.

The number of falls decreased significantly in June. There were a total of 138 compared with 174 in May. 34 were at K&CH, 45 at QEQMH and 56 at WHH. 1 fall resulted in a hip fracture at WHH, 2 in wrist fractures at K&CH and 1 in a humeral fracture at K&CH. All falls resulting in fractures have been investigated by the specialist Falls Team and were unavoidable.

To support continued improvement the Falls Team are working hard to embed the "Fallstop" programme and have had a band 4 post approved, with interviews to be held this week. Aimed at falls prevention, this programme is available to all wards across the Trust sites. With a new focus on self- directed development to promote engagement, the project has now been implemented at the William Harvey Hospital, with further implementation planned across the remaining sites.

Going forward we will use "Fallstop" audit data to benchmark our wards. The target for the coming year is to improve completion of risk assessments at each site by 10% (based on the national inpatient falls audit result from 2015). We will also use the results of the 2017 national audit (when the report is available). Many wards have already begun to use the Qlikview audits to assess compliance with falls risk assessments. The next step will be to use the post fall audit to routinely audit post fall care against the Trust's Post Fall Protocols.

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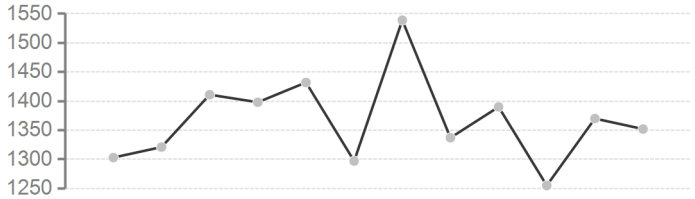
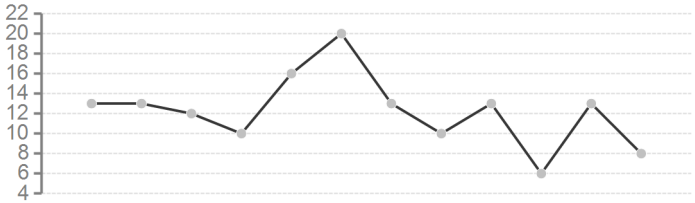
Strategic Theme: Patient Safety

Incidents

Jun	Clinical Incidents: Total (#)	16,405 (5.9%)		Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Jun	Blood Transfusion Errors	147 (1.4%)		The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

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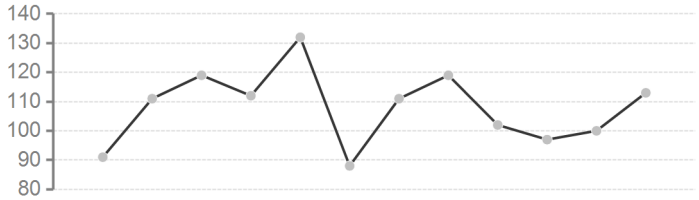
Strategic Theme: Patient Safety

Jun

Medicines Mgmt. Incidents

1,295
(1.3%)



The number of medicine management issues sourced from Datix.
Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

A total of 1342 clinical incidents have been logged as occurring in Jun-17 compared with 1366 recorded for May-17 and 1412 in Jun-16. In Jun-17, no incidents have been graded as death and two incidents have been graded as severe harm. In addition, 12 incidents have been escalated as a serious near miss, of which 8 are still under investigation. The number of moderate harm incidents reported during Jun-17 is higher than in previous months [Jun-17: 25 compared with May-17: 15 and Jun-16: 13].
Eight serious incidents (including one Never Event) were required to be reported on STEIS in June. Ten cases have been closed in June; there remains 67 serious incidents open at the end of June.
Over the last 12 months incident reporting has risen significantly at WHH, has gradually increased at QEH and is declining at K&CH.
Blood transfusion
In June, there were eight blood transfusion errors reported (13 in May-17 and 16 in Jun-16). Themes included two allergic reactions to transfusion and two delays in provision of blood products. Five incidents were graded no harm and three low harm. Reporting by site: three at K&CH, three at QEH and two at WHH.
Medicines management
There were 112 medication incidents reported as occurring in June (99 in May-17 and 119 in Jun-16). On average, over the last 12 months, the numbers of medication incidents reported at WHH have risen, at K&CH have decreased and at QEQM remained constant.
Of the 112 reported, 77 were graded as no harm (including no serious near misses) and 33 as low harm. One incident has been graded moderate harm: a renal transplant patient had not been provided with prednisolone causing a significant decline in renal function (not attributable to EKHUFT). No incidents were graded severe harm or death. Top reporting areas were: ITU (WHH) with seven incidents; A&E (WHH) with six incidents; Folkestone ward / Pharmacy (WHH) with five incidents each; Cambridge J (WHH), Bishopstone ward / CDU (QEH) with four incidents each; Pharmacy (K&CH), Cheerful Sparrows Female / Kingsgate ward / Sandwich Bay ward (QEH) with three incidents each; other areas reported 2 incidents or fewer. Twenty-two incidents occurred at K&CH, 37 at QEH and 52 at WHH.
*Missing Drugs are broken down as follows: 10 incidents relating to stock control/documentation errors, two incidents of medication missing on the ward, one incident of excessive ordering of a controlled drug by a ward and one incident where medication was missing in transit between sites.

Total
Drug error - prescribing 9
Drug error - dispensing 25
Drug error - administering 49
Drug shortage (not available or in stock) 4
Drug missing* (stock discrepancy or lost between wards/pharmacy) 14
Adverse drug reaction 3
Infusion injury - extravasation 5
Infusion problems - medication related 3
Totals: 112

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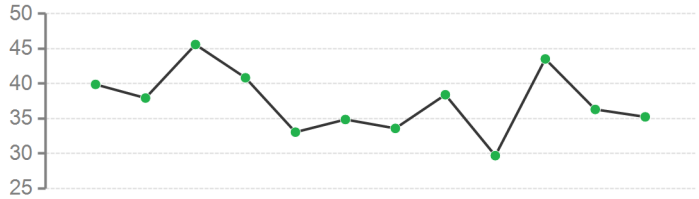
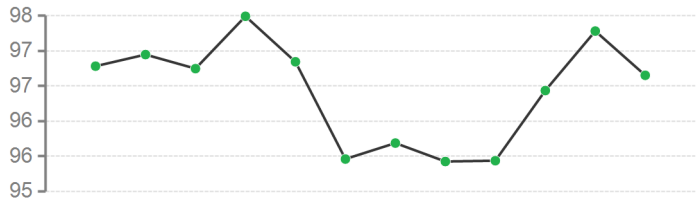
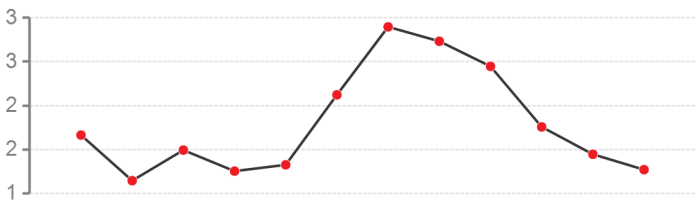
Strategic Theme: Patient Safety

Friends & Family Test

Jun	FFT: Response Rate (%)	37 (10.3%)		The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	FFT: Recommend (%)	96 (0.5%)		Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	FFT: Not Recommend (%)	1.8 (2.5%)		Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During June-17 we received 9091 responses in total. Overall 37% eligible patients responded and 91% would recommend us to their friends and family and 5% would not. The total number of inpatients, including Paediatrics who would recommend our services was 96.71% (95.1% May-17), for A&E it was 79.8% (82.8% May-17), maternity 100% (98.5% May-17), outpatients 93.3% (89.1% May-17) and day cases 95% (94.8% May-17). The Trust star rating in May is 4.57 (4.49 May-17).

Response rates for June were slightly lower in maternity, inpatients and A&E. The response rate for inpatients was 35.2% (36.8% May-17), A&E 15.8% (21.5% May-17), maternity 10% (23.4% May-17). (Please note as per DH guidelines only the Birth experience is given a response rate, FFT questions at other stages in the patient's pathway are not calculated or required nationally). The response rate for day cases was 22% (29.8% May-17) but for outpatients whose response rates are no longer reported either locally or nationally.

All areas receive their individual reports to display each month, containing the feedback left by our patients which will assist staff in identifying areas for further improvement. This is monitored and actioned by the Divisional Governance teams.

FFT - Top 5 Positive & Negative Themes
ED
Positive Themes –Staff attitude, Care, Implementation of care, Communication and Competence.
Negative Themes – Care, Waiting times, Staff attitude, Environment, Communication.

Inpatients
Positive Themes – Staff attitude, Care, Cleaning, Implementation or care and Competence.
Negative Themes –Care, Environment, Implementation of Care, Communication and Cleaning.

Strategic Theme: Patient Safety

Out patients
Positives Themes –Care, Staff attitude, Communication, Implementation of care and Competence.
Negative Themes – Care, Staff attitude, Communication, Waiting time and Environment.

Maternity
Antenatal
Positive Themes – None
Negative Themes – None

Birth
Positive Themes – Staff attitude, Care, Compassion, Implementation of care and Communication
Negative Themes – None

Postnatal ward
Positive Themes – Staff Attitude, Care, Compassion, Implementation of Care and Commitment.
Negative Themes – None

Postnatal community
Positive Themes – Staff Attitude, Compassion, Communication, Commitment and Care
Negative Themes - None

Day Case
Positive Themes –Care, Staff attitude, Competence, Implementation of care, Cleaning
Negative Themes – Care, Staff attitude, Communication, Clinical treatment and Competence.

Special Day Case
Positive Themes – Care, Staff attitude, Cleaning, Implementation of Care and Competence.
Negative Themes – None

The trust needs to improve on staff attitude, Care and communication. Maternity received no negative themes for June, which is an outstanding achievement. It should be highlighted that there are considerably more positive themes/comments regarding Staff attitude, care, communication and competence, which staff must be congratulated on.

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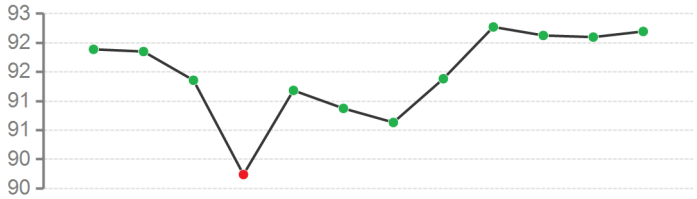
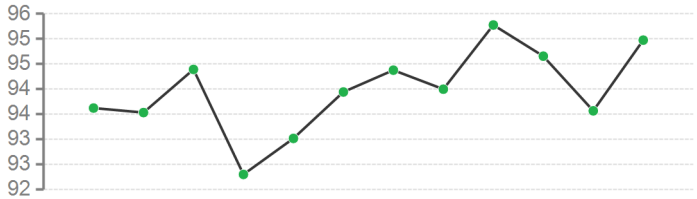
Strategic Theme: Patient Safety

Patient Experience 1

Jun	Overall Patient Experience %	91 (0.9%)		Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	Care Explained? %	91 (4.2%)		Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	Care that matters to you? %	94 (1.3%)		Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).

Comments:

This month patient experience as recorded in real-time by the patients has improved with all 6 of the criteria being rated as green. Overall performance has improved over the last 12 months across all these elements of patient feedback.

Significant improvement is seen this month in the reporting for the experience of patients in relation to whether patients received the care that matters to them. There has also been further improvement in patient feedback on overall patient experience, the explanation of care or treatment in an understandable way and whether they were treated with respect and dignity.

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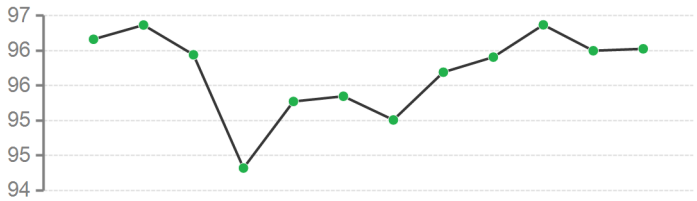
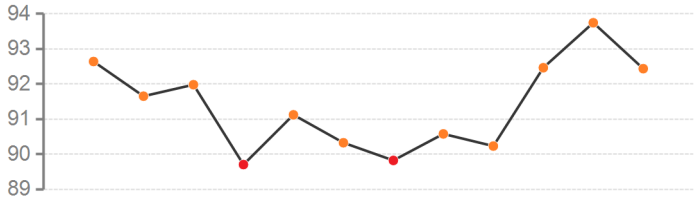
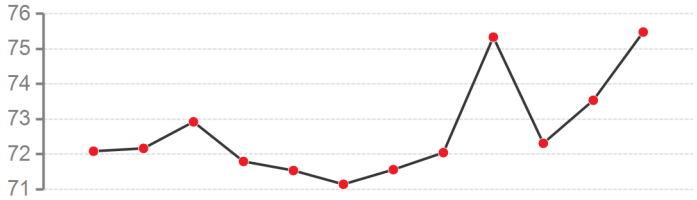
Strategic Theme: Patient Safety

Patient Experience 2

Jun	Respect & Dignity? %	96 (0.2%)		Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Jun	Cleanliness? %	91 (0.0%)		Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Hospital Food? %	73 (1.9%)		Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

Evaluation of the Patient Safety Heatmap demonstrates that the majority of wards are now compliant with capturing patient experience in June. Escalation to Divisional heads of nursing and matrons has taken place to enable focused local improvements. Patient volunteers are now assisting patients with the completion of the Inpatient Survey at each acute site, thus enabling nursing staff to focus on patient care.

Cleaning dips slightly in June to 91 which remains in the green, ward auditing remains at 98 for the month.

Hospital Food remains high at 73 reflecting marginally swings, in both directions, due to the small numbers sampled. Both metrics are not statistically significant.

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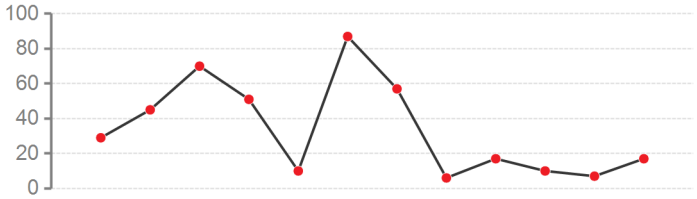
Strategic Theme: Patient Safety

Mixed Sex

Jun	Mixed Sex Breaches	406 (44.5%)		Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During June-17, 3 non-justifiable incidents of a mixed sex accommodation breach occurred within the WHH CDU due to capacity issues. This information has been reported to NHS England via the Unify2 system.

There were 7 mixed sex accommodation occurrences in total, affecting 34 patients. This number has increased since last month when there were a total of 5 occurrences affecting 19 patients. The remaining incidents occurred at QEQM CCU (2) and Fordwich (2) which are justifiable mixes based on clinical need.

June-17 daily reporting of mixed sex occurrences has improved at one acute site demonstrating improvement and a more robust recording of mixed sex occurrence. However, there has been an issue with the recording all the correct data into the daily reporting form for mix sex occurrences at two of the acute sites, which is being continuously addressed.

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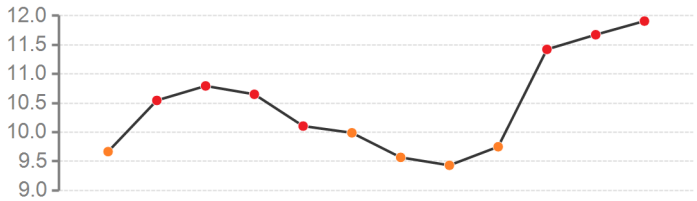
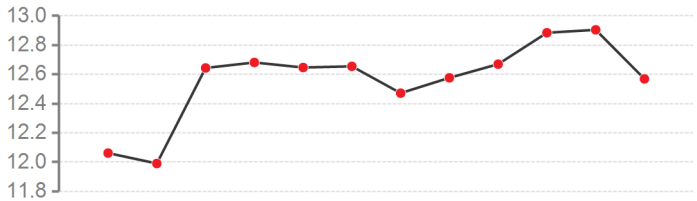
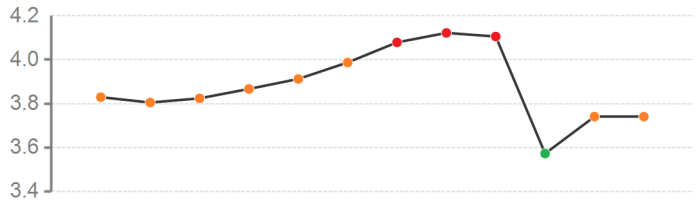
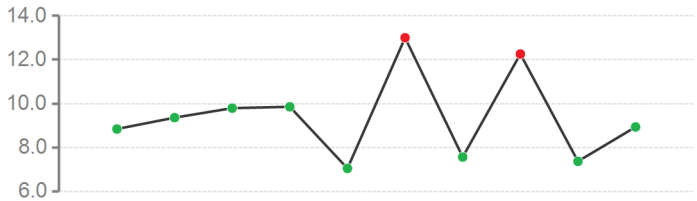
Strategic Theme: Human Resources

Gaps & Overtime

Jun	Vacancy (%)	10.5 (18.9%)		% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Staff Turnover (%)	12.6 (12.7%)		% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Sickness (%)	4.0 (6.9%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the
Jun	Overtime %	9.4 (15.0%)		% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).

Comments:

Gaps and Overtime

The Turnover rate in month is 12.6%, which is a slight reduction on last month. The vacancy rate increased marginally to 11.9%. Continued action is being taken for roles which have been identified as hard to recruit either because of repeated difficulty in recruiting to EKHUFT posts or because of shortages in labour supply nationally. Some posts are agreed as 'on hold' as part of cost improvement plans.

Sickness absence increased slightly in May 2017 (the most recent data available) from April's position (2017) to 3.7%. Approximately 75% of this sickness absence is categorised as long term, therefore the Trust will be reviewing long term sickness management.

All metrics are reviewed and challenged at a Divisional level in the monthly Executive Performance Reviews.

