Board of Directors Meeting - Open (April 2020)

16 April 2020, 09:45 to 12:15
Teleconference webex

Agenda

Agenda

20/1
Chairman's Welcome (09:45)

15 minutes
Verbal
To Note
Chair

20/2
Apologies for Absence

Verbal
To Note
Chair

20/3
Declaration of Interests

To Note
Chair

20-03 - REGISTER 2020-21 V01 - from April.pdf (5 pages)

20/4
Minutes of Previous Meeting held on 12 March 2020

Approval
Chair

20-04 - Unconfirmed BoD 12.03.20 Public minutes.pdf (15 pages)

20/5
Matters Arising from the Minutes on 12 March 2020

Discussion
Chair

20-05.1- Front Sheet Open Actions from Public Board.pdf (2 pages)

20-05.2 - Appendix 1 Public Board of Directors Action Log.pdf (1 pages)

20/6
Chair's Report (10:00)

10 minutes
Discussion
Chair

20-06 - Chair Report April 2020 BoD.pdf (3 pages)

20/7
COVID-19 – urgent issues in relation to: (10:10)

30 minutes
Discussion
Chief Executive / Executive Team

- **patient safety**
- **capacity**
- **infection control**
- **staff deployment**
- **staff wellbeing**

20-07 - COVID-19 Apri Public Board Briefing v3.pdf (8 pages)

20/7.1

Finance and Performance Committee (FPC) Update
Verbal

Discussion

Chair Finance and Performance Committee - NIgel Mansley

20/7.2

Quality Committee (QC) Update
Verbal

Discussion

Chair Quality Committee - Wendy Cookson

20/8
COVID-19 - Planning (10:40)

15 minutes

Verbal

Discussion

- **Finance Report**

Chief Executive/Executive Team

20/9
Advice requirements and guidance from NHS England/NHS Improvement (NHSE/I) (10:55)

15 minutes

Verbal

Discussion

Chief Executive / Executive Team

TEA/COFFEE BREAK - 11:10 (10 Mins)

20/10
Corporate Reporting: (11:20)

15 minutes

20/10.1

Highest Mitigated Strategic Risks Report

Discussion

Chief Executive/Executive Team

20-10.1.1 - Front sheet Strategic Risk Register BoD 09.04.2020.pdf	(3 pages)
20-10.1.2 - Appendix 1 Strategic Risk Register 06.04.2020.pdf	(12 pages)
20-10.1.3 - Appendix 2 Corporate Risk Register (Risks outside Risk Appetite).pdf	(4 pages)

20/11
Report from the Learning and Review Committee (LRC) - Maternity (11:35)

10 minutes

Discussion

Chief Executive / Independent Chair - Learning and Review Committee (joining by telephone)

20-11.1 - EKHFT Committee Front Sheet 16.4.20.pdf	(2 pages)
20-11.2 - Appendix 1 EKHFT comittee report 16.4.20.pdf	(2 pages)

20/12
Nominations and Remuneration Committee - Chair Report - (11:45)

10 minutes

- **Terms of Reference**

Approval

Acting Chair Nominations and Remuneration Committee - Wendy Cookson

20-12.1 - NRC Chair Report March 2020.pdf	(2 pages)
20-12.2 - Appendix 1 NRC ToR March 2020.pdf	(6 pages)

20/13
Charitable Funds Committee - Chair Report (11:55)

10 minutes

- **Terms of Reference**

Approval

Chair Charitable Funds Committee - Sunny Adeusi

20-13.1 - CFC Chair Report March 2020 Final.pdf (4 pages)

20-13.2 - Appendix 1 ToR EKH Charity 2019-20.pdf (7 pages)

20/14

Post Meeting Communication (12:05) 15 minutes

Verbal Discussion

Chief Executive/Executive Team

Date of Next Meeting: Thursday 19 May 2020 in the Board Room, William Harvey Hospital, Ashford.

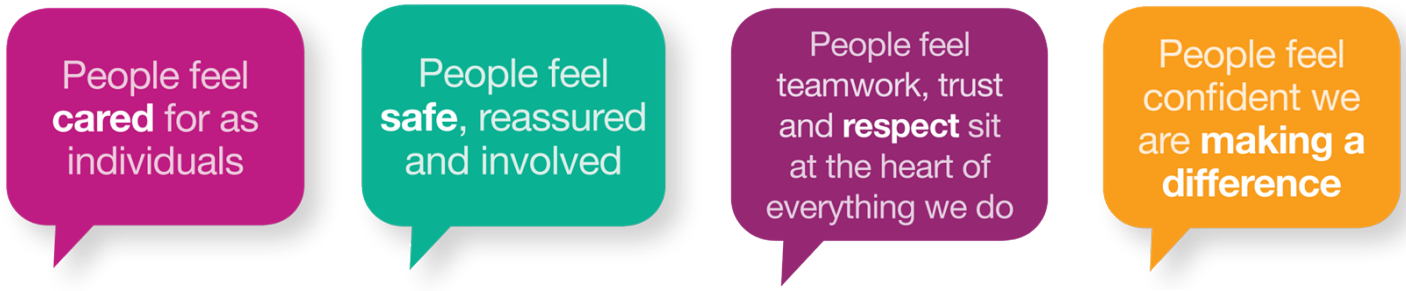
The public will be excluded from the remainder of the meeting due to the confidential nature of the business to be discussed.

East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS MEETING – THURSDAY 16 APRIL 2020

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place as a teleconference webex, commencing at **9.45 am to 12.15 pm**.

This Board meeting is held in public and will be conducted in line with the Trust Values below:



AGENDA

20/	**OPENING MATTERS**			
1	Chairman's welcome		**09:45**	Chair
2	Apologies for Absence			
3	Declaration of Interests			
4	Minutes of Previous Meeting held on 12 March 2020			
5	Matters Arising from the Minutes on 12 March 2020			
6	Chair's Report	**Discussion**	**10:00** **10 mins**	Chair
7	COVID-19 – **urgent issues** in relation to: • patient safety • capacity infection control • staff deployment • staff wellbeing	**Discussion**	**10:10** **30 mins**	Chief Executive/ Executive Team
7.1	Finance and Performance Committee (FPC) update	**Discussion Verbal**		Chair Finance and Performance Committee – Nigel Mansley
7.2	Quality Committee (QC) update	**Discussion Verbal**		Chair Quality Committee – Wendy Cookson

8	COVID-19 – planning	**Discussion Verbal**	**10:40 15 mins**	Chief Executive/ Executive Team
9	Advice requirements and guidance from NHS England/NHS Improvement (NHSE/I)	**Discussion Verbal**	**10:55 15 mins**	Chief Executive/ Executive Team
TEA/COFFEE BREAK			**11:10 10 MINS**	
10	Corporate Reporting			
	10.1 Highest Mitigated Strategic Risks Report	**Discussion**	**11:20 15 mins**	Chief Executive/ Executive Team
11	Learning and Review Committee (LRC) – Maternity	**Discussion**	**11:35 10 mins**	Des Holden – Chair of LRC
12	Nominations and Remuneration Committee (NRC) – Chair Report	**Approval**	**11:45 10 mins**	Wendy Cookson – Acting Chair of NRC
13	Charitable Funds Committee (CFC) – Chair Report	**Approval**	**11:55 10 mins**	Sunny Adeusi – Chair of CFC
14	Post meeting communication	**Discussion**	**12:05 15 mins**	Chief Executive/ Executive Team

Date of Next Meeting: Tuesday 19 May 2020 in the Board Room, William Harvey Hospital, Canterbury.

The public will be excluded from the remainder of the meeting due to the confidential nature of the business to be discussed.

REGISTER OF DIRECTOR INTERESTS 2020/21 FROM APRIL 2020

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) (started 16 October 2017) **(4)**	Appointed 1 April 2018
ADEUSI, SUNNY	Non Executive Director	Leadership role for Zimmer Biomet (global US medical device/technology corporation in Europe, Middle East & Africa (EMEA) Regional Commercial & Marketing) (started 16 September 2019) **(4)**	1 November 2015 (Second term)
ASHMAN, ANDREA	Director of HR	MY Trust (started 11 November 2014) **(4)**	Appointed 1 September 2019
CAVE, PHILIP	Director of Finance and Performance	Wife works as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Groups (CCGs) of East Kent in their contracting (started 9 October 2017) **(5)** Non Executive Director of Beautiful Information Limited (started 3 November 2017) **(1)**	Appointed 9 October 2017
COOKSON, WENDY	Non Executive Director	Managing Director of IdeasFourHealth Ltd, a consultancy for the healthcare industry (started 22 July 2011) **(2)** Sole Shareholder for IdeasFourHealth Ltd (started 6 January 2017) **(3)** Chair of Bede House Charity, a local community charity in Bermondsey, London (started 28 August 2019) **(4)** Member of Health Advisory Board for OCS Group UK (started 15 March 2018) **(5)** Non Executive Director of Medway Community Healthcare (started 1 August 2018) **(1)**	6 January 2017 (Second Term)