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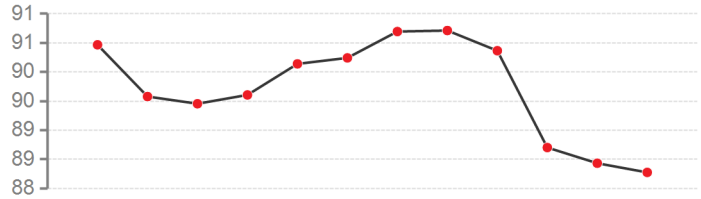
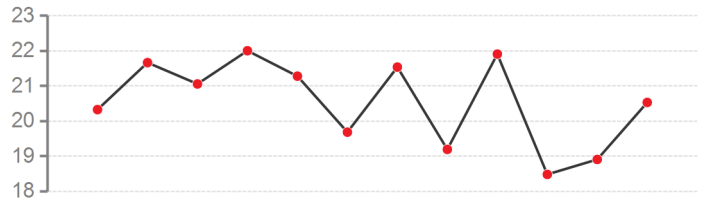
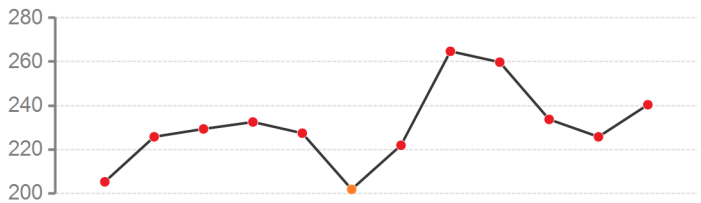
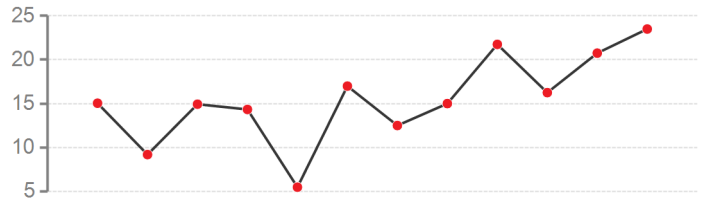
Strategic Theme: Human Resources

Temporary Staff

Jun	Employed vs Temporary Staff (%)	89.7 (-2.1%)		Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Agency %	20.6 (13.5%)		% of temporary staff who work via agency Number indicates average of last 12 months data (as shown in graph).
Jun	Temp Staff (WTE)	229 (8.9%)		WTE Count of Temporary Staff Used
Jun	Local Induction Compliance %	15.5 (57.1%)		Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).

Comments:

WTE temporary staff increase from 226 wte in May to 240 wte in June. There was also a decrease in employed staff in post staff from 6913 wte in May to 6900 wte in June.

Agency costs are monitored at EPR. The Agency Taskforce review strategies for reducing agency costs. Greater efficiencies are being sought in the use of E-Roster aimed at maximising use of substantive staff, for example, using net hours owed before booking overtime or agency cover. Breaches in pay caps continue to be reported and monitored. Divisions are all now monitoring Agency use on a post by post basis through the agency reduction plans in Aspyre with support from HR and Improvement Delivery Teams. These plans identify detailed and specific actions to eliminate where possible spend on agency.

Local induction compliance and reporting continues to be an area of concern and focus for the executive team.

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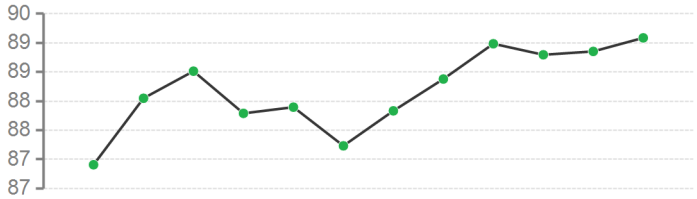
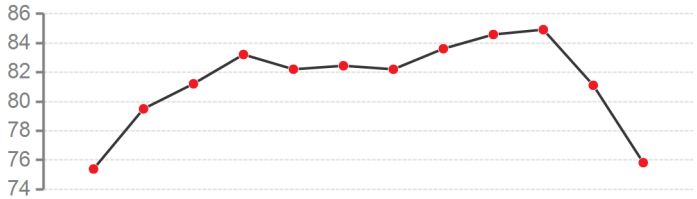
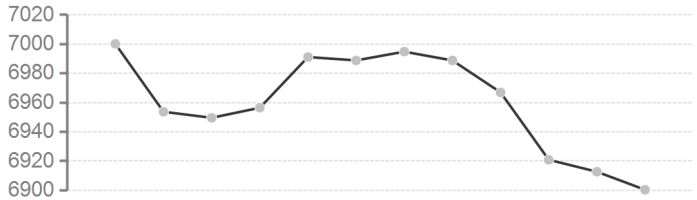
Strategic Theme: Human Resources

Workforce & Culture

Jun	Statutory Training (%)	88 (4.3%)		The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Appraisal Rate (%)	81.4 (2.3%)		Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Time to Recruit	12 (2.5%)		Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Total Staff In Post (SiP)	6900 (-0.2%)		Count of total staff in post (WTE)

Comments:

Statutory training compliance remained steady at 89%. This remains above the target of 85%. Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements. There remains an on-going issue with the recording of Information Governance, so this is being sent manually in some cases.

The Trust staff appraisal rate decreased again from 81.1% to 75.8%. (below the 90% target) Divisions are working on plans to complete appraisals due in (traditionally high volumes are due in April/May) to avoid a further drop in appraisal rates.

The Q1 (April-June) 2017 Staff Friends and Family score was made available in July. This shows that place for treatment has stayed the same at 76% in green and the place to work score whilst reaming in amber reduced by 2% to 52%. High level analysis shows that as expected the impact of financial special measures and the temporary transfer of services from Kent and Canterbury to other sites has affected morale of colleagues. Great place to work plans are being refreshed to ensure plans within the Divisions.

Strategic Theme: Activity

East Kent Hospitals University NHS Foundation Trust

Activity vs. Internal Business Plan

Key Performance Indicators

Jun

	Jun-17				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	15,444	15,201	243	2%	43,422	43,916	(-494)	-1%	43,422	44,667	(-1,245)	-3%	<=0%
Referral Non-Primary Care	13,983	13,867	116	1%	41,507	40,804	703	2%	41,507	42,833	(-1,326)	-3%	<=0%
OP New	20,851	21,005	(-154)	-1%	57,704	57,836	(-132)	0%	57,704	62,295	(-4,591)	-7%	>=0%
OP Follow Up	42,780	44,026	(-1,246)	-3%	122,303	122,090	213	0%	122,303	124,637	(-2,334)	-2%	>=0%
Elective Daycase	6,553	6,317	236	4%	18,231	17,972	259	1%	18,231	20,811	(-2,580)	-12%	>=0%
Elective Inpatient	1,305	1,349	(-44)	-3%	3,591	3,720	(-129)	-3%	3,591	3,792	(-201)	-5%	>=0%
A&E	17,800	18,216	(-416)	-2%	53,351	53,891	(-540)	-1%	53,351	53,013	338	1%	>=0 & <5%
Non-Elective Inpatient	6,942	7,042	(-100)	-1%	20,842	21,329	(-487)	-2%	20,842	17,928	2,914	16%	>=0 & <5%
Chemotherapy	1,280	1,402	(-122)	-9%	3,593	3,888	(-295)	-8%	3,593	3,838	(-245)	-6%	>=0%
Critical Care	1,734	1,831	(-97)	-5%	5,335	5,458	(-123)	-2%	5,335	5,309	26	0%	>=0%
Dialysis	6,609	6,752	(-143)	-2%	20,111	20,504	(-393)	-2%	20,111	20,792	(-681)	-3%	>=0%
Maternity Pathway	1,139	1,158	(-19)	-2%	3,478	3,378	100	3%	3,478	3,458	20	1%	>=0%
Pre-Op Assessments	3,037	3,424	(-387)	-11%	8,460	9,502	(-1,042)	-11%	8,460	8,478	(-18)	0%	>=0%
Diagnostic	451,908	470,127	(-18,219)	-4%	1,298,858	1,303,753	(-4,895)	0%	1,298,858	1,358,524	(-59,666)	-4%	<=0%
Other	4,627	5,124	(-497)	-10%	13,910	14,972	(-1,062)	-7%	13,910	11,445	2,465	22%	>=0%

The 2017/18 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2016/17 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals. The plan is capped at our total capacity and as such further activity (or demand reduction schemes would be required to achieve sustainable elective services. Further adjustments for patient safety/best practice issues such as reductions or increases in new to follow up rates have been applied. Finally EKHUFT have taken a view on the viability of CCG QIPP schemes achieving a reduction in demand in 2017/18. It should be noted that this does not reflect demand levels agreed within the 2017/18 contract. All trajectories to support attainment of the Sustainability and Transformation Funding have been based on this activity plan.

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

June 2017

Elective Care

In June Primary Care referrals were 2% above plan which reduced the YTD variance to -494. Evidence suggests the reduction in referrals observed in April was an outlier and there is currently no evidence that this will develop into a trend moving forward.

The Trust was within 0.7% of the New Outpatient plan in June 2017. Strong performance within Paediatrics, ENT and Orthoptics helped deliver the in-month position. Despite achievement at Trust level, a number of services have increased YTD variances and are included within the recently instigated grip and control recovery process intended to ensure delivery of the income targets. Cardiology (-684), Physiotherapy (-462) Orthopaedics (-242), Gynaecology (-131) and Stroke (-166) have all now formally entered this process and have produced quantifiable recovery plans intended to respond to this underperformance.

Whilst the Trust delivered the new Outpatient plan in Quarter 1, this was set at substantive capacity levels with a significant reduction applied for annual leave and as such was not enough to maintain the RTT waiting list size. The number of patients waiting to be seen for a first consultant led appointment has increased by almost 3,500 over the first quarter of the year. This trend is expected to slow significantly in Quarter 2 when plans to substantively deliver the additional activity are expected to be realised.

The Trust under-performed the follow up plan in June (-3%) but remains at planned levels for the quarter. There remain a number of large underperformances particularly within Physiotherapy (-1,709), Rheumatology (-855) and Ophthalmology (-837). The Physio service are reporting induction delays, a high vacancy rate and unusually high levels of maternity leave as the key drivers behind the underperformance, plans have been developed to recover the performance. There is a capacity shortfall within the Rheumatology service affecting the follow up position, this is being addressed with locum capacity in August and September and recruitment of an additional nurse, expected to commence in October 2017.

Despite a sizable and successful recruitment drive in Ophthalmology, not all of the new clinical team or technical support were in place by April 1st. In addition to this the service is no longer using the insourcing provider to deliver activity. It is expected that primary care providers will soon start to offer services for existing long term conditions Wet AMD and Glaucoma. In addition to the services detailed above, Endocrinology and Neurology have been added to the grip and control recovery process.

In June the Trust over achieved the Daycase plan by 4% which has generated a YTD surplus of 1% (+259). Despite the improved performance Orthopaedic services remain a huge risk. A number of unavoidable recruitment delays combined with significant unplanned leave is driving an underperformance in activity. In addition to this, the service continues to lose capacity to short notice cancellations for Trauma and DNA's. Changes to the waiting list initiative payment has limited the services ability to recover the position with additional sessions in month, as such they have now developed long term plans to address the underperformance and deliver the full year plan.

Non Elective Care

The Trust sees non elective admissions to all of its 3 sites. These are typically some of the patients who attend the Trust Accident & Emergency departments, or are admitted directly through to the wards upon agreement with General Practitioners. These patients have an urgent clinical need that cannot wait for an elective pathway or outpatient appointment to be given, and so are monitored within the hospital site as diagnosis and treatment for their clinical condition is conducted.

In Quarter 1 both Non-elective and A&E Activity is at expected levels, with sites continuing to see an-uplift in the proportion of majors attending, as seen over the previous year.

In addition to activity counts we balance this with additional monitoring metrics detailed below to determine if patients are able to flow through the hospital without significant delays and bottlenecks.

The Bed occupancy of Trust sites continued to be at challenging levels throughout June, with the transfer of acute medical services from the Kent & Canterbury site creating a need to reduce the occupied beds at the other sites. This reduced bed occupancy at the sites to close to 90%, with a notable reduction made during the month, driven by additional discharge capacity & acute management improvements throughout June.

The Medical Outliers metric shows the daily average number of medical patients which were bedded in non-medical wards. This can happen for a variety of reasons; such as care being recently transferred to a medical specialty consultant, or as a result of the ward in question having free beds available for patients at the time of clinical need. Patients remain under the medical consultant responsible for their care for the purpose of treatment and clinical review. During June the number of medical outliers maintained a reduced position seen at the end of May, with a monthly average of 43 outliers (May end ~46).

Over the first few weeks of July, the bed occupancy position at The Queen Elizabeth the Queen Mother Hospital in Margate has remained close to 90%. William Harvey Hospital in Ashford has increased above the site position of 92% bed occupancy (96% week ending 23rd July).

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	2,200	2,695	-18%	-495
300 - General Medicine	360	508	-29%	-148
104 - Colorectal Surgery	2,081	2,218	-6%	-137
107 - Vascular Surgery	578	710	-19%	-132
140 - Maxillo Facial	1,944	2,053	-5%	-109
101 - Urology	1,831	1,936	-5%	-105
301 - Gastroenterology	2,225	2,114	5%	111
658 - Orthotics	347	234	48%	113
420 - Paediatrics	1,654	1,459	13%	195
329 - TIA	345	0		345
Total	**43,422**	**43,916**	**-1%**	**-494**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	8,783	9,319	-6%	-536
650 - Physiotherapy	3,455	3,625	-5%	-170
110 - Trauma & Orthopaedics	5,038	5,190	-3%	-152
328 - Stroke Medicine	252	394	-36%	-142
100 - General Surgery	714	831	-14%	-117
101 - Urology	1,956	1,841	6%	115
800 - Clinical Oncology	2,968	2,837	5%	131
655 - Orthoptics	483	283	71%	200
329 - TIA	230	0		230
130 - Ophthalmology	3,013	2,352	28%	661
Total	**41,507**	**40,804**	**2%**	**703**

OP New

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	5,814	6,498	-11%	-684
650 - Physiotherapy	4,705	5,167	-9%	-462
110 - Trauma & Orthopaedics	5,244	5,486	-4%	-242
328 - Stroke Medicine	209	375	-44%	-166
107 - Vascular Surgery	745	901	-17%	-156
100 - General Surgery	1,039	840	24%	199
300 - General Medicine	722	480	50%	242
103 - Breast Surgery	1,846	1,602	15%	244
655 - Orthoptics	849	541	57%	308
420 - Paediatrics	2,139	1,773	21%	366
Total	**57,704**	**57,836**	**0%**	**-132**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
650 - Physiotherapy	15,515	17,224	-10%	-1,709
410 - Rheumatology	3,560	4,415	-19%	-855
130 - Ophthalmology	14,183	15,020	-6%	-837
302 - Endocrinology	564	1,268	-56%	-704
140 - Maxillo Facial	3,116	2,560	22%	556
300 - General Medicine	1,157	590	96%	567
800 - Clinical Oncology	10,891	10,214	7%	677
655 - Orthoptics	2,709	2,013	35%	696
290 - Community Paediatrics	5,835	4,826	21%	1,009
320 - Cardiology	5,702	4,341	31%	1,361
Total	**122,303**	**122,090**	**0%**	**213**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	1,148	1,342	-14%	-194
303 - Clinical Haematology	763	876	-13%	-113
410 - Rheumatology	354	461	-23%	-107
101 - Urology	2,082	2,023	3%	59
330 - Dermatology	1,205	1,144	5%	61
320 - Cardiology	779	711	10%	68
502 - Gynaecology	566	474	19%	92
130 - Ophthalmology	1,231	1,138	8%	93
800 - Clinical Oncology	1,074	914	18%	160
300 - General Medicine	5,238	5,006	5%	232
Total	**18,231**	**17,972**	**1%**	**259**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	113	172	-34%	-59
110 - Trauma & Orthopaedics	776	810	-4%	-34
420 - Paediatrics	46	73	-37%	-27
400 - Neurology	80	106	-24%	-26
103 - Breast Surgery	108	132	-18%	-24
120 - Ear, Nose & Throat	176	197	-11%	-21
430 - HCOOP	39	18	118%	21
502 - Gynaecology	431	407	6%	24
104 - Colorectal Surgery	137	100	37%	37
300 - General Medicine	274	227	21%	47
Total	**3,591**	**3,720**	**-3%**	**-129**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
180 - Accident & Emergency	1,205	1,779	-32%	-574
430 - HCOOP	2,986	3,169	-6%	-183
100 - General Surgery	1,454	1,537	-5%	-83
107 - Vascular Surgery	113	80	42%	33
422 - Neonatology	131	94	40%	37
410 - Rheumatology	60	14	316%	46
501 - Obstetrics	1,211	1,159	5%	52
320 - Cardiology	559	486	15%	73
300 - General Medicine	6,483	6,403	1%	80
110 - Trauma & Orthopaedics	1,070	979	9%	91
Total	**20,842**	**21,329**	**-2%**	**-487**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	1298858	1303753	0%	-4,895
Other	13910	14972	-7%	-1,062
Pre-Op	8460	9502	-11%	-1,042
A&E	53351	53891	-1%	-540
Dialysis	20111	20504	-2%	-393
Chemotherapy	3593	3888	-8%	-295
Critical Care	5335	5458	-2%	-123
Maternity Pathway	3478	3378	3%	100

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

4 Hour Emergency Access Standard

Key Performance Indicators

78.15 %

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
4 Hour Compliance	82.85%	82.27%	84.21%	79.30%	75.75%	74.25%	70.57%	75.94%	80.16%	76.93%	76.78%	78.15%
12 Hour Trolley Waits	0	0	0	0	1	1	2	0	0	0	0	1
Left without being seen	4.59%	4.11%	3.31%	3.85%	3.96%	4.35%	4.87%	3.53%	3.08%	3.82%	3.57%	3.62%
Unplanned Reattenders	8.62%	9.01%	8.78%	8.58%	8.68%	8.98%	8.20%	8.62%	9.11%	8.48%	9.04%	9.41%
Time to initial assessment (15 mins)	85.2%	81.0%	86.9%	79.5%	74.4%	78.5%	76.1%	76.4%	77.8%	77.9%	93.8%	93.9%
% Time to Treatment (60 Mins)	46.3%	48.9%	48.5%	40.9%	39.9%	39.9%	39.8%	40.8%	40.7%	39.4%	51.1%	51.6%

2017/18 Trajectory (NHSI Return 7th June 2017)

-1.85 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Trajectory	75.0%	75.0%	80.0%	83.0%	87.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	95.0%
Performance	76.9%	76.8%	78.2%									

The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard.