REGISTER OF DIRECTOR INTERESTS 2020/21 FROM APRIL 2020

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
HALLUMS, AMANDA	Chief Nurse & Director of Quality and Patient Experience	Trustee of St Francis Hospice (started 1 April 2019) **(1)**	Appointed 1 October 2019
HOLLAND, CHRISTOPHER	Associate Non Executive Director	Director of South London Critical Care Ltd Companies House register number 09862130 **(1)** Shareholder in South London Critical Care Ltd **(2)** Dean of Kent and Medway Medical School, a collaboration between Canterbury Christ Church University (Charity Number 1098136) and the University of Kent, an exempt charity (HMRC reference number XN5452 **(4)** South London Critical Care solely contracts with BMI The Blackheath Hospital for Critical Care services. **(5)** Member of Liberal Democrats, until 14 June 2020 **(6)**	Appointed 13 December 2019
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd (started 1 July 2017) **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) (started 22 January 2018) **(1)**	1 July 2017 (First term)
MARTIN, LEE	Chief Operating Officer	None	Appointed 1 August 2018
MARTIN, REBECCA	Chief Medical Officer	None	Appointed 17 February 2020
OLLIS, JANE	Non Executive Director	The Heating Hub (started 8 May 2017) **(1)** Board Member of the Kent Surrey Sussex Academic Health Science Network (AHSN) (started 1 July 2018) **(1)** Director of MindSpire (started 30 October 2018) **(1)** Non Executive Director of Community Energy South (started 30 October 2018) **(1)** Vice President of the British Red Cross in Kent (started November 2018) **(4)** Non Executive Director of 2gether Support Solutions (started 22 May 2019) **(1)** Non Executive Director of Riding Sunbeams (started	8 May 2017 (First term)

REGISTER OF DIRECTOR INTERESTS 2020/21 FROM APRIL 2020

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
		February 2020) **(1)**	
PALMER, KEITH	Non Executive Director	Non Executive Director of 2Gether Support Solutions (started 26 May 2018) **(1)** **Closed interests** Non Executive Director of Spencer Private Hospitals (started 8 December 2017/finished 31 March 2020) **(1)**	1 January 2017 (First term)
REYNOLDS, SEAN	Non Executive Director	Chair of Spencer Private Hospitals (started 13 May 2019) **(1)** **Closed interest** Trustee of Building Heroes **(1)** (finished 13 September 2019)	20 August 2018 (First term)
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	None	Appointed January 2004
SMITH, STEPHEN	Chair	Stephen Smith Ltd (started 27 March 2003) **(1)** Non Executive Director of NetScientific Plc (started 17 February 2016) **(1)** Trustee of Pancreatic Cancer UK (started 16 August 2016) **(1)** Trustee of Epilepsy Society UK (started 27 November 2018) **(4)** Chairman of Signum Health Ltd (started 17 April 2019) **(1)** Senior Advisor of Ministry of Health Saudi Arabia **(4)** (started 23 September 2019) **Closed interests** Non Executive Director of uMed Ltd (started 1 March 2018/finished 1 March 2019) **(1)**	1 March 2018

REGISTER OF DIRECTOR INTERESTS 2020/21 FROM APRIL 2020

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
		Non Executive Director of Draper and Dash (started 27 November 2018/finished 14 October 2019) **(1)** Chairman of Biotechspert Ltd (started 4 September 2017/finished 7 February 2020) **(1)** Chair of Scientific Advisory Board (started 1 March 2018) **(4)**	
WILDING, BARRY	Senior Independent Director	Trustee of CXK, a Charity in Ashford inspiring people to thrive (started 16 May 2018) **(4 & 5)**	11 May 2015 (Second term)

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

The Trust has a number of subsidiaries and has nominated individuals as their Directors in line with the subsidiary and associated companies articles of association and shareholder agreements

2gether Support Solutions Limited:
Keith Palmer Non-Executive Director in common
Jane Ollis Non-Executive Director in common
Alison Fox Nominated Company Secretary

Spencer Private Hospitals:
Sean Reynolds Chair
Nic Goodger Nominated Director
Heather Munro Nominated Director
Alison Fox Nominated Company Secretary

Healthex Limited:
Elisa Llewellyn Nominated Director
Bernard Pope Nominated Director
Alison Fox Nominated Company Secretary

Beautiful Information Limited:
Philip Cave, Nominated Director
Paul Stevens, Nominated Director
Alison Fox, Nominated Company Secretary

REGISTER OF DIRECTOR INTERESTS 2020/21 FROM APRIL 2020

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 ONE-HUNDRETH MEETING OF THE BOARD OF DIRECTORS THURSDAY 12 MARCH 2020 AT 9.45 AM BOARD ROOM, WILLIAM HARVEY HOSPITAL, ASHFORD

PRESENT:

Professor S Smith	Chair	StS
Ms S Acott	Chief Executive Officer	SAc
Mr S Adeusi	Non-Executive Director	SA
Mrs A Ashman	Director of Human Resources	AA
Mr P Cave	Director of Finance and Performance	PC
Mrs W Cookson	Non-Executive Director	WC
Mr N Mansley	Non-Executive Director	NM
Mrs J Ollis	Non-Executive Director	JO
Mr K Palmer	Non-Executive Director	KP
Ms L Shutler	Director of Strategic Development and Capital Planning/ Deputy Chief Executive	LS
Mr B Wilding	Non-Executive Director	BW

ATTENDEES:

Professor C Holland	Associate Non-Executive Director	CH

IN ATTENDANCE:

Miss A Bedford	Governor and Membership Lead	AB
Dr D Holden	Independent Chair – Learning and Review Committee (LRC)	DH
Miss S Hayward-Browne	Executive Director Office Manager & Committee Secretary (Minutes)	SH-B

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs J Chittenden – Governor
Professor J East – Governor
Miss E Hargreaves - Public
Miss V Morgan - Public
Mr J Ransley - Public
Mr K Rogers – Governor
Mr P Schofield- Governor
Mr B Thew - Public

MINUTE NO.		ACTION
19/161	**CHAIRMAN'S WELCOME** The Chair welcomed attendees to the meeting. He also welcomed two new Board members: Rebecca Martin who was recently appointed to the role of Chief Medical Officer; and Professor Chris Holland appointed as the Associate Non-Executive Director who is a non-voting member on the Board.	
19/162	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Mrs A Fox (AF), Group Company Secretary; Miss A Hallums (AH), Chief Nurse & Director of Patient Experience and Quality; Mr L Martin (LM), Chief Operating Officer; Mr S Reynolds (SRe), Non-Executive Director; and Mrs N Yost (NY), Director of Communications and	

Engagement.

19/163 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

19/164 **MINUTES OF THE PREVIOUS MEETING HELD ON 13 FEBRUARY 2020**

DECISION: The Board **APPROVED** the minutes of the previous meeting held on 13 February 2020 as an accurate record.

19/165 **MATTERS ARISING FROM THE MINUTES ON 13 FEBRUARY 2020**

ACTIONS B/043/19 AND B/044/19 – FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT: 6 FACET SURVEY AND ESTATE CONDITION
LS reported the 6 facet survey would be completed by the end of March 2020, this would provide clarity in relation to the risk score regarding risk SRR4: Estate Condition and identify the issues to be addressed. This risk would be reviewed in on completion of this survey in relation to the risk scores, actions to be taken forward and the risk register updated as appropriate.

ACTION B/046/19 – CHIEF EXECUTIVE'S REPORT: PERINATAL DEATHS
SAc confirmed an independent review would be undertaken by Bill Kirkup into the East Kent Maternity Services, which would include a review of perinatal deaths to identify any potential avoidable deaths.

DECISION: The Board discussed and noted the updates and **APPROVED** the action for closure.

19/166 **CHAIR'S REPORT**

The Chair summarised items detailed in the report, which included an update regarding maternity services that would also be covered within the Chief Executive's report. He confirmed a separate report had been presented to the Board and a presentation would be received from the Independent Chair of the internal Learning and Review Committee regarding progress and actions of the individual workstreams in relation to the maternity improvement programme.