Summary Performance

June performance against the 4 hour target was 78.2%, against the NHS Improvement trajectory of 80.0%.This shows an improvement in performance compared to the previous month. There was one 12 Hour Trolley Waits reported in month. The number of patients who have left the department without being seen remains below 4% for a fifth month.

The priority and focus for June has been to continue to maintain safe patient care; improving performance and patient flow across the whole emergency patient pathway. On the 19 June, acute medical services were transferred out of the Kent and Canterbury Hospital as part of a business continuity plan in response to the GMC and Health Education England's request that junior doctor posts at Kent and Canterbury Hospital were transferred to the other two acute sites in order to improve the level of consultant supervision and training. In preparation for the transfer on the 19th June a detailed whole system action plan was successfully implemented to support an improvement in bed occupancy down to 90% and improve patient flow.

Patient attendances were on plan, however, there continues to be surges in attendances with notable high activity in the evenings and weekends. June also saw the highest daily attendance of 700 patients on the 26th June, which coincided with a heat wave causing a high number of patients to attend by ambulance and self-presenting to the sites.

Medical staffing vacancies at Speciality Doctor (middle grade level) remain high with on-going recruitment in place via monthly interview panels. Although there over 10 doctors have been offered posts and are in the recruitment pipeline it takes several months for a new recruit to take up their post due to the length of time it takes for Visa applications to be completed.

The IR35 challenges have continued, particularly at QEQMH. The agency doctors we had been using to provide ED cover have not returned to work and this continues to leave the rotas seriously depleted. In order to mitigate this risk and ensure that safe patient care is provided daily senior meetings (ED Consultant and General Manager) have been implemented to monitor the clinical risk and with daily escalation to the Divisional Director and Divisional Medical Director as appropriate.

Actions taken include:

- Reviewing the rotas at WHH and QEQMH to assess the depth of cover and skill mix to agree a sharing of staff across both sites.
- Two GP's are now being booked to provide ad hoc cover within their availability.
- Alternative specialities, i.e. Consultant Physicians have been booked to fill the gaps in the rota.
- Senior core trainee level doctors who had experience of working in ED were booked to fill gaps.
- The implementation of new pathways in line with K&CH medical services moves, designed to maximise the acute medical model (ambulatory care) and greater support discharge to people's own homes. These changes are now being reviewed and refined to support sustainability.
- Recruitment to senior site management has taken place.

- Additional recruitment for ED doctors via an agency is being taken forward supported by the Medical Director.

Ambulance Handover

The Ambulance handover improvement plan continued to show excellent performance with a significant reduction in delays with less than 5% being delayed by 60 minutes and less than 15% being delayed for over 30 minutes. This continues to be a joint team effort from SECAMB and EKHUFT with both organisations signed up to a data set with agreed standards and an escalation plan which included active management of the daily ambulance flow. The early improvements have continued and become embedded with the clinical teams working together to handover patients as safely and quickly as possible.

Risks to delivery of the standard:

- Middle grade medical staffing vacancies and unfilled gaps in rotas due to lack of agency or substantive staff. QEQMH is a particular risk due to the geographic location of the hospital.
- Continued high levels of activity, particularly in the evenings.
- Overcrowding in ED due to poor patient flow and lack of timely bed availability.
- Delays in mental health bed availability for adult.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

Cancer Compliance

Key Performance Indicators

74.47 %

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Green
62 day Treatments	70.94%	74.58%	71.50%	70.00%	72.77%	75.94%	60.61%	70.45%	77.30%	72.40%	70.19%	74.47%	>=85%
>104 day breaches	56	57	45	53	44	31	40	40	40	38	32	46	<0
Demand: 2ww Refs	3,142	3,013	3,171	2,951	3,307	2,636	3,150	2,936	3,672	2,650	3,356	3,660	2990 - 3305
2ww Compliance	96.44%	94.77%	94.81%	96.62%	97.45%	96.49%	95.82%	96.08%	97.41%	93.59%	95.67%	96.76%	>=93%
Symptomatic Breast	93.10%	93.22%	95.31%	94.59%	96.43%	86.61%	97.27%	94.81%	93.57%	90.91%	90.71%	89.87%	>=93%
31 Day First Treatment	94.31%	93.64%	93.39%	96.10%	94.93%	95.79%	93.63%	96.96%	97.42%	95.68%	94.81%	95.91%	>=96%
31 Day Subsequent Surgery	96.61%	90.38%	92.59%	89.23%	89.09%	89.19%	82.22%	94.12%	90.24%	89.29%	92.00%	85.45%	>=94%
31 Day Subsequent Drug	97.33%	98.88%	100.00%	100.00%	99.12%	98.39%	96.94%	95.77%	97.50%	97.06%	95.24%	95.35%	>=98%
62 Day Screening	83.33%	87.50%	93.94%	89.55%	96.23%	91.89%	91.67%	76.47%	89.23%	92.00%	95.00%	95.74%	>=90%
62 Day Upgrades	82.35%	85.71%	100.00%	80.00%	83.33%	70.73%	75.68%	92.59%	69.77%	66.67%	80.56%	76.09%	>=85%

2017/2018 Trajectory

-2.33 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	71.60%	66.60%	76.80%	80.90%	83.40%	85.90%	85.60%	85.80%	86.00%	86.00%	85.50%	87.00%	Sep
Performance	72.40%	70.19%	74.47%										Sep

The 62 Day Cancer Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance. A Cancer Recovery Plan is in place with an aim to improve performance and ensure that the cancer standards are sustainably delivered across all tumour sites.

Summary Performance

June performance is currently 74.47 % against the improvement trajectory of 76.80%, validation continues until the beginning of August in line with the national time table. The total number of patients on an active cancer pathway is 3,013; this is higher than the previous month and predominately increased in the front part of the pathway (under 40 days). There are currently 46 patients waiting 104 days or more for treatment, 18 of whom have a cancer diagnosis and 13 have a decision to treat.

Risks to delivery of the standard:

- Key areas of concern for the Trust are Colorectal, Urology, Lung, Head and Neck, Radiology (both appointment and reporting capacity) and adequate surgical theatre capacity.

Actions taken to mitigate risk and improve performance:

- PTL meetings have been revised to clearly identify who is taking actions forward. All incomplete actions are escalated to the weekly performance meeting for resolution.
- Daily cancer huddle meetings have been implemented for Lung, Lower GI and Head and Neck with the focus on patients between day 40 to 62, to ensure all breaches are prevented as far as possible, this will be reviewed at the end of July to understand the impact that this has had on compliance. This will be implemented for urology in due course.
- All tumour sites and diagnostic elements of the pathway have agreed specific action plans. These are reviewed monthly with each tumour site.
- A summary of the PTL is shared with Divisional Directors each week to support escalation and resolution of pathways of patients on the cancer PTL.
- The Information team have developed a daily report for radiology which focuses on patients that require diagnostics and their next key event milestone, with the aim for this to decrease.
- A webpage style PTL is currently being developed with the Information team. This will refresh data every 30 minutes from Infloflex providing a real time position and validation for each tumour site. This will also be RAG rated against the gold standard pathway milestones. This is due to be rolled out from July.
- Plans are being revised to maximise all capacity with the aim to deliver compliance in September.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

18 Week Referral to Treatment Standard

Key Performance Indicators

85.07 %

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Green
Performance	86.65%	85.52%	85.11%	86.03%	85.79%	83.83%	83.79%	84.35%	85.40%	84.85%	85.82%	85.07%	>=92%
52w+	25	20	27	21	13	12	18	24	28	29	36	30	0
Waiting list Size	45,487	45,352	45,531	44,822	46,191	46,398	45,682	45,449	46,483	47,649	49,241	50,377	<38,938
Backlog Size	6,072	6,568	6,781	6,262	6,563	7,502	7,407	7,111	6,785	7,218	6,980	7,519	<2,178
Demand: PC Referrals	16,194	15,668	15,530	14,908	16,635	13,620	15,072	14,922	17,862	13,813	16,414	16,683	<15,484
Demand: Additions to IP WL	3,170	3,200	3,202	3,233	3,710	2,896	3,441	3,212	3,791	2,895	3,329	3,702	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

2017/2018 Trajectory

0.88 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	84.13%	83.46%	84.20%	84.44%	83.91%	84.45%	84.75%	85.71%	84.95%	85.18%	86.00%	86.93%	87%
Performance	84.85%	85.82%	85.07%										Sept

The Referral to Treatment Waiting Time Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against this standard. An RTT Recovery Plan has been developed jointly with local CCGs in order to address both short term backlog clearance and longer term increases in recurrent demand. The aim of the plan is to improve performance and ensure that the RTT Standards are sustainably delivered throughout the Trust.

Summary Performance

June performance decreased to 85.07%. Whilst performance has improved, the Trust was again unable to provide enough activity to sustain waiting list sizes throughout the month, despite specialities delivering their business plans. Waiting list size has reached its highest point to date. Sustainable long terms plans to resolve capacity constraints and deliver RTT 2017/18 trajectory are planned to start and come in to effect from quarter two/quarter three.

The number of patients waiting over 52 weeks for first treatment decreased from 36 to 30, General Surgery (10), Gynaecology (11), ENT (1), Ophthalmology (2), T&O (1), Neurology (1) Other specialities (4). A trajectory has been submitted to reduce the 52 week waits to 5 or less by March 2018 and then maintain this position.

Risks to delivery of the standard:

- Continued Increase in Orthopaedic & General Surgery waiting list additions.
- Higher than planned demand within business plan resulting in no flexibility within capacity in key specialities such as Orthopaedics, Dermatology, Maxillo Facial and Gynaecology.
- Recruitment constraints in services such as Neurology leading to long outpatient waits.
- Gastroenterology & Endoscopy capacity due to high demand.
- Change in payment for waiting list initiatives, has led to a significant reduction in medical staff providing additional capacity outside agreed job plans.
- General Surgery capacity for patients presenting with high BMI for benign disease (single handed surgeon) creating 52 week waits.
- Gynaecology capacity for named sub-specialty conditions resulting in 52 week waits.
- ENT surgical demand remains in excess of capacity in key subspecialties resulting in 52 week waits.

Actions taken to mitigate risk and improve performance:

- The new Interactive Patient Tracking Technology has been implemented which allows real time recording of patient pathways and supports the operational teams in delivery.
- Focused management of undated pathways waiting over 30 weeks and risks to 52 weeks, particularly within General Surgery, ENT and Gynaecology, daily patient focus meetings and weekly progress reports to COO and CEO.
- Action plans in key specialties to ensure improved performance reviewed weekly.
- Continued sourcing of outpatient internal capacity is being established for Orthopaedics, ENT, General Surgery, Maxillo Facial and Gynaecology.
- Saturday working in new consultants contracts across the trust to improve utilisation of theatre capacity and increase capacity.
- Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste has commenced.
- The Trust is developing long term solutions to sustainably address the imbalance in capacity and demand, through a number of schemes, including; increasing theatre utilisation to 50 weeks per year (commencing July 2017), develop local anaesthetic cataract surgery in Buckland Hospital, Dover releasing 5 theatre sessions per week at acute hospitals William Harvey and Queen Elizabeth the Queen Mother Hospitals (October/November 2017).

- Exploring opportunities to increase theatre base with semi-permanent POD solutions, creating a minimum of 10 additional theatre sessions per week (October/November 2017).
- The increase in the waiting list will be discussed at the next performance meeting with the CCGs

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.5%

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Green
Performance	99.77%	99.56%	99.74%	99.91%	99.88%	99.72%	99.65%	99.67%	99.78%	99.06%	99.36%	99.46%	>=99%
Waiting list Size	13,321	10,269	14,728	14,011	15,457	15,023	14,171	14,048	15,580	14,882	14,480	14,709	<14,000
Waiting > 6 Week Breaches	31	45	39	12	19	42	49	46	35	140	92	80	<60
Average Wait													<4

2017/18 Trajectory

0.4%

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	Apr
Performance	99.06%	99.36%	99.46%										Apr

Summary Performance

The standard has been met for June 17 with a compliance of 99.46%. As at the end of the month there were 80 patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 63, 56 in Computed Tomography, 6 in Non-Obstetric ultrasound and 1 in Magnetic Resonance Imaging
- Cardiology: 12
- Endoscopy: 3
- Gynaecology: 1
- Neurophysiology: 1

Risks to delivery of the standard:

- The Radiology Booking team remain under extreme pressure to book additional lists to meet current operational demand. Additionally sourcing of Locums remains in place to mitigate backlogs and where possible clinicians agreeing to undertake the additional list. The IR35 arrangements and new waiting list payments for Consultants has impacted- the uptake of additional shifts has noticeably reduced since overtime payments were reduced.
- Reporting in each modality remains a concern for the Division - There is an identified increasing clinical risk of patients waiting too long on a diagnosis. This is on the Division Risk Register and on the Corporate Risk Register.
- 4 datix issues have been raised in month due to findings within the backlog. These will be fully investigated and reported to patient safety and governance boards
- Current number of backlog CT = 1247 and MRI = 1246Total = 2493 (This is a total in month reduction of 260 broken down by CT 299 and increase in MRI + 39 compared to 15/06/17
- Cardiology diagnostics is a fluctuating picture. The number of breaches has reduced this month however in-month capacity continues to cause bottlenecks and booking concerns.

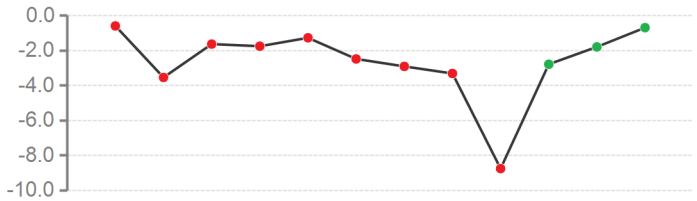
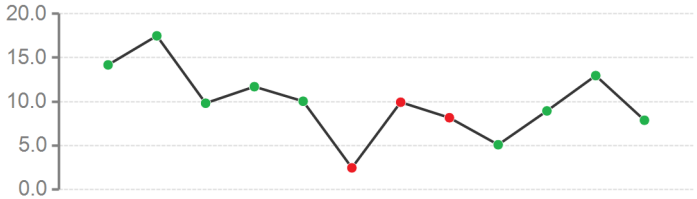
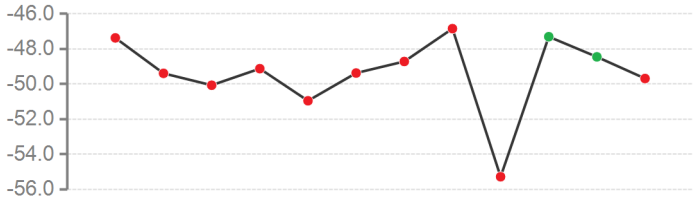
Actions taken to mitigate risk and sustain performance:

- The Division are actively recruiting substantive and interim locums to support the demand and address the reporting concerns.
- The Division are working with third party companies to support additional reporting in close liaison with procurement.
- All equipment is monitored closely and regularly serviced to ensure we maximise capacity.
- Extend opening hours of the CT's and MRI until 8pm and including BH to add extra capacity into the system
- Buying additional daily mobile CT and MRI from 3rd party providers to add in daily resilience
- Replacement of the 2 MRI scanners is under way at K&CH
- Additional lists being undertaken by locums to include both extended days during the week and Saturday lists.
- Daily oversight continues.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Finance

Jun	I&E £m	-36.6 (-61.9%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £6.3m deficit adjusted for "extra" CIPS
Jun	Cash Balance £m	7.9 (-39.3%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Total Cost £m	-49.7 (2.5%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Forecast I&E £m	-19.0 (0.0%)		This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Jun

Normalised Forecast £m

-19.0
(0.0%)

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

Comments:

The Trust's I&E deficit in June (month 3) was £1.1m (consolidated position excluding Sustainability and Transformation Funds and after technical adjustment) against a plan of £1.5m.

The year to date I&E deficit is £6.6m against a plan of £8.2m (£1.6m better than plan). A reconciliation of the various adjustments is presented below.

A full report on the EKMS/Spencer Wing reported deficit at Q1 has been requested.

Pay costs in the month of £28.7m were £0.2m up on May but also £0.2m better than plan. Permanent staff reduced by £0.3m, bank staff was unchanged, but overtime increased by £0.1m and agency/locum staff by £0.4m. The move of Kent and Canterbury medical trainees to WHH and QEQM took place on 19 June necessitating additional costs. Invoicing from NHSP continues to be investigated. Temporary staff spend in month is a concern and will need to see a reduction in future months if workforce CIPS are to be delivered. Waiting list payments continued to be depressed at £0.16m, a small increase on May. Pay is now £1.5m better than plan year to date.

Activity/income was £1.2m better than plan in month with total income now £0.9m better than plan ytd.

Against the £32m CIPS target, including income, £1.79m was reported in month against a target of £1.97m. Year to date £5.2m is reported against a plan of £4.7m. Of the reported position, £1.3m (25%) is non recurrent and steps are being taken to ensure that this is made up recurrently.

The cash balance as at the end of May was £7.9m. No new borrowings were required.

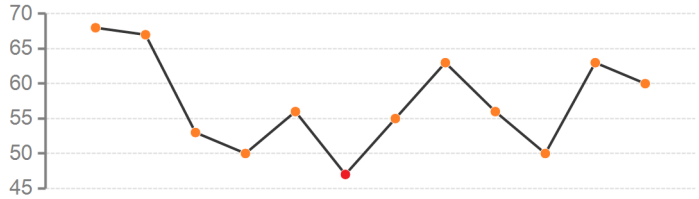
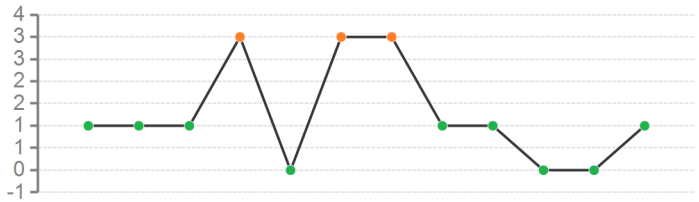
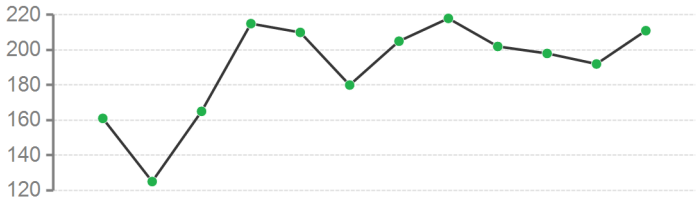
No agreement on the 2016/17 contract value outturn or CQUIN has yet been reached with East Kent CCG commissioners. A proposal has been forwarded to them and further discussions are planned before the end of July. Total risks net of opportunities of £11.4m have been identified.

The Trust's Financial Recovery Plan has been received and accepted by NHSI. This is for an £18.9m deficit target (excluding Sustainability and Transformation Funds). The third review meeting took place on 3 July and was a constructive and positive discussion. The Trust remains in Financial Special Measures.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

Jun	Representation at H&S	688 (37.3%)		% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	RIDDOR Reports (Number)	15 (-11.8%)		RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Formal Notices	0 (-100.0%)		Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).
Jun	Health & Safety Training	2282 1041.0%		H&S Training includes all H&S and risk avoidance training including manual handling

Comments:

H&S representation at committee's remains positive in June.

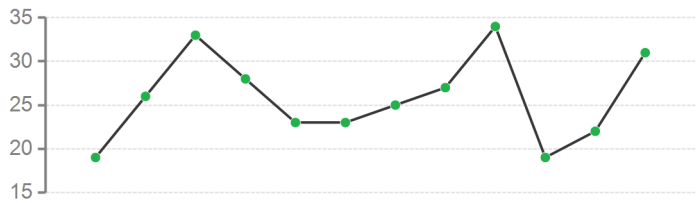
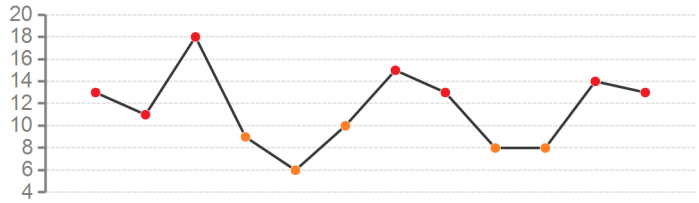
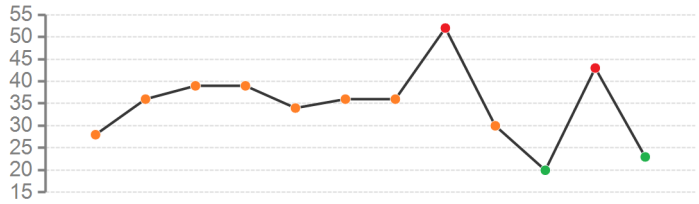
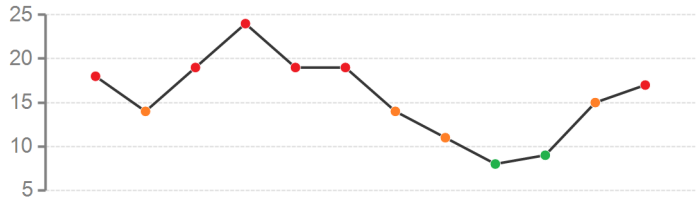
There is 1 RIDDOR to report this month - relating to a injury sustained by a staff member who was supporting a patient suffering a fit.

The provision of H&S training remains extremely positive

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

Jun	Accidents	310 (-36.3%)		Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Fire Incidents	138 (7.8%)		Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Violence & Aggression	416 (3.5%)		Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Jun	Sharps	187 (31.7%)		Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

The number of accidents rose in June although this remains in the green for the Trust.

The number of Fire incidents marginally decreased from May. Also following the Grenfell Tower incident the Trust has been supporting the DoH with its cladding review and assessment on Hospital sites. The Trust has not been identified as a site of interest following the review. Additionally we have met with Kent Fire and Rescue at both Buckland and William Harvey Hospitals, both visits raised no concerns for the Trust. A further update on the remaining site visits will follow in next months IPR and in the six monthly H&S report to Board in September.

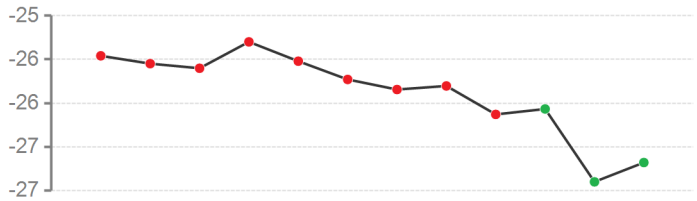
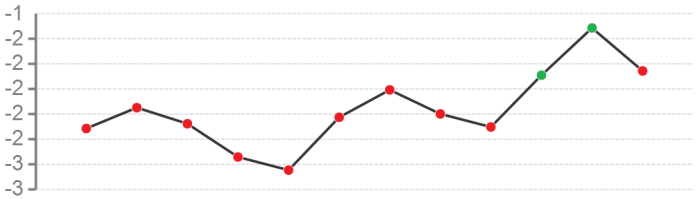
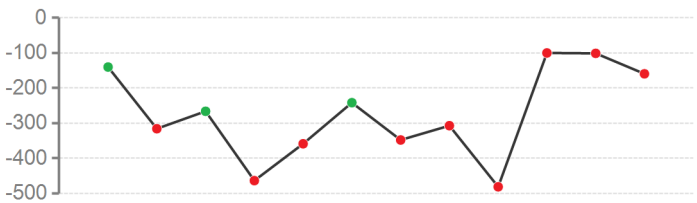
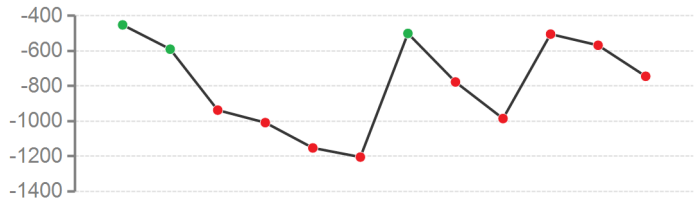
Violence & Aggression decreased in June and returned to green for the month.

Sharps incidents rose this month although below the highs seen earlier this year. Nursing and H&S teams continue to support education and training so as to reduce the likelihood of incidents, the majority of incidents remain human error at the time of localised procedures or disposal.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

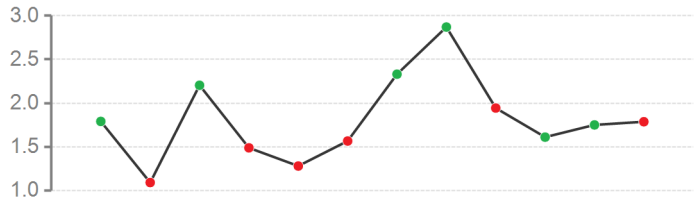
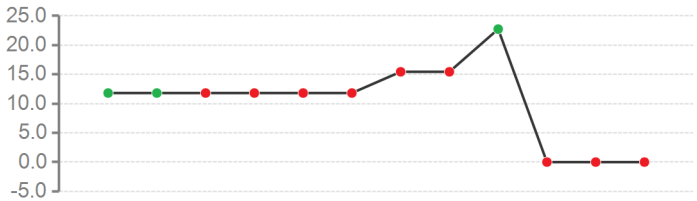
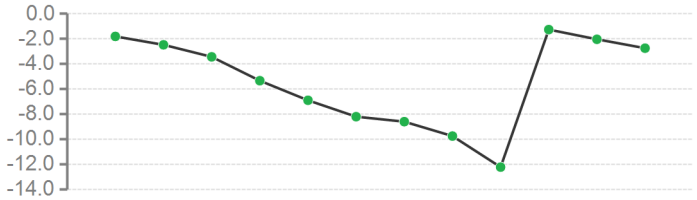
Jun	Payroll Pay £m	-26.7 (-0.8%)		Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Agency Spend £m	-1.9 (22.7%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Additional sessions £k	-159 (57.7%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Jun	Independent Sector £k	-744 (31.1%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: Pay performance is favourable to plan ytd by £1.5m (1.7%). Pay CIPs are favourable to plan ytd by £0.4m. Total expenditure on pay in June was £28.7m, an increase in spend of £0.2m when compared to May. Permanent staff reduced by £0.3m, bank staff was unchanged, but overtime increased by £0.1m and agency/locum staff by £0.4m. Expenditure on substantive staff groups is favourable to plan ytd by £1.4m and temporary staffing expenditure is adverse to plan by £0.8m.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Balance Sheet

Jun	CIPS £m	23.9 (2.1%)		Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.
Jun	Cash borrowings £m	27.8 (897.1%)		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Jun	Capital position £m	-67.9 (35.1%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.

Comments:

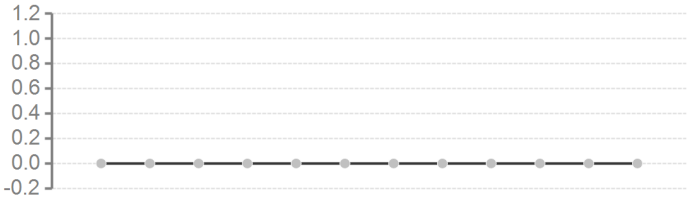
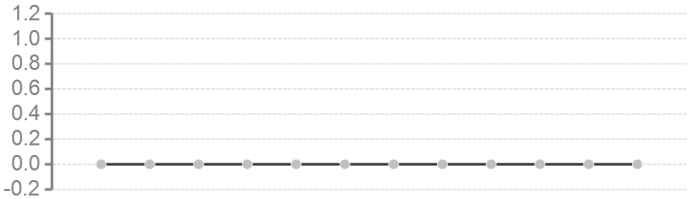
Against the £32m CIPS target, including income, £1.79m was reported in month against a target of £1.97m. Year to date £5.2m is reported against a plan of £4.7m. Of the reported position, £1.2m is non recurrent and steps are being taken to ensure that this is made up recurrently

The cash balance as at the end of May was £7.9m. No new borrowings were required.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Productivity

Jun	Clinical Productivity: Theatres	0.0		Clinical Productivity graph: theatre sessions v plan.	★ ☆ ☆
Jun	Clinical Productivity: Outpatient	0.0		Clinical Productivity graph: outpatient sessions v plan	★ ☆ ☆

Comments: A full programme of CIPS valued at £32m for 2017/18 is being rolled out with £16m of pay savings, £8m of non pay savings and £8m of income generation.

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Strategic Theme: Improvement Journey

		Feb	Mar	Apr	May	Jun	
MD01 - End Of Life	Lost Days (Fast Track)	20	20	19	16	12	
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	76.24	80.45	78.57	76.48	78.15	>= 95
	ED - 1hr Clinician Seen (%)		37	39	42	44	>= 55
MD04 - Flow	IP - Discharges Before Midday (%)	15	14	15	15	13	>= 35
	Medical Outliers	88	67	57	61	35	
	Lost Days (Non-EKHUFT)	89	86	70	81	61	
	DToCs (Average per Day)	56	59	49	62	56	< 28
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	70.45	77.30	72.40	70.19	74.47	>= 85
MD07 - Maternity	Midwife:Birth Ratio (%)	26	27	30	28		< 28
	Staff Turnover (Midwifery)	12	13	13	13	13	<= 10
	Vacancy (Midwifery) %	3	5	7	7	7	<= 7
MD08 - Recruitment & Staffing	Staff Turnover (%)	12.6	12.7	12.9	12.9	12.6	<= 10
	Vacancy (%)	9.4	9.8	11.4	11.7	11.9	<= 7
	Staff Turnover (Nursing)	13	13	13	13	13	<= 10
	Vacancy (Nursing) %	16	17	12	13	14	<= 7
	Vacancy (Medical) %	9	10	13	12	12	<= 7
MD09 - Workforce Compliance	Appraisal Rate (%)	83.6	84.6	84.9	81.1	75.8	>= 90
	Statutory Training (%)	88	89	89	89	89	>= 85
	Local Induction Compliance %	15.0	21.8	16.3	20.8	23.5	>= 85
KF01 - Complaints	Complaint Response in Timescales %	79	84	86	86	79	>= 85
	Complaint Response within 30 days %	14	25	13	25	12	>= 85

KF02 - Workforce & Culture	Staff FFT - Work (%)	54	54	52	52	52	>= 60
	Staff FFT - Treatment (%)	76	76	77	77	77	>= 81.4
KF09 - Medicines Management	Pharm: Fridges Locked (%)	89	86	86	86	90	>=95
	Pharm: Fridge Temps (%)	83	80	80	82	86	>= 100
	Pharm: Drug Trolleys Locked (%)	98	98	99	99	100	>= 90
	Pharm: Resus. Trolley Check (%)	88	80	84	85	85	>= 90
	Pharm: Drug Cupboards Locked (%)	89	90	89	89	93	>= 90

East Kent Hospitals University NHS
NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 1hr Clinician Seen (%)	% of A&E attendances seen within 1 hour by a clinician	>= 55	
	ED - 4hr Compliance (%)	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge.	>= 95	100 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	<= 90	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 28	30 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Lost Days (Fast Track)	Beddays lost due to delayed discharge (Fast Track)		
	Lost Days (Non-EKHUFT)	Beddays lost due to delayed discharge (Non-EKHUFT)		
	Medical Outliers	Number of patients recorded as being under a Medical specialty but was discharged from a Surgical Ward (Patients admitted to a ward which is not related to their clinical reason, mainly due to capacity reasons)		
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %
Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %

Clinical Outcomes	Cleanliness Audits (%)	Cleaning Schedule Audits	>= 98	5 %
	Clinical Audit Prog. Audit	Agreed Clinical Audit programme meets national programme requirements	>= 3	5 %
	Clinical Audit Review	Review of the Clinical Audit Programme	>= 3	5 %
	FNoF (36h) (%)	% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database. Reporting one month in arrears to ensure upload completeness to the National Hip Fracture Database.	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90	5 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>=95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Policies in Date (%)	All documents that are marked as policies are in date on the SharePoint system	>= 95	10 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 60	50 %
Data Quality & Assurance	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings.	< 4	25 %
	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	< 0.25	25 %

Data Quality & Assurance	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code %	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	< 7	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £6.3m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %
	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %

Health & Safety	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	< 1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	Representation at H&S	% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 76	20 %
	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 25	10 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.	< 1	
	Blood Transfusion Errors	The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Falls (per 1,000 bed days)	Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 94	10 %
	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.	>= 98	20 %
	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		

Incidents	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.	< 1	30 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls	>= 1	0 %
	Pressure Ulcers Cat 2 (per 1,000)	Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 0.15	10 %
	Pressure Ulcers Cat 3/4 (per 1,000)	Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	C. Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	< 1	
	Cases of C.Diff (Cumulative)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month.	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	E. Coli	The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 44	10 %
	E. Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	

Infection	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	< 1	
	MSSA	The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	
Initiatives	Antimicrobial Resistance & Stewardship CQUIN Delivered %	CQUIN made up of two parts – reducing antibiotic consumption in named antibiotics and review of patients on antibiotics after 48/72 hours	>= 100	20 %
	End of Life Pathway CQUIN Delivered %	CQUIN linked to current improvement work and multi-agency policy	>= 100	20 %
	Patient Flow CQUIN Delivered %	CQUIN linked to SAFER project	>= 100	20 %
	Sepsis CQUIN Delivered %	CQUIN including acute wards and with antibiotic review at 72 hours	>= 100	20 %
	Staff Health & Wellbeing CQUIN Delivered %	CQUIN made up of three parts – staff access to healthy activities, health food options on site and flu vaccine uptake	>= 100	20 %
Mortality	Crude Mortality EL (per 1,000)	The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.	< 90	35 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	< 87.45	30 %
	SHMI	Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data.	< 0.95	15 %

Observations	Cannula: Daily Check (%)	The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-8pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 8pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant.	>= 95	20 %
Patient Experience	Care Explained? %	Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 89	4 %
	Care that matters to you? %	Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).	>= 89	4 %
	Cleanliness? %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	5 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	FFT: Not Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 1	10 %
	FFT: Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	30 %

Patient Experience	FFT: Response Rate (%)	The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 15	1 %
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	Mixed Sex Breaches	Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Number of Complaints	The number of complaints recorded per ward. Data source - Datix.	< 1	0 %
	Number of Compliments	The number of compliments recorded overall Data source - Patient Experience Team (Kayleigh McIntyre).	>= 1	0 %
	Overall Patient Experience %	Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 90	10 %
	Respect & Dignity? %	Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 89	2 %
Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use – allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 90	20 %
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	< 5	10 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	< 1	

RTT	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency %	% of temporary staff who work via agency Number indicates average of last 12 months data (as shown in graph).	<= 10	
	Agency & Locum Spend	Total agency spend including NHSP spend		
	Agency Filled Hours vs Total Agency Hours	% hours worked which were filled by the NHSP against the total number of hours worked by agency staff		
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	
	Agency Staff WTE (Bank)	WTE Count of Bank Hours worked		
	Agency Staff WTE (NHSP)	WTE Count of NHSP Hours worked		
	Bank Filled Hours vs Total Agency Hours	% hours worked which were filled by the Bank (Staffflow) against the total number of hours worked by agency staff		
	Bank Hours vs Total Agency Hours	% hours worked by Bank (Staffflow) against the total number of hours worked by agency staff		
	Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available.		
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
	Local Induction Compliance %	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	
	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	< 28	2 %
	NHSP Hours vs Total Agency Hours	% hours worked by NHSP against the total number of hours worked by agency staff		
	Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	
	Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
	Roster Effectiveness (%)	The time ward staff attribute to clinical duties as a % of the ward duty roster. Data source - eRoster.		15 %

Staffing

Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA)	>= 80	15 %
Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 80	15 %
Sickness (%)	% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 3.6	10 %
Stability Index (excl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		
Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		
Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	15 %
Staff Turnover (Midwifery)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Midwives. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
Staff Turnover (Nursing)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Nurses. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
Temp Staff (WTE)	WTE Count of Temporary Staff Used	< 182	1 %
Time to Recruit	Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
Total Staff Headcount	Headcount of total staff in post		
Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
Total Staff In Post (SiP)	Count of total staff in post (WTE)		1 %
Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %
Vacancy (%)	% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	15 %

Staffing	Vacancy (Medical) %	% Vacant positions against Whole Time Equivalent (WTE) for Medical Staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
	Vacancy (Midwifery) %	% Vacant positions against Whole Time Equivalent (WTE) for Midwives. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
	Vacancy (Nursing) %	% Vacant positions against Whole Time Equivalent (WTE) for Nurses. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	
	Statutory Training (%)	The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.	< 0	
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	< 0	
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	< 0	
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		
	Independent Sector £k	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	

Data Assurance Stars

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

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

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

East Kent Hospitals University NHS
NHS Foundation Trust

Patient Safety Heatmap - JUNE 2017

KEY

	data not yet available
NULL	null return, data not received
N/A	metric is not applicable