The Chair highlighted as part of the Well Led review a 2019/20 Board skills, experience and competency review had been undertaken. This had identified the Board would benefit from the provision of a Chief Information Officer or Clinical Information Officer, which would be considered and discussed around how this could be taken forward.

The Chair reported the Annual Joint Council of Governors (CoG) meeting with the Non-Executive Directors had been held that Monday, discussions included the Lead Governor role description that was appended to the report for Board approval. There was also discussion and agreement to introduce a Deputy Lead Governor role also requiring approval by the Board. He highlighted the new Governors both staff and public welcomed to Council as of 1 March as detailed in the report. He stated Sarah Andrews, the Lead Governor, term of office finished later that month and extended his thanks to Sarah for her hard work, commitment, skills, experience

and support to the Trust over many years since she had been in post as a Governor and Lead Governor. A replacement Public Governor had been appointed and would take up post once Sarah stepped down. Discussions had been held with CoG providing updates regarding maternity services and preparations and response to COVID-19.

WC queried the point within the person specification for the Lead Governor regarding 'To show integrity in accordance with the Nolan Principles'. She emphasised there were seven Nolan Principles and all of these principles needed to be adhered to, which was agreed by the Board agreed.

DECISION: The Board discussed and noted the Chair's report and **APPROVED**:

- The Lead Governor role description;
- The introduction of the role of Deputy Lead Governor.

19/167 **CHIEF EXECUTIVE'S REPORT**

SAc reported she had recently met with Roger Gough, the new leader of Kent County Council (KCC) maintaining the close working relationships with the Trust and KCC and also the local Borough Council. Discussions related to a number of pertinent health issues including maternity, stroke services and the developing situation regarding the Coronavirus.

SAc stated in response to the potential increase of patients due to Coronavirus the Trust was working with colleagues in Kent as part of the national NHS planning process in respect of management of patients with Coronavirus. The Trust was also following the national guidelines required for testing. She confirmed the Government was taking a strategic approach in dealing with this issue currently in containment phase. The Trust was taking the necessary actions in respect of this containment phase, with different actions and responsibilities required as and when movement to delayed phase. The Trust had a process in place in relation to testing, with support from Public Health England (PHE) in relation to those tested positive and tracing their movements. External isolation PODS had been installed outside the Accident and Emergency Departments (A&E) for patients to wait for swabbing to ensure they did not enter the main hospital. She explained that as numbers increased and to ensure a quicker process, as implemented in London there would be the provision of drive-in testing to book testing sessions. All patients tested positive and were unwell were being transferred to the National isolation units. Personal Protective Equipment (PPE) was provided to all staff coming into contact and caring for suspected and positive patients, PPE training for staff was also being increased. With regards to preparations and capacity the Trust had in place business continuity plans and these would be revised as necessary against national learning and requirements in line with the regular teleconferences and feedback with the Centre.

SA asked what action was being taken to ensure the appropriate provision of medical, consumables and PPE supplies in respect of the management of the Coronavirus and the potential risks with the disruption of supplies. SAc reported Nationally the NHS was very robust and organised in relation to its co-ordination with regards to securing provisions with its supply chain. Also locally the Trust was in a good position following preparations in managing EU Exit in relation to

management of issues with stock and supplies. All organisations would co-ordinate and work together. The NHS was working to flatten the peak as we moved into the Summer period with the anticipation that there was not a significantly large peak.

JO raised concern regarding staff, who could become unwell are unable to come to work and what was being done to ensure staff remained well whilst managing the current pressures. AA responded that discussions had already commenced regarding staffing resources as part of the Kent & Medway Sustainability and Transformation Partnership with local trusts and providers, with local passport arrangements in place to allow staff to work across the local NHS organisations, as well as supporting nursing and care homes. The Trust would support staff to be able to self isolate if needed and to enable staff to be fast tracked for testing to be able to return to work. SAc stated the centralised laboratory for testing was in Collingdale and if they became unable to meet demand the Trust's laboratories would be able to support testing in a couple of weeks. This would help the prompt testing of clinical front line staff and nursing and care homes staff. As well as enabling those staff that were able to for them to work from home. Along with other methods ensuring oversight of patients, e.g. within outpatients implementing telephone appointments so that patients did not have to visit the hospital.

SAc reported the Trust had been successful in securing capital funding of £14m for the centralisation of Elective Orthopaedics with the provision of four new operating theatres at Kent & Canterbury Hospital (K&CH) specifically for orthopaedics.