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
KCH - Kent & Canterbury																	
Specialist																	
KBRA - BRABOURNE (KCH)	100.0	0	1	0	0	0	12	100	100	100	17	100	0.0	88.2	71	100	12
MARL - MARLOWE WARD	100.0	1	4	0	0	0	0	100	92	100	23	100	0.0	86.9	96	96	10
Surgical																	
CLKE - CLARKE WARD	100.0	6	3	0	1	2	5	NULL	NULL	NULL	29	97	0.0	89.7	90	84	6
KENT - KENT WARD	100.0	6	1	0	0	0	1	100	88	88	35	100	0.0	96.1	96	94	8
KITU - KCH ITU	100.0	0	0	0	0	0	56	N/A	N/A	N/A	N/A	N/A	N/A	95.3	83	94	25
Urgent Care																	
HARB - HARBLEDOWN WARD	100.0	0	8	0	0	0	7	98	100	100	50	88	3.8	88.9	95	108	7
INV - INVICTA WARD	100.0	1	2	0	0	0	0	NULL	NULL	NULL	11	100	0.0	87.5	86	120	6
KCDU - EMERGENCY CARE CENTRE	94.1	0	0	0	0	0	0	NULL	NULL	NULL	23	90	6.1	36.3	64	65	41
KING - KINGSTON WARD	100.0	2	1	0	0	1	0	NULL	NULL	NULL	34	95	0.0	96.9	90	134	7
KNRU - EAST KENT NEURO REHAB UNIT	100.0	1	1	0	0	0	0	80	90	95	10	100	0.0	80.9	93	133	6
MTMC - MOUNT/MCMASTER WARD	100.0	3	2	0	0	0	8	100	100	100	20	100	0.0	82.7	94	124	6
TAY - TAYLOR WARD	100.0	0	0	0	0	0	0	100	90	100	150	100	0.0	0.0	50	72	9
TREB - TREBLE WARD	100.0	0	7	0	0	0	25	100	92	100	24	100	0.0	80.9	88	124	7
QEH - Queen Elizabeth Queen Mother																	
Specialist																	
BIR - BIRCHINGTON WARD	100.0	1	2	0	0	0	131	95	92	90	62	98	0.0	94.8	90	99	6
KIN - KINGSGATE WARD	100.0	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	99.9	92	80	22
QSCB - QEH SPECIAL CARE BABY UNIT	100.0	0	0	0	0	0	14	N/A	N/A	N/A	N/A	N/A	N/A	87.8	87	104	11
RAI - RAINBOW WARD	100.0	0	0	0	0	0	1	N/A	N/A	N/A	29	100	0.0	93.8	94	96	13
Surgical																	
BIS - BISHOPSTONE WARD	100.0	1	3	0	0	0	0	NULL	NULL	NULL	2	100	0.0	80.4	101	109	8
CSF - CHEERFUL SPARROWS FEMALE	100.0	0	3	0	0	1	27	97	98	99	72	99	0.0	69.9	90	91	6
CSM - CHEERFUL SPARROWS MALE	100.0	3	3	0	0	1	20	89	91	93	47	98	0.0	81.8	82	95	7
QITU - QEH ITU	100.0	0	0	0	0	0	44	N/A	N/A	N/A	N/A	N/A	N/A	87.8	87	99	33

Apdx.

KEY

- data not yet available
- NULL — null return, data not received
- N/A — metric is not applicable

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
QX - QUEX WARD	100.0	0	1	0	0	1	126	95	88	96	92	98	1.2	97.4	100	97	6
SB - SEA BATHING WARD	95.8	0	0	0	0	0	0	100	100	100	0	NULL	NULL	79.6	89	94	6
Urgent Care																	
DEAL - DEAL WARD	100.0	1	4	0	0	2	0	100	98	99	16	75	0.0	85.7	120	152	9
FRD - FORDWICH WARD STROKE UNIT	100.0	1	2	0	0	0	0	100	100	100	61	100	0.0	82.3	111	125	11
MW - MINSTER WARD	95.5	2	7	0	1	2	13	NULL	NULL	NULL	40	94	0.0	87.1	91	98	6
QCCU - QEH CCU	100.0	0	0	0	0	0	13	NULL	NULL	NULL	62	100	0.0	96.8	97	101	9
QCDU - QEH CDU	100.0	0	0	1	0	0	18	100	100	100	19	84	7.3	96.5	118	171	14
SAN - SANDWICH BAY WARD	100.0	1	2	0	0	0	1	100	91	99	14	100	0.0	97.7	154	188	10
SAU - ST AUGUSTINES WARD	100.0	0	5	0	0	1	0	100	100	100	11	75	25.0	101.9	117	143	6
STM - ST MARGARETS WARD	100.0	0	2	0	0	0	1	NULL	NULL	NULL	21	100	0.0	97.5	148	178	9
WHH - William Harvey																	
Specialist																	
FF - FOLKESTONE	100.0	0	0	0	0	2	0	NULL	NULL	NULL	N/A	N/A	N/A	88.4	80	62	14
KEN - KENNINGTON WARD	100.0	0	0	0	0	1	0	93	95	95	24	100	0.0	81.6	75	97	9
PAD - PADUA	100.0	0	0	0	0	0	1	N/A	N/A	N/A	12	100	0.0	89.7	90	94	11
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	32	N/A	N/A	N/A	N/A	N/A	N/A	93.9	95	98	14
Surgical																	
ITU - WHH ITU	100.0	0	0	1	0	0	1	N/A	N/A	N/A	N/A	N/A	N/A	101.4	135	128	31
KA2 - KINGS A2	100.0	0	1	0	0	0	112	93	91	97	50	96	1.9	87.7	105	132	7
KB - KINGS B	100.0	0	2	0	0	1	122	79	86	89	55	100	0.0	89.7	94	108	6
KC - KINGS C1	100.0	0	1	0	0	0	88	91	95	95	19	100	0.0	88.4	108	99	6
KC2 - KINGS C2	100.0	0	6	0	0	0	76	100	100	100	63	98	0.0	86.5	86	95	7
KDF - KINGS D FEMALE	100.0	2	2	0	0	0	263	94	82	93	31	100	0.0	93.7	N/A	N/A	N/A
KDM - KINGS D MALE	95.8	5	3	0	0	1	0	95	93	95	35	94	0.0	N/A	101	115	12
RW - ROTARY WARD	100.0	0	0	0	0	0	42	95	90	98	52	98	0.0	87.7	101	100	9
Urgent Care																	
CCU - CCU	100.0	0	0	0	0	0	0	NULL	NULL	NULL	132	96	0.0	96.9	69	63	17
CJ2 - CAMBRIDGE J2	100.0	0	3	0	0	0	6	100	99	100	7	100	0.0	72.4	118	105	8
CK - CAMBRIDGE K	96.3	0	1	0	0	0	0	94	84	93	75	97	1.6	87.2	115	98	7
CL - CAMBRIDGE L REHABILITATION	96.2	3	7	0	0	1	0	100	91	100	55	96	4.2	100.3	101	140	7

KEY

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NULL	null return, data not received
N/A	metric is not applicable

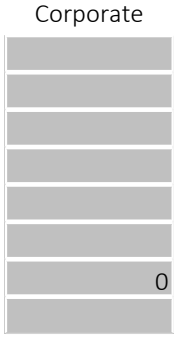
	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
CM1 - CAMBRIDGE M1 SHORT STAY	100.0	1	5	0	0	1	0	96	85	95	21	100	0.0	68.7	N/A	N/A	N/A
CM2 - CAMBRIDGE M2	100.0	0	3	0	0	2	29	91	88	92	59	100	0.0	91.3	105	111	6
OXF - OXFORD	100.0	2	4	0	0	0	0	100	81	85	48	100	0.0	90.6	110	106	8
RST1 - RICHARD STEVENS 1 STROKE UNIT	100.0	0	0	0	0	1	0	93	88	89	46	100	0.0	78.2	110	113	9
WCDM - WHH CDU MIXED	100.0	0	0	0	0	0	0	98	95	98	13	72	20.7	89.4	102	108	16

East Kent Hospitals University NHS
NHS Foundation Trust

Human Resources Heatmap

	Central	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term
Agency %		4.8	3.0	5.8	9.9	11.1	7.1	19.2	49.5
Appraisal Rate (%)	85.7	80.5	84.1	67.0	60.9	79.0	65.3	81.8	66.3
Employed vs Temporary Staff (%)	80.3	86.7	91.5	89.6	85.9	92.1	87.5	90.6	84.5
Sickness (%)	12.0	3.0	1.7	2.9	2.9	4.0	3.1	4.4	3.9
Staff Turnover (%)	0.0	13.1	7.4	18.5	18.6	12.8	10.5	11.3	13.1
Statutory Training (%)	85	92	95	90	82	90	94	86	88
Total Staff In Post (SiP)	15	1458	123	195	93	1330	325	1717	1644
Vacancy (%)	19.7	13.8	8.5	11.2	14.1	8.0	12.5	9.4	15.6

Apdx.


Corporate
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REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**BUSINESS CONTINUITY PLANNING UPDATE**
BOARD SPONSOR:	**CHIEF OPERATING OFFICER**
PAPER AUTHOR:	**HEAD OF EMERGENCY AND RESPONSE**
PURPOSE:	**DECISION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

1. **Introduction**

The Civil Contingencies Act 2004 requires the Trust to have in place business continuity plans to maintain its core services. The Trust has in place an overarching plan that divisional and departmental plans dovetail into. The responsibility for divisional and departmental specific plans rests with the Divisional Directors with their departmental managers.

2. Vision

It is the vision of the Trust to have in place a current Business Continuity Plan for all core functions and services. This is also in line with the NHS Core Standards for Emergency Planning Response and Recovery (EPRR). A further aim is that the plans are supported by an awareness campaign, exercise testing and a training programme. This is a continuous process of improvement building on some excellent work in parts of the Trust.

3. Progress

3.1 Clinical Support Services Division

A great deal of effort has been made by this division with clear senior leadership and ownership by the Divisional Director. The plans in this division underpin a number of core services provided to other divisions. Managers in this division have co-operated and worked with other trusts to ensure parity and mutual aid in a number of areas. There has been a gap analysis with peer review and an action plan developed which has led to some well-developed plans.

The division took the opportunity in 2016 to work differently with the Emergency planning team; raising the profile of business continuity and recognising that the Division had a large number of interdependent services (Radiology Out Patient Department (OPD), Pharmacy and Pathology) that could have the ability to cause major disruption to the Trust's services. The Division identified that their business continuity plans did not contains sufficient detail and were not fully embedded with teams, and have worked hard to rectify this with the Divisional Director championing the work at the highest level.

The Divisional Director and Heads of service outlined a work plan and timeline to construct a set of plans for the Division. Working in collaboration with the Emergency Planning team and partner organisations. The team met regularly either as 1-1's or as a group testing assumptions and narratives to deliver a set of good plans that could be tested and kept alive with in each section.

The business continuity plans were built to provide for recovery and restoration of normal service thereby avoiding additional financial penalties or loss of public confidence following a period of disruption.

Additionally and because the Division is so highly reliant on the engagement of external distributors and suppliers they needed to address response times from suppliers and cover arrangements for large elements of services.

The business continuity plans were formatted to an agreed template and the content essentially followed the Seven P's (Emergency Preparedness, Civil Contingencies Secretariat, 2005):
· Programme- proactively managing the process- setting out what business as usual is?
· People- roles and responsibilities, awareness and education- Who delivers the activities?
·Processes- all organisational data and processes, including ICT-How the activities are delivered
· Premises- buildings, facilities and equipment- Where the activities are delivered
· Providers- supply chain, including outsourcing and utilities- who the dependencies are?
· Profile– brand, image and reputation. Protecting Trust and personal reputation
· Performance– benchmarking, evaluation and audit- Key Performance Indicators (KPIs)

Whether caused by a natural disaster or something less dramatic, interruption of Trust imaging services can quickly compromise patient care. For example the Division were truly tested last year when an upgrade in Radiology failed – considering the vital role of medical images, limiting such interruptions is essential, so radiology departments have disaster recovery and business continuity plans in place. The Divisions work on having strong down time procedures in place for the department mitigated a lot of the issues and meant they could continue to run all services and capture data and this really minimised the impact to the patients.

The Division have undertaken further internal assessments supported by Emergency planning team to test other areas of service such as OPD and Health records this has offered to further review assumptions and responses and helped then review the documentation further.

The Division now have a better understanding of what could go wrong and how and what action they would take to recover and this continues to be work in progress, and further refinement is required. The Division need to continue to have campaigns and promote the work through awareness, workshops, training and exercising to make it everyone's business.

3.2 Urgent Care & long term conditions Division

This division has been engaged in a significant business continuity project with the move of services from the Kent and Canterbury Hospital and the transfer of acute medicine junior doctors from the site. The move presented challenges and has been a good test of business continuity at the highest level and has indicated areas to focus on this year. There are specific gaps in business continuity where patient moves are required or services relocated. It is clear that a focussed effort with senior leadership is required this year in the division to address the issues highlighted by the move. The learning from the move has also been shared with other organisations.

Risk management and business continuity planning are essential tools to managing all aspects of the Urgent Care & Long Term Condition (UC&LTC) business, to provide assurance that patient safety and service sustainability are considered as part of routine business.

The Division has local business continuity plans for areas such as Endoscopy, Cardiac Catheter Suites, wards and A&E departments. Plans for incidents such as IT downtime have been in place for a number of years and are well tested. However, the Division recognises that there is an urgent requirement to review and update all of these plans in line with that undertaken in Clinical Support Services Division (CSSD). A programme to review and update all business continuity plans is currently underway for 2017/18. This programme is being supported by the Emergency Planning Team so that a standardised business continuity plan for all clinical areas of the Division in achieved. The Division is managed via

a triumvirate of a General Manager, lead nurse and consultant and each speciality has a triumvirate leadership team who is accountable for the business continuity of their services.

3.3 Surgical Division

The Division are currently working with the Emergency Planning team to update and review their business continuity plans, the review requires a senior lead project group to take this forward, especially in critical areas such as Theatres, which can only be done with the Co-operation from other teams such as Estates. A lead for each speciality will be identified as part of this review. The plan will then be reviewed and updated quarterly at the Divisional Business Board. The plan will also be exercised with the support of the Emergency Team and any learning incorporated into the plan. Once the review is complete Heather Munro, Divisional Head of Nursing with support of one the Divisional General Managers will lead business continuity for the Division on an on-going basis.

3.4 Specialist Services Division

Following the cascade event in June 2017 and the feedback received from the specialties, the Division has dedicated time to look at business continuity. The Division has business continuity plans in place; however they recognise that these have yet to be robustly exercised to ensure they are fit for purpose. The Division has been working with the Emergency Planning Team, on a Division wide Business Continuity session planned for 17 October 2017. The Division are also running a series of table top exercises to test the robustness of the departmental business continuity plans, exercising incident including IT failure, water leak in a Dialysis Satellite Unit and staffing issues. The plan is to issue a scenario to a team in the morning, running the table top business continuity exercise and report back. The feedback and learning from these table top exercises will then feed into the October exercise.

This Division also has some specialist areas provided on multiple sites. An example is the Renal services provided on other trust sites such as Maidstone. This has generated good liaison with the managers of those services. At Maidstone for instance EKHUFT staff will be taking part in a Maidstone & Tunbridge Wells NHS Trust business continuity exercise in October. The division also has services that are networked with other units such as paediatrics.

3.5 Estates & Facilities

Estates & Facilities (E&F) have a named resource Bob Gadd who leads on the collation / checking and testing of all E&F business continuity plans. They have a comprehensive list of services which require strong supporting Business Continuity processes and up to-date documentation, testing of these plans is underway.

This department has had significant challenges but has made good progress establishing a divisional business continuity taskforce with senior leadership. The output has been plans that are now being tested and circulated. A piece of work is now in progress with Emergency Planning and the water supply companies looking at water failure plans that will culminate in live exercises in Spring 2018. Estates have recently reacted to (1) a fire (2) failure of a generator, and were also on standby for (3) loss of water due to the East Kent pumping station failing, all these incidents were well managed with no harm to staff, patients or public and it enabled estates to test current plans internally, and with partners (fire brigade and SERCO).

The department has recognised the need for robust plans due to the size and age of the estate which means failures are more probable. The Deputy Director Estates and Facilities led Silver Control on two of the above incidents and managed a Bronze level control during the water incident, this enabled representation from both Estates &Facilities and Clinical teams to work together through those challenges in a very positive way.

Estates and Facilities have also participated in exercises led by the Emergency Planning team and the Deputy Director Estates and Facilities (Gary Lupton) meets with the Head of

Emergency Planning and Response on a regular basis to monitor progress of the Estates and Facilities Business Continuity plans. Health and Safety teams are also working more closely with Emergency Planning and building up a very positive working relationship.

3.6 IT Services

This division has been engaged in significant work to support and underpin the Trusts IT resilience. Its response to the Cyber-attack has already been reported to Board. Areas such as Telecoms resilience are work in progress which is being monitored and reported to the Resilience Committee.

3.7 Human Resources

This department has been very proactive in reviewing business continuity plans related to departmental functions and the wider workforce impacts to the Trust. As there have been some changes to HR function this year. The plans will now be reviewed in 17/18.

4. Conclusion

The Trust has made progress on its service resilience this year with significant achievements in some areas.

The core requirement is management time to provide leadership and oversight within divisions. The Trust Resilience Committee is challenging divisions to present at its meetings to provide a focus. Business Continuity needs to be embedded into Business Case and project management so new services have the requirement for business continuity within the project team and associated costs. This along with a programme of monitoring and challenge by the Resilience Committee will ensure that business continuity planning becomes part of everyday procedures.

The Trusts exercise programme will start to increasingly incorporate business continuity challenges into the scenarios. Business Continuity will be reviewed and monitored monthly by the Resilience Committee and will be part of the EPRR assurance process in August 2017.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	• Not complying with statutory legislation (Civil Contingencies Act)
LINKS TO STRATEGIC OBJECTIVES:	**Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	• Loss of utilities such as water and powers and incidents such fire is included within risk registers.
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Resilience Committee

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

RECOMMENDATIONS AND ACTION REQUIRED:

5. Recommendations

(a) The Board are asked to note the report and the progress made.
(b) The Board are asked to endorse the continued importance of business

continuity within the Trust and the need for senior ownership within the divisions.

(c) The Board are encouraged to attend exercises for both business continuity and major incidents.

(d) The Board are asked to nominate a Non-Executive Director to support the EPRR portfolio in the organisation aligned to the Trust Resilience Committee.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**11 AUGUST 2017**
SUBJECT:	**MEDICAL DIRECTOR'S REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: TRAUMA & ORTHOPAEDICS ABRIDGED PRESENTATION FOR GETTING IT RIGHT FIRST TIME (GIRFT) VISIT 28 JULY 2017** **APPENDIX 2: VASCULAR SURGERY GIRFT REPORT**

BACKGROUND AND EXECUTIVE SUMMARY

This report encompasses the following areas:

1. Getting It Right First Time (GIRFT) Orthopaedics follow up visit
   Professor Tim Briggs, National Director of Quality and Efficiency, conducted a follow up visit to review progress in Orthopaedics Friday 28 July. Key points emphasised included achieving the equivalent of four joints in an all day list; reduction in loan kit costs; continued scrutiny of deep infection rates; rationalisation of small volume arthroplasties; review of hip fracture mortality.
2. GIRFT visit programme
   The GIRFT work streams relevant to us include general surgery, breast surgery, ENT, obstetrics and gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedics, spinal surgery, trauma surgery, urology and vascular surgery. To date we have had orthopaedic, vascular and ophthalmology visits. The Obstetrics and Gynaecology visit takes place Monday 7 August.
3. Infection Prevention and Control (IPC)
   NHS Improvement (NHSI) will have conducted a quality review of infection prevention and control on the 8 and 9 August and verbal feedback from this visit will be presented.
4. Mortality Update
   The overall Trust mortality indices continue to remain favourable in comparison with national data but the Mortality Information Group continue to review site differences in mortality which require further investigation. One such area is fracture neck of femur mortality which is being evaluated currently to understand why mortality is higher at the William Harvey Hospital (WHH) Ashford site in comparison with Queen Elizabeth the Queen Mother Hospital (QEQMH) Margate.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks Actions
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do

	it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to maintain the quality and standards of patient care CRR 18 - Failure to comply with the recommendations in the Mazar's report which include case note review of each and every patient death CRR 47 - Inability to prevent deterioration in the number of healthcare associated infection metrics
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to note, review and discuss the risks and required actions as necessary.

1. Getting It Right First Time (GIRFT) Orthopaedics follow up visit

   The GIRFT programme began as an initiative of the British Orthopaedics Society under the leadership of Professor Briggs. It has since been adopted by NHSI and rolled out as a national programme in a number of different surgical and medical specialties. This is now the third visit that Orthopaedics have had and a number of specific questions had been posed by Professor Briggs at the previous visit, the purpose of this visit being to review progress.

   The powerpoint presentation prepared by the clinical lead for Trauma & Orthopaedics details a brief background to the East Kent service and addresses the questions posed by Professor Briggs. Overall he was satisfied with the progress that has been but emphasised certain key points including:

   - Theatre efficiency - achieving the equivalent of four joints in an all day list and bringing back operative procedures that have been outsourced by the Trust
   - reduction in loan kit costs
   - continued scrutiny of deep infection rates
   - rationalisation and centralisation of small volume arthroplasties
   - review of hip fracture mortality (more detail below)

   The last slide in the attached powerpoint at Appendix 1 details progress to date.

2. GIRFT Programme Workstreams

   The GIRFT work streams relevant to us include general surgery, breast surgery, ENT, obstetrics and gynaecology, ophthalmology, oral and maxillofacial surgery, orthopaedics, spinal surgery, trauma surgery, urology and vascular surgery. To date we have had orthopaedic, vascular and ophthalmology visits. The vascular surgery visit took place in March but we have only just received the report (attached at Appendix 2 for information). The recommendations form part of the vascular network workstreams and are being enacted. The ophthalmology visit took place on the 15 May but as yet no report has been produced. The Obstetrics and Gynaecology visit takes place Monday 7 August.

   A report from GIRFT general surgery visits to 50 Trusts was published on Friday 4 August in which there are 20 recommendations. The national headline from this report is that it highlights opportunities to improve patient care and outcomes, and deliver potential efficiencies of over £160 million annually. We have not yet had our general surgery visit but the surgical division will undertake a gap analysis against the 20 recommendations to give us a sense of where we sit.

3. Infection Prevention and Control

The Board receive regular reports relating to Infection Prevention and Control (IPC) and the Trust's IPC action plan was presented at the last Board Meeting. NHSI are conducting a quality review meeting of IPC on the 8 and 9 August and verbal feedback will be presented.

This new financial year the Healthcare Acquired Infection Data Collection System has expanded the number of organisms it is routinely collecting data on and in addition to MRSA, MSSA and C.difficile data is now collected and reported for E.coli, Klebsiella and Pseudomonas. Data to date is shown in the table below presented as infection rates per 1000 bed days in order to show comparison with other acute trusts in the South of England (figures in parentheses indicate the range). Red font denotes adverse performance with the other South of England acute trusts.

Organism	EKHUFT rate/1000 bed days	South of England rate/1000 bed days
MRSA	2.1	0.7 (0-3.9)
MSSA	10.5	9.7 (2.0-21.1)
C.difficile	14.7	15.2 (3.4-29.4)
E.coli	26.2	27.0 (10.6-42.3)
Klebsiella	13.6	6.5 (0-16.5)
Pseudomonas	4.2	4.2 (0-15.4)

4. Mortality Update

The Mortality Information Group continue to meet on a monthly basis review mortality data and also both steer the introduction of the standardised review process to identify where death may have been avoidable and to learn how our care and processes can be improved upon.

A review of hip fracture mortality between January 2016 and December 2016 was conducted in response to a mortality alert from the National Hip Fracture Database (NHFD). The Trust submits data to the NHFD by site and review of this data had shown a rise in 30 day mortality on the WHH site from 6.4% in April 2016 (when National 30 day mortality was higher at 6.8%) to 10.4% in February 2017, this has since come down slightly to 9.9% in April 2017 (latest figures). The 30 day mortality on the QEQMH site has also risen from 3.9% in April 2016 to 7.1% in February 2017, again this has come down slightly to 6.1% in April 2017, latest National 30 day mortality is 6.9%. The QEQMH time to operation has risen significantly from 34.7 hours in April 2016 to 40.8 hours (latest data June 2017), the corresponding National figure is 32.8 hours. Although the rise is less marked time to operation at the WHH has also risen from 29.4 hours to 32.8 hours over the corresponding time period.

Internal analysis (January 2016 to December 2016 data) shows the following:

- 1011 patients had a diagnosis of hip fracture somewhere in their record either as a primary or secondary diagnosis.
- There was not much difference between WHH and QEQM about how many cases where classed as primary diagnosis, however the percentage of deaths in a primary diagnosis is significantly less at WHH than at QEQM despite the higher overall 30 day mortality on the WHH site.
- The crude mortality rate split by site does illustrate that the outcome for WHH is above the 75th percentile benchmarked to peer.

An analysis of case notes form the WHH site is currently being undertaken, preliminary findings are of a significant increase in time to surgery after a fracture in hospital despite the overall data for the WHH site suggesting practice similar to the national practice. As soon as the analysis is complete a full report will be issued.

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TRAUMA & ORTHOPAEDICS (T&O)

Pre-Visit Preparation

Friday 28 July 2017

We care

Introduction

- East Kent
  - Population of 759,000
  - T&O consultants 25
  - 1:30,000

Introduction cont/

East Kent Hospitals University NHS Foundation Trust

- 2 acute and elective sites
  - Queen Elizabeth Queen Mother (QEQM), Margate
  - William Harvey Hospital (WHH), Ashford
- Day Case surgery
  - Kent and Canterbury

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Annual Volumes

	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017
#NOF PROCS	374	390	370	392	355
#NOF PROCS – HEMIARTHOPLASTY	397	418	440	368	336
PRIMARY HIP	648	712	672	723	687
PRIMARY HIP REVISIONS	149	127	132	130	129
PRIMARY KNEE	757	762	726	725	733
PRIMARY KNEE REVISIONS	87	67	58	62	50
TOTAL	**2412**	**2476**	**2398**	**2400**	**2290**

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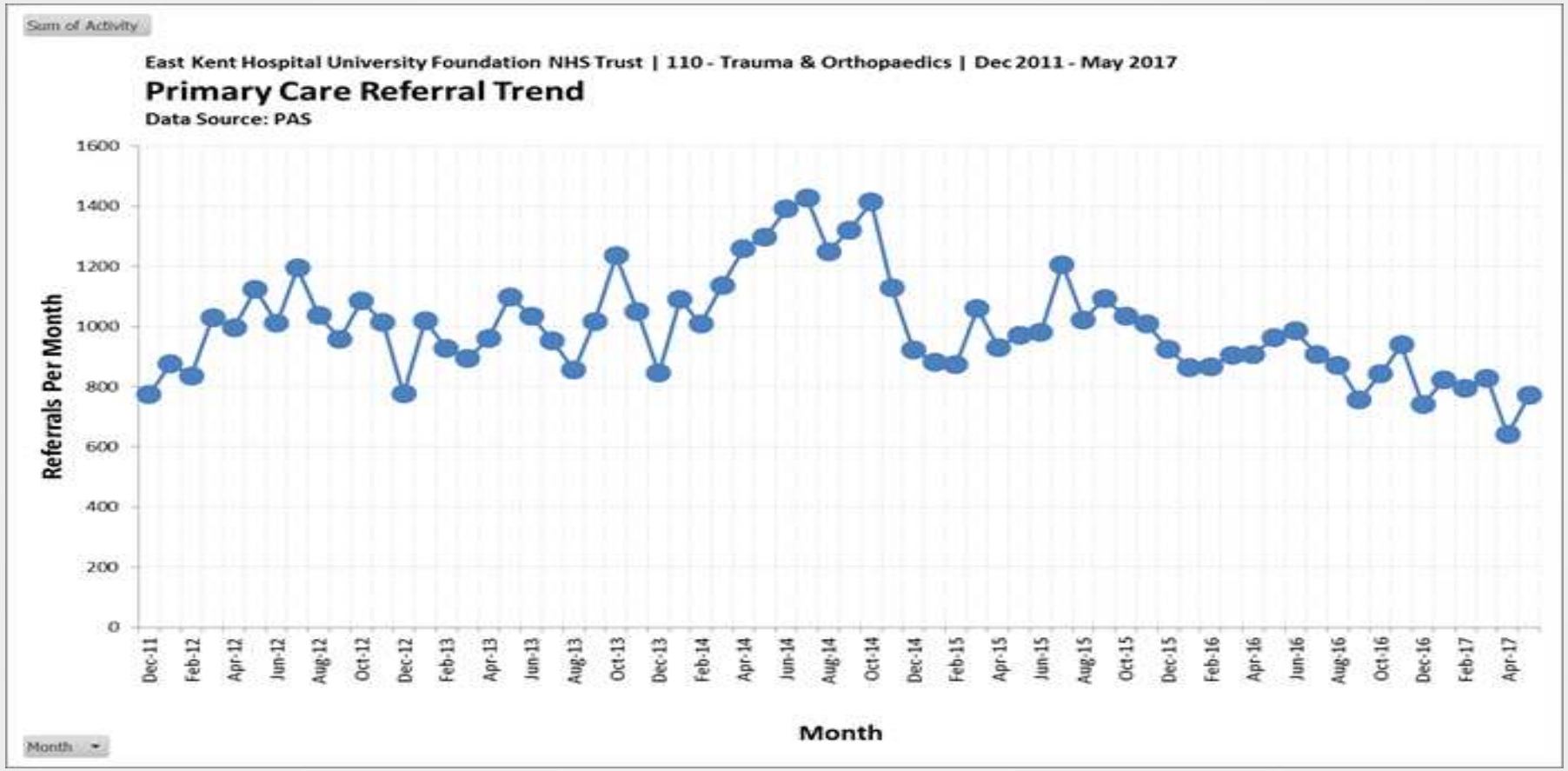
Referral Trend



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Point Of Delivery	2017/18 Demand	2017/18 Capacity	Gap (Raw)
OP New	23,220	22,703	(-517)
OP Follow Up	37,776	30,158	(-7,618)
Daycase	6,670	5,192	(-1,178)
Inpatient	4,578	2,826	(-1,653)

We care

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Outsourcing

	Day Cases	In Patients
2015 / 2016	4810	786
2016 / 2017	2248	536
2017 / 2018 projected	0	420

We care

How do we manage Low Volume Procedures

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- Primary Hips
- Revision Hips
- Primary Knees
- Revision Knees
- Patella Femoral
- Unicondylar

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Hip Replacement Volumes

PRIMARY HIPS		REVISION HIPS	
	195		5
	310		73
	220		22
	475		47
	68		
	244		6
	5		<5
	<5		
	29		
	170		42
	204		17
	334		<5
	108		11
	42		<5
	131		5
	9		
	770		193

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Knee Replacement Volumes

PRIMARY KNEES		REVISION KNEES	
	141		5
	258		62
	262		8
	353		27
	34		<5
	238		<5
	7		
	28		
	124		22
	192		11
	280		<5
	158		23
	80		
	40		
	23		
	294		32

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Surgeon Data

Metric	Source and Year of current report	Value	England	Position	Variation chart
Primary hip replacement	NJR Jan-Dec 2015	22.73%	22.00%	82 of 138	
Revisional hip replacement	NJR Jan-Dec 2015	45.45%	38.40%	111 of 135	
Primary knee replacement	NJR Jan-Dec 2015	19.05%	9.61%	113 of 133	
Revisional knee replacement	NJR Jan-Dec 2015	41.67%	50.92%	77 of 134	
Shoulder replacement	NJR Jan-Dec 2015	▼	34.91%	--	Not applicable

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Actions:

- Recognise the need for change
- Development of MSK pathways
- Understand our information and act upon anomalies
- Review productivity / data of all surgeons
- Monitor NJR data
- Every surgeon to present individual NJR figures at appraisal and revalidation
- Low volume surgeons to discuss practice with Lower Limb Lead and or Head of Department (3 Surgeons have voluntarily stopped joint replacements, 1 Surgeon will be stopping knee surgery)

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Length of stay – Hip and Knee

Have you been able to maintain or reduce your length of stay (LOS) since our last visit?

- Yes in most areas, work in sub specialty groups using benchmarking to address anomalies

What issues are you facing that might be preventing you from keeping LOS low ?

- Access to external rehabilitation

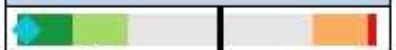
We care

Length of Stay

East Kent Hospitals University NHS Foundation Trust

4. Elective activity

4.3a Elective joint procedure length of stay (days) for patients aged 60+ years

Metric	Source and Year of current report	Value	England	Position	Variation chart
Hip procedures					
Primary hip replacement	HES 2015/16	4.01	4.37	34 of 154	
Revisional hip replacement	HES 2015/16	10.84	8.64	117 of 147	
Knee procedures					
Primary knee replacement	HES 2015/16	4.08	4.29	48 of 152	
Revisional knee replacement	HES 2015/16	13.87	8.35	141 of 148	
Shoulder procedures					
Primary shoulder replacement	HES 2015/16	2.15	3.09	26 of 153	
Revisional shoulder replacement	HES 2015/16	2.13	3.70	48 of 124	
Elbow procedures					
Primary elbow replacement	HES 2015/16	▼	3.04	–	Not applicable
Revisional elbow replacement	HES 2015/16	No value	3.71	–	Not applicable
Hand and wrist procedures					
Wrist replacement	HES 2015/16	No value	1.74	–	Not applicable
Foot and ankle procedures					
Primary ankle replacement	HES 2015/16	3.45	3.21	55 of 82	
Revisional ankle replacement	HES 2015/16	▼	3.24	–	Not applicable

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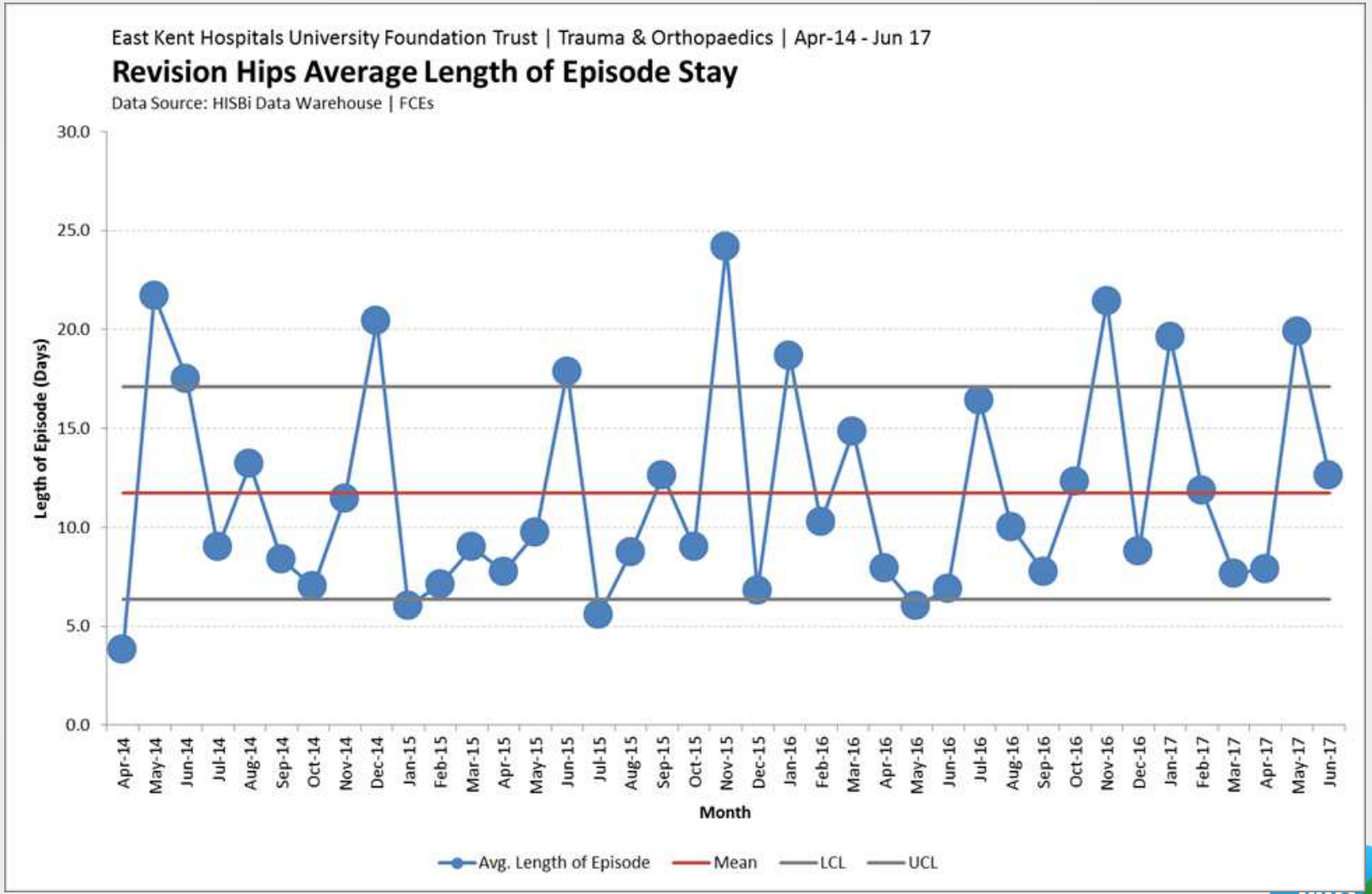
East Kent Hospitals University Foundation Trust | Trauma & Orthopaedics | Apr-14 - Jun 17

Revision Hips Average Length of Episode Stay

Data Source: HISBi Data Warehouse | FCEs



Upper Limb

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- Shoulder and Elbow Replacements – NJR DATA
- Shoulder replacements - Primary
  - 242 over 3 years
  - 10% above national average
- Shoulder - Revisions
  - 26 over 3 years
  - Above national average
- Total Elbow replacements
  - Low numbers (11 over 3 years)
  - Typical for the UK

We care

Why maintain Upper Limb services local?

- Trauma:
  - Elderly population
  - Elbow replacement not uncommon
  - Local skill mix essential to maintain service of good standard – recommend 2 surgeons per site

- Elective:
  - WHH good individual experience
  - QE and WHH to hold MDTs.

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Ring Fenced Beds

Do you have ring fenced beds?

- Quex Ward at QEQM
- Kings C2 Ward at WHH

If so, how many?

- Quex - 19 funded beds + 1unfunded
- Kings C2 - 24 beds

Are they in a separate bay / ward?

- Yes Quex - 4 bays & 4 side rooms
- Kings C2 - 4 bays of 8 beds each

Do you have a protocol in place for medical outliers?

- Yes - policies

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Strategy

- Participation in Sustainability and Transformation Plan (STP) Kent and Medway
- New build of Orthopaedic Clinic at William Harvey Hospital
- Transformation of Trauma service delivery including Virtual Fracture Clinic
- Development of a Single site elective unit
- 2 models:
  - Refurbishing existing facilities – cost: £10 - £15 million
  - New build, supported by separate rehab centre – cost: £20 - £25 million
  - 6 Theatres, 2 X 5 hour sessions, 50 weeks / year

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Waiting Times

Are you meeting your Referral to Treatment (RTT) targets for:

RTT Performance Over Time

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Lower Limb	76.5%	73.1%	73.8%	75.4%	78.3%	76.9%
Spines	83.5%	82.6%	84.5%	83.9%	84.4%	82.7%

If not, why?

- Demand and Capacity
- Theatre availability
- Recruitment of additional Consultants / other staff
- Cancellations
- Bed pressures
- Recovery plan has been submitted which includes additional staff and additional 8 theatre sessions

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Theatre Teams

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Do you have dedicated elective Orthopaedic theatres?

- Not across all sites

Do you have dedicated elective Orthopaedic teams

- Allocated in teams led by a Band 7, each Surgeon has a dedicated Band 6 to address their needs. Staff may rotate to gain experience and enable theatre management to cover in times of sickness and leave

Do you have trouble recruiting?

- Challenges in departments across sites

AGENCY SPEND FOR ALL SPECIALTIES FOR ANAESTHETICS AND NURSING

NURSING: 2016/2017	ANAESTHETICS: 2016/2017
WHH £146,526	WHH £0
QEQM £36,443	QEQM £370,726
KCH £83,803	KCH £0
Total: £266,772	**Total: £370,726**

NURSING: 2017/2018 Up to Month 3	ANAESTHETICS: 2017/2018 Up to month 3
WHH £29,790	WHH £0
QEQM £11,341	QEQM £40,481
KCH £10,221	KCH £0
Total: £51,352	**Total: £40,481**

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Theatre Efficiency

Describe your elective Orthopaedic theatre output?

- Case per session – Lower Limb 1.9 Cases Per Session

Are you achieving the equivalent of four joints in an all day list?

- Not as a standard for all consultants

Do you have laminar flow theatres?

- QEQM - Yes
- WHH - No

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Procurement

Are you registered / using the enhanced orthopaedic procurement data set on the NJR?

Do you know how much you spent on loan kit costs last year?

- Loan kit and associated costs 2016/2017
  - WHH £764,389
  - QEQM £538,301
  - K&C £27,581

Do you have a plan to reduce your loan kit spend?

- Yes there has been a reduction in the available budget to £700K. This has been allocated out to each of the sub specialty leads

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Loan Kit and Associated Costs 2017 > month 3

- Lower Limb £113,000
- Shoulder £40,000
- Foot and ankle £38,000
- Hand £16,000
- Spine £3,000
- Working in conjunction with procurement to reduce costs for loan kit across specialities

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Prosthesis Costs

	Stem	Cup	Total
Cemented THR	£323 + £70	£68 + £70	£531
Hybrid THR	£323 + £70	£400	£793
Uncemented THR	£476	£400	£876
TKR			£897 / £843

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Efficiency

Have you been able to improve efficiency and make any savings since we last visited?

- Trauma contract
- Elective Hips and Knees prosthesis

Can you tell me about your plans for the next year

- Review of support staffing
- Recruitment of 5 Consultant posts

We care

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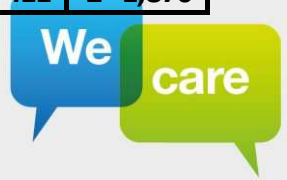
Orthopaedics - Cost Improvement Programmes 2017/18

Aspyre Reference	Brief Description	Risk RAG Rating	GROSS £000's	COST £000's	NET SAVING £000's
SU 4017	Loan kit reduction/standardisation	Green	£ 700	0	£ 700
SU 3016	Rollout of RMO Model - Orthopaedics (WHH)-Agency	Green	£ 224	150	£ 74
SU 3016	Rollout of RMO Model - Orthopaedics (WHH)- Vacant medical staff posts	Green	£ 227	149	£ 78
SU 4025	Zimmer Biomet 100% Hips	Green	£ 363	0	£ 363
SU 6027	Review of Fee for Service (WLI payments) - Orthopaedics	Green	£ 202	0	£ 202
WKF 103	Vacancies Review - Orthopaedics	Green	£ 198	0	£ 198
SU 4018	Cement/Non-Cement to 80/20	Amber	£ 101	0	£ 101
WKF 117	Additional SMART Agency Plans - T&O (QEQM) RMO Model	Green	£ 266	112	£ 154
SU3022	Additional Theatre Capacity - One Ashford (Previously additional POD scheme)	No RAG	TBC	TBC	TBC
	TOTAL		**£ 2,281**	**£ 411**	**£ 1,870**



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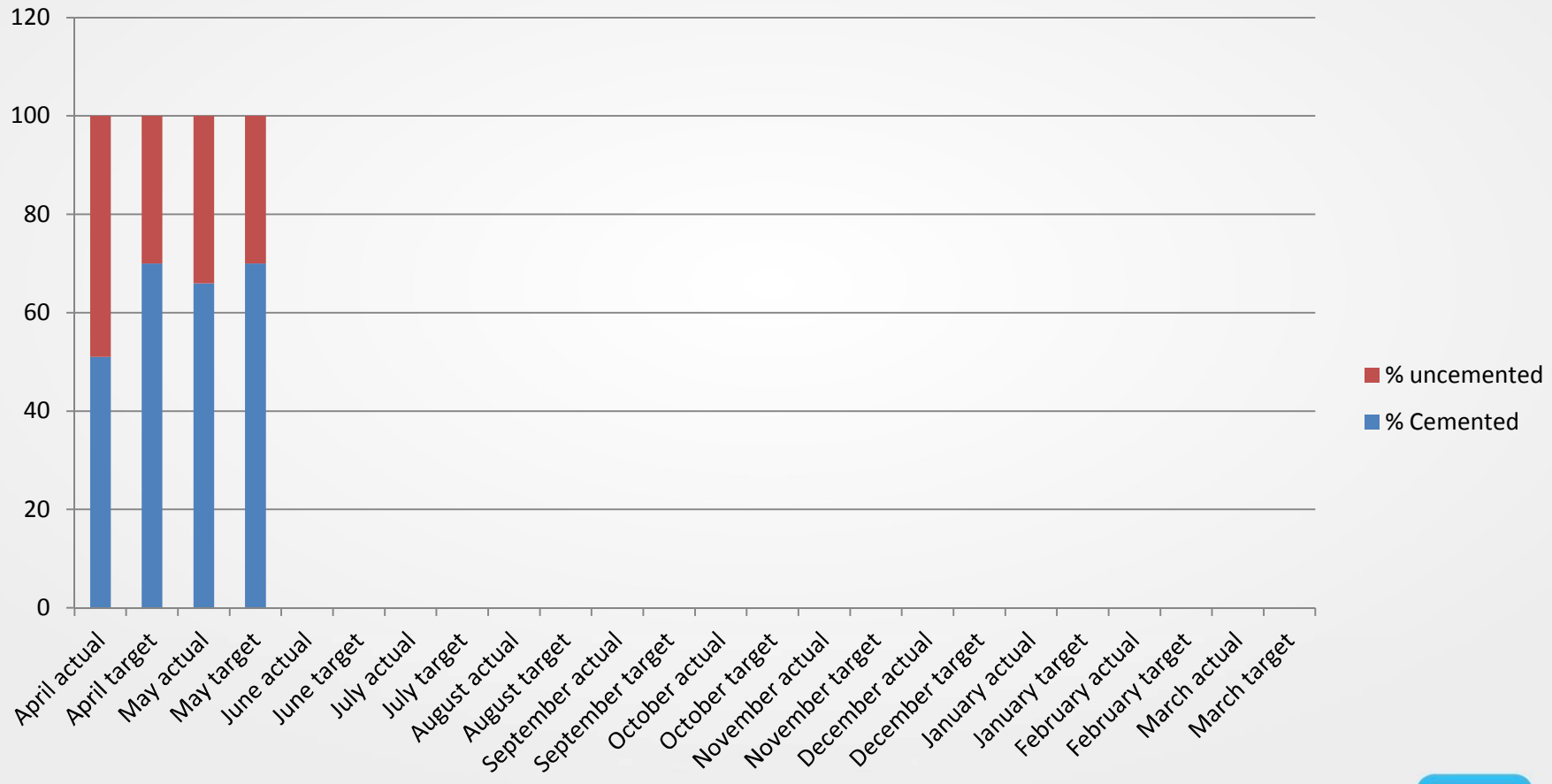
Cemented Vs Uncemented Hips



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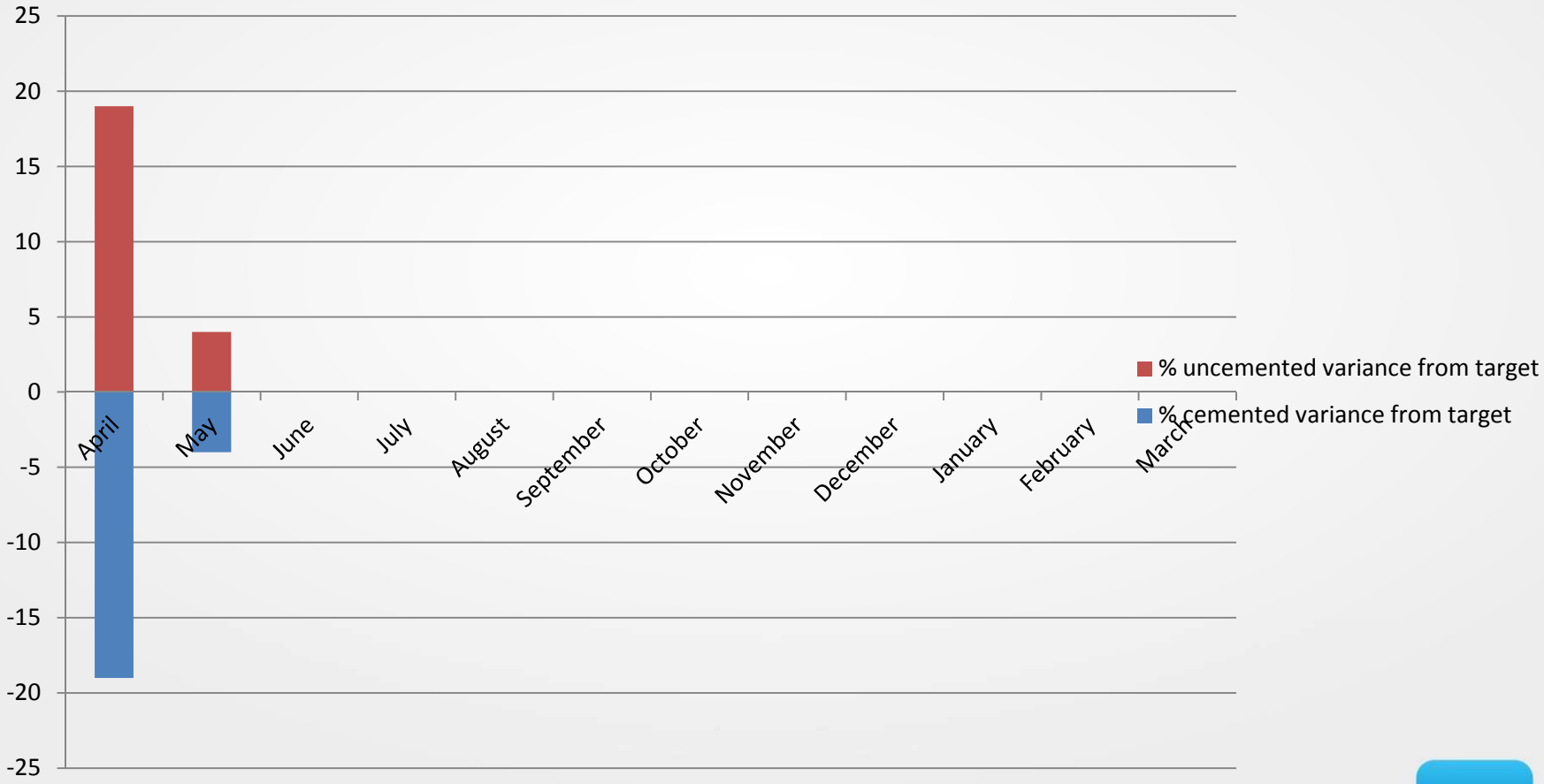
Cemented vs Uncemented Variance from Target



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Cemented vs Uncemented

- 1st Quarter
  - 59% cemented

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Deep Infection Rates

Do you systematically record your deep infection rate for hip, knee, shoulders, elbow and ankles?

- QEQM & WHH – Infection Control & NJR
- WHH – MDM meeting Wednesday 12:00

Therapeutic Arthroscopies

What moves have you made to scrutinise therapeutic arthroscopies on patients over the age of 60 who have then gone on to have a total knee replacement within 1 year?

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Litigation

Are you having regular meetings to discuss threatened or actual litigation?

- Discussed at Surgical Governance Board

9.3 Litigation cost

Metric	Source and Year of current report	Value	England	Position	Variation chart
All adult trauma & orthopaedic					
Number of litigation claims (3 year)*	NHSLA Apr 2013 - Mar 2016	47	25	--	Not applicable
Reserve cost of claims (3 years) (£)**	NHSLA Apr 2013 - Mar 2016	£3,745,085	£3,538,276	--	Not applicable
Reserve litigation cost per admission (T&O) (£)***	NHSLA Apr 2013 - Mar 2016 & HES Apr 2012 - Mar 2015	£89	£203	24 of 140	
Adult orthopaedic surgery, excluding spinal surgery or injections					
Number of litigation claims (3 year)*	NHSLA Apr 2013 - Mar 2016	41	22	--	Not applicable
Reserve cost of claims (3 years) (£)**	NHSLA Apr 2013 - Mar 2016	£3,396,335	£2,416,723	--	Not applicable
Reserve litigation cost per admission (orthopaedic procedure excluding spinal) (£)****	NHSLA Apr 2013 - Mar 2016 & HES Apr 2012 - Mar 2015	£107	£160	43 of 140	

*Date range based on the NHSLA notification date.

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Further Work to do:

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- Length of stay for revision hip and knee replacement
- Monitor arthroscopy rates
- Improve fracture neck of femur service.

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Conclusion

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- Since last review:
  - Right sized our capacity to meet demand
  - Recruited 4 consultants.
  - Reduced Trauma and Elective prosthesis costs by moving to single providers
  - Developed a clear clinical strategy for two emergency and one elective site.
  - Invested in Out Patient Department
  - Transforming the way we deliver emergency care.
  - Transformed Junior Doctor Staffing
  - Improved our processes for monitoring Low Volume Surgery.

We care

Department of Health

GETTING IT RIGHT FIRST TIME

GETTING IT RIGHT FIRST TIME

East Kent Hospitals University NHS Foundation Trust

Vascular Surgery

Observation Notes

Date Visited: 15 March 2017

Report sent to: Noel Wilson

Written by: Neha Patel and Michael Horrocks

1. Background

This document captures the key points arising from the recent GIRFT review meeting that Professor Mike Horrocks (the GIRFT programme lead Vascular Surgery) and Neha Patel undertook at East Kent and Canterbury Hospital on 15 March 2017. This is a companion document to the trust report that was issued prior to the review meeting.

The ambition of the programme is to identify areas of unwanted variation in clinical practice and/or divergence from the best evidence. The work will culminate in a report and set of national recommendations aimed at improving quality of care and also reducing expenditure on complications, litigation, procurement and unproven treatment.

General feedback

In this report, we will look at the main points discussed in our recent visit to your Trust. Overarching points that arose during the meeting included:

- The provision of vascular care should be considered by clinicians and management as an urgent service, which need the ability to assess, investigate and treat all patients in a well-managed flexible service that minimises delay and can meet appropriate standards and timelines. Ideally all patients should be treated by the vascular team 24/7.

- Improve your NVR/HES data collection and input process – consider investing in administrative support for consultants in order to improve the quality of the data submitted.

- Currently, there are few vascular/care of the elderly physicians taking part in direct care of vascular inpatients. The introduction of such a service has been shown to reduce length of stay and reduce the rate of emergency re-admission for non-surgical problems in the first 30 days following surgery, and we would recommend the introduction of this service. We understand you have requested a vascular physician.

- Friends and Family – room for improvement. Data collection needs to be better to ensure that it is more meaningful.

- Ensure comorbidities are correctly recorded and assessed to assist in reducing the length of stay and readmission rate.

- Ensure all AAA patients, both screened and non-screened follow the same pathway and timelines.

- Improve carotid referral pathway to ensure patients are treated promptly and equally regardless of which hospital they are transferred from.

- There are some issues around how data is collected on post-surgery destination. Many patients are being recorded as moving to HDU/PACU and as there is no differentiation in the NVR this is causing some confusion. Many patients are being moved to HDU for a few

hours in order to monitor their blood pressure, after which, they are returned to the ward. This is not reflected in the data.

2 Context

2.1 Network

Your network overs a population or around 1 million patients and is made up of the following Trusts:

Network board – Noel Wilson is clinical lead and chair of board for the network. Anil is the deputy.

No hub in place yet – in discussion. This needs to be urgently assessed.

Single arterial centre with multiple non-arterial centres.
Maidstone
Pembury
Tunbridge Wells

Ideally, the hub should be centrally located within the emergency centre hospital with specialties.

The vascular network model works best when all vascular service contracts are based at the hub, including all staff contracts. This allows for the ability to share surgeons and Interventional Radiologists across the network including spoke hospitals.

2.2 Flow of patients to network and trusts for vascular surgery procedures

Patients flow to your network from 4 main CCGs: NHS South Kent Coast CCG, NHS Ashford CCG, NHS Canterbury and Coastal CCG and NHS Thanet. Also, NHS Medway CCG, NHS West Kent CCG and NHS Swale CCG.

2.3 Trust level quality metrics

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS.
The response rate for the Friends and Family test is too low, despite being above the national average. It also seems that the only patients providing a response are those who are satisfied with the treatment they have received. The recommendation here is to improve the method of collecting this data and to focus on ensuring it is completed properly. The alternative is to stop collecting the data, as currently it is not meaningful.

The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic.
We note your SHMI has been improving since this data was collected.

2.4 Estimates of case-mix complexity and patient demographics - of patients with a procedure

The data shows that the population covered by this network is deemed to be slightly fitter than the national average. However, this may be inaccurate, probably due to under-recording of comorbidities. Your deprivation index is around the national average. We note you have a varied deprivation population with Thanet CCG area having the highest deprivation.

Whilst your level of comorbidities recorded is around average, we suspect you are currently significantly under-recording comorbidities. Good recording of comorbidities with subsequent assessment and management can assist with reducing length of stay and emergency readmission rates, particularly as the data shows patients who are readmitted are rarely surgical issues and mostly due to problems related to comorbidity.

2.5 Prevalence in primary care

The prevalence of diabetes and peripheral arterial disease appears around average across the network.

3 Specialist Vascular Unit Organisational Audit

3.1 Organisational metrics from the National Vascular Registry Organisational Audit 2015

I Canterbury you have 3 consultant vascular surgeons with 4 half-day in-patient vascular lists each. The total number of in-patient vascular lists per consultant should be in the order of 3 half-day lists per week, which if agreed should provide a sufficient volume to incorporate all urgent cases in a timely way and ensure efficient resource management.

5 surgeons and 5 Interventional Radiologists in Medway.

You currently have 4 interventional radiologists based here. We recommend that you should have a comprehensive 24/7 on-call IR service to be able to provide a full vascular service.
We note you are struggling to recruit and/or retain IRs because they can't cover both vascular and non-vascular work. We also note that there is an urgent need for another IR suite.

You have 4.6 vascular nurse specialists across the network.

There are 24 vascular beds on the vascular ward. This should be sufficient if the service is run efficiently.

There is no weekend working at present but that is understandable, as don't have enough surgeons to cover weekends. In order to develop a 7 day service you will need to review your staffing levels

Both units have a hybrid theatre. You could improve the service by having a full day list and half day list each day and run a 7-day service.

4 Abdominal Aortic Aneurysm (AAA) pathway

4.1 Male AAA screening from National Abdominal Aortic Aneurysm Screening Programme

Your screening programme has been running for 6 years.
Screening is good and above average across most of the network except in Thanet, which is consistent with the population, profile there. The number of diagnosed aneurysms >=3cm is around average for Ashford and Thanet but lower in South Kent and Canterbury. The number of aneurysms >=5.5cm is high in South Kent and Ashford but lower in Canterbury and Thanet.

4.2 AAA activity (from HES data)

4.3 AAA activity (NVR data)

4.4 National Vascular Registry compliance – AAA

There is a national issue with the accuracy of data drawn from both the HES and NVR. The figures do not match and the tables show low NVR compliance and inaccurate recording of HES in almost every vascular network/trust. As these metrics require accurate data to draw precise conclusions and as funding for vascular procedures rely on good data, it is essential that this problem be addressed.
The responsibility for ensuring the data is correct is properly shared between management and individual responsible clinicians. Surgeons and radiologists must ensure that their data is checked and submitted accurately, and appropriate clerical staff and time must support this process. Management should ensure this message is disseminated, understood and actioned, as future funding and contracts will depend on the quality of data.

We would recommend the introduction of a checking process where data is checked by the responsible clinician before it is submitted to the NVR or HES. The responsibility for good data lies with the clinician, not with the coders who may not be aware of the differences in procedure types.

4.5 Annual AAA activity (from HES data) per 100,000 weighted population

There may be difficulty in maintaining the skills for complex open surgery for all vascular surgeons. This is a national issue for all surgeons on the emergency on-call rota. One solution is to routinely double up the surgeons for complex procedures including open aortic aneurysm repair. Management of more complex aneurysms may need to be centralised to regional/supra-regional centres where all modalities of treatment are carried out and the appropriate skills are readily available. Both proposals are being considered at a national level.

4.6 AAA – pathway metrics from NVR

Patients with aortic aneurysm, whether they come from national screening or other sources, should have a clear pathway with timelines from referral to surgery. Where possible these timelines should be the same, whatever the source of the aneurysm, and be managed in a similar way with delays clearly flagged up and dealt with. It is important that patients from the catchment area of spoke hospitals are seen, investigated and treated in the same timescale as those from the catchment area of the hub hospital.

Your median days from assessment to surgery are reasonably good but with room for improvement. We recommend a review of your pathway and timelines, as patients should be

treated a little quicker than they are. We note you aspire to treat all patients on the same pathway and timelines, which we strongly support.

4.7 AAA Treatment metrics from the NVR organisation audit 2015
Good 3D planning by both vascular surgeon and IR.

EVARs available 24/7 but not consistently.

4.8 AAA – Average length of stay (HES Data)
In general, it is advisable that patients be admitted on the morning of their surgery, even for open aortic surgery. To support this it is essential for there to be thorough pre-operative assessment with input from the vascular anaesthetists and objective measure of fitness, particularly for those having open aortic surgery. During pre-admission, all patients should be assessed for suitability for early discharge and suitable arrangement should be put in place whenever possible. To facilitate admission on the day of surgery, it would be advisable to have a dedicated theatre admission unit to ensure no delay in starting the operating list.
The introduction of a pre-admission hotel has been shown to be particularly useful for patients who live away from the hub hospital.

Your length of stay data for open procedures is good with only a small number of longer stayers. Your length of stay for EVARs is also good with only a small number of long stayers. Early discharge planning would help reduce length of stay. Set patient expectations prior to surgery on how long they are likely to remain in hospital. Also ensure that you are recording when patients are medically fit for discharge and the reasons for any delay in addition to the actual discharge date.
An enhanced recovery programme may be beneficial to assist with reducing length of stay.
We note currently all patients are admitted on the day of surgery and are mostly discharged the next morning. You have a pre-assessment process which is specialty specific.
We note that in Medway patients are admitted on the day of surgery, but you sometimes have issues with a lack of available beds. We advise you should have an admissions unit that is not on the ward.

4.9 AAA Post surgery metrics (NVR data)
Your unruptured open aneurysm patients have a higher than expected rate of being returned to theatre and are also being readmitted in 30 days. We recommend you review this data to ensure it is correct, as there may be some data issues, but if the data is correct you should introduce an on-going audit.

Your complication data for patients readmitted within 30 days is high and should be reviewed. This might be due to small numbers, but an audit would show any anomalies. Keeping a log would help identify any emerging themes.

Your mortality rate is good and lower than the average.

4.10 AAA Return admission for another vascular procedure within 30 days of discharge
Readmissions data looks good for both open and EVAR.

4.11 AAA Emergency readmission within 30 days of discharge

The percentages of patients being returned to theatre or readmitted as an emergency within 30 days are good indicators of quality of care.
The high rate of emergency readmission within 30 days for any reason highlights the frailty of these patients, particularly those patients with an aortic aneurysm or with peripheral vascular disease. Currently, there are few vascular/care of the elderly physicians taking part in direct care of vascular inpatients. The introduction of such a service has been shown to reduce length of stay and reduce the rate of emergency re-admission for non-surgical problems in the first 30 days following surgery, and we would recommend the introduction of this service.
If a patient is readmitted as an emergency within 30 days of surgery, the funding for the primary procedure may be withdrawn. This may act as a perverse incentive to keep patients in hospital longer after surgery, and this is clearly not desirable.

Your emergency readmissions for both open and EVARs are high. However, most are probably due to problems related to comorbidities or other medical problems. It would be helpful to have a system in place where the vascular team is notified that a patient has returned prior to any formal readmission. The patient can then be assessed and steps taken to avoid any unnecessary readmission. An audit of readmissions would give a clearer idea of where the main issues lie.
We recommend giving patients a card with a number to contact the vascular team post discharge if they have any concerns. You should also consider introducing a policy of phoning all patients a few days following discharge.

We understand that your process following discharge has much improved. Patients are now phoned a few days after discharge. They are also provided with a number to call if they are concerned and a leaflet with advice on what to expect and what to do if they are concerned.

5 Carotid endarterectomy pathway

5.1 Carotid endarterectomy activity (HES data)

Medway don't seem to be doing enough endarterectomy for the catchment population that they cover.

We note all carotid endovascular patients go to St. Thomas' in London, but this will be very few in number.

We recommend having a discussion with your stroke teams regarding your pathway and timelines for carotid patients.

5.2 National Vascular Registry compliance - Carotid endarterectomy

Compliance is reasonably good but can be improved.

5.3 Carotid treatment metrics from the National Vascular Registry Organisational Audit 2015

There is no real need for a specific carotid MDT as there is a risk that treatment may be delayed in order to present the cases to the MDT. An alternative system is to ensure all difficult cases or those from which learning can be gained, are presented at the general vascular MDT.

Ideally you should have a regular meeting with the stroke teams to discuss difficult cases or problems with referral. Patients need to be seen, assessed and treated within days of presentation, and this should include all patients in the catchment of the network.

5.4 Carotid endarterectomy - Pathway metrics (NVR data)
For carotid surgery, the current accepted timelines have been gradually reduced and these patients should ideally be seen, assessed, operated on and discharged within days of onset of their symptoms. This requires planning of the vascular surgery service to absorb all urgent patients (e.g. Carotid endarterectomy and ischaemic/diabetic feet) in a much shorter timescale. This requires a high level of co-operation between relevant physicians and the vascular service, supported by sufficient beds and theatre time to allow prompt treatment. Ideally, all efforts should be made to operate on carotid patients within a few days after presentation, and all ischaemic legs investigated and treated as soon as possible with minimal delay.

Canterbury - your median days from symptom to carotid surgery are good at 7-days. The percentage of patients referred within 7-days of symptom and receiving surgery within 7-days of referral is between 68 – 74% and the pathway and timelines for carotids should be reviewed to improve this.

Medway – your median days from symptom to surgery are long at 12-days and should be improved. The percentage of patients referred within 7-days of symptom and receiving surgery within 7-days of referral is between 41 – 58% and the pathway and timelines for carotids should be reviewed to improve this.

5.5 Carotid endarterectomy (HES data)
For carotid endarterectomy patients, it should be the norm to admit on the day of surgery and discharge as soon as possible, usually within a day or two of surgery.
Following surgery carotid patients who require post-stroke rehabilitation should be transferred to the stroke team, ideally in the stroke unit. The transfer of patients back to medical care after surgery should be formally recorded and coding needs to be modified to reflect transfer from surgical service and admission to the medical service. This is clearly a national problem and is being addressed. Currently long periods of postoperative stay for medical reasons are often recorded as surgical care.

Your length of stay data is reasonable but with only a number of long stayers. Ideally all patients should be discharged within a day or two of surgery provided they are fit.
It is also useful to formally record when patients are medically fit for discharge and the reasons for any delay so it is clear to see how much longer they are staying in hospital.

5.6 Carotid endarterectomy - Post-surgery metrics (NVR data)
Complication data shows a higher percentage of returns to theatre and readmissions, which would benefit from a review.

The in-hospital mortality data is good and lower than average.

5.7 Carotid endarterectomy - Emergency readmission within 30 days of discharge (3-years of HES data)
There are a number of readmissions but they are mostly non-surgical. See above.

6 Lower limb procedures for patients with peripheral arterial disease
6.1 Lower limb angioplasty for patients with peripheral arterial disease - Activity per 1,000,000 population (HES data)
Angioplasty levels for both diabetics and non-diabetics are lower than average across the network and do not match the PAD prevalence data. This should be reviewed.

6.2 Lower limb bypass/revascularisation for patients with peripheral arterial disease - Activity per 1,000,000 population (HES data)
Low levels of revascularisation across the network for both diabetics and non-diabetics.

6.3 Lower limb amputation for patients with peripheral arterial disease - Activity per 100,000 population (HES data)
There are more than expected amputations for both diabetics and non-diabetics.

The above data suggests that either you are not doing as much limb salvage as you could, or there is late presentation with delayed referrals.

We recommend an in-depth review of your referral pathways and timelines. You should also do an in-depth review of a cohort of patients and make sure there were no delays or missed opportunities for revascularisation.
It would also be useful for your vascular nurses to liaise with community and GP nurses, who are often best placed to initiate any referral, in order to improve the referral rate.

Nationally non-diabetics are struggling to receive the same care as diabetics. We recommendation you should consider holding acute/urgent foot clinics rather like diabetic foot clinics to give non-diabetic patients a clear pathway with timelines into the service.

We understand a lot of work has been done on improving the diabetic foot service since this data was collected.

6.4 Lower limb procedure for patients with peripheral arterial disease - Average length of stay (days) (HES data)
In peripheral vascular disease, the patients requiring lower limb angioplasty, either diabetic or non-diabetic, can usually be treated as a day case, provided there are adequate facilities. This may also help to shorten the delay between presentation to the diabetic team and subsequent treatment, whether angioplasty or lower limb bypass. For patients having bypass/revascularisation, there should be minimal delay between admission, investigation and subsequent surgery. Length of stay following reconstructive surgery need only be 4-5 days provided there is no further surgery required and the patient is mobilised during the post operative phase. Ideally, this requires a full 7-day physiotherapy service to support the vascular unit.

Your length of stay for elective patients is relatively good.

Your length of stay for non-elective patients is also reasonable in comparison to the national average. However, the national average is much too long in general and needs to be addressed. We would recommend an audit of your long stayers and a review of you pathways and timelines, as improvement is required.

All angios should be carried out as day cases. We recommend development of a dedicated day case IR unit, ideally at the hub but also at the spoke if possible.

You need another IR suite, as the current setup is inappropriate. This applies to both Canterbury and Medway. We strongly recommend an investment into a second IR suite to improve the patient flow and reduce length of stay.

We recommend you introduce a procedure for recording when patients are medically fit for discharge with reasons for any delay.

6.5 Lower limb metrics from the National Vascular Registry Organisational Audit 2015
Reasonable amputation data. Most patients are being operated on an elective list but this figure needs to be improved. You should consider having a telephone standby list to improve efficiency.

An investment into rehabilitation would assist with getting patients mobile and reduce length of stay.

Consider investing in a 7-day physiotherapy and OT service to mobilise patients and reduce length of stay.

6.6 Lower limb procedures for patients with peripheral arterial disease - selected metrics (HES data)
The ratio of amputation to revascularisation is higher than expected and should be improved. Some of this is likely to be due to late presentation but it looks like you should be more aggressive with limb salvage.

The period between diabetic foot admission and major amputation is too long at 19 days. This pathway and timelines needs to be urgently reviewed.

6.7 National Vascular Registry compliance - lower limb procedures for patients with peripheral arterial disease
Compliance should be improved.

6.8 Post-surgery metrics for lower limb angioplasty for patients with peripheral arterial disease (HES data)
If patient comorbidities are recorded correctly, there is an opportunity to review and treat these problems and help reduce length of stay and readmission rates, particularly as the data shows patients who are readmitted are rarely surgical issues and mostly due to problems related to comorbidity. These re-admissions may be coded as a readmission under the vascular code, which will result in skewed data.

Your mortality data is higher than expected and should be reviewed.

6.9 Post-surgery metrics for lower limb bypass/revascularisation for patients with peripheral arterial disease
You have a much higher than average percentage of readmissions. See above for advice about reducing these.

Mortality data is 3% and average.

6.10 Post-surgery metrics for major amputation for patients with peripheral arterial disease
Mortality data looks reasonable.

There are a high percentage of readmissions. See above for advice.

7 Patient Experience
7.1 PROMS average health gain – Aberdeen varicose vein questionnaire
Not helpful – metric to be removed.

8 Cost metrics
8.1 National tariff cost per procedure – cost to CCGs
8.2 Average unit NHS reference cost per procedure - cost to provider
We would recommend a full discussion with your finance team regarding the figures. The data looks reasonably good but there are still places where it looks as though your expenditure is higher than it needs to be.

8.3 Litigation costs for vascular surgery admissions
The estimated litigation cost per vascular admission is high. We recommend a full review of these cases to see where learning can be gained and changes made.

Other comments
Provision of vascular ultrasound should be reviewed nationally?
Renal access should also be considered in the future.