SAc highlighted the new Harmonia (Dementia) Village behind the Buckland Hospital in Dover that was due to open shortly. The Trust had now received Care Quality Commission registration.

SAc commented in respect of the stroke services review the High Court had rejected the judicial review and ruled in favour of the development of three new hyper-acute stroke units in Kent. These units would be at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital. A time-line for the implementation of these units was being developed. She highlighted this was predominately around the focus of staff resources and the centralisation of specialist stroke staff both medical and rehabilitation services, as well as expanding scanning capacity.

It was noted the Trust continued to develop its 'We Care' improvement programme, including developing the key areas of focus and identifying the organisation's 'True North' objectives. The aim of this programme was to improve services, deliver better, safer care and engage more with the community.

The T3 programme continued to be progressed. This was a major change programme introducing electronic prescribing and paperless health records to the Trust. This electronic patient record system from Allscripts was expected to be implemented following the Easter bank holiday. This would allow staff to order tests and review results electronically. As well as enabling multiple professional users to access and view patient records, speed up the management, treatment and oversight of patients, whilst avoiding the risk of systematic error and robust audit arrangements.

SAc had visited staff within the Women's and Children's Care Group departments across all of the hospital sites receiving positive feedback regarding training and the

friendly and team-orientated culture. She highlighted the recent move of the children's Padua ward into a refurbished and much improved environment, along with the launch of digital development of a paediatric version of Care Flow especially for children, in respect of oversight of patients and monitoring vital signs.

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

19/168 **MATERNITY SUPPORT PROGRAMME – LEARNING AND REVIEW COMMITTEE (LRC)**

SAc introduced Dr Des Holden, the Independent Chair of the LRC who had produced the initial report presented to the Board. This provided the Board and the regulators with assurance around transparency and openness that this internal review was being externally chaired and led by an independent community representative. As well as providing assurance that the actions being taken and implemented around learning were being embedded, appropriately prioritised and actioned to improve maternity services. As well as monitoring progress of the required culture changes.

DH provided a background regarding his professional and clinical experience, confirming that two LRC meetings had been held with seven workstreams reporting to the Committee, with good attendance and senior representation. He had amended the Terms of Reference (ToR) to include the Freedom to Speak Up Guardians as members of the LRC. He had met with the individual workstream leads, with the exception of the data workstream, and was confident and assured of their commitment that actions were being taken seriously and implemented. As well as identifying and raising any issues where things were not working. This would support implementation of the actions. He explained the aim of the LRC in relation to reviewing the Trust's response and whether it had implemented the recommendations from previous historic reports issued. Assist with assuring the Board that the recommendations from HM Coroner (HMC) in relation to the death of baby Harry Richford were being implemented and the evidence to support this. There were also a number of workstreams in respect of the improvement and sustainability programme that would also need to be aligned. The LRC would also assess whether the Birthing Excellence: Success Through Teamwork (BESTT) improvement programme addressed these past and current action plans. The LRC would identify the information to assure the Board that the Trust's maternity and neonatal services were safe, well led and sustainable.

DH reported the second meeting of the LRC focussed mainly on the HMC's recommendations, some of which were National and some actions had already been implemented and completed. It was noted the actions in relation to how the Trust employed locums was not yet complete but was assured that these were being taken forward and were being appropriately prioritised with creative thinking outside the box around how issues could be dealt with. This was in respect of supporting and engaging with locums whilst encouraging them to want to return to work for the Trust. Updates were provided from all the workstreams. He commented that the work of the Coroner's recommendations workstream would lead the LRC in alignment with the work of the other workstreams enabling the improvement in maternity services and that these were sustainable.

DH commented that he had not yet met with the lead of the data workstream. He suggested an area to be reviewed in relation to new metrics with regards to the Trust's multi-site hospitals and the closure of a site to admissions due to capacity issues. To review the outcomes for these mothers that had had to travel to provide assurance in respect of deviations from their birth plan, that robust plans were in place with appropriate patient clinical outcomes or whether changes needed to be

made to the capacity plan.

JO raised a question whether there was sufficient engagement, openness, determination and commitment from the clinicians to support and embed the improvement programme. DH assured the Board of this commitment from the worksteam clinical leads who were fully engaged and appreciative of being given protected time to undertake this work.

SA enquired how the Board and Trust could be assured that learning was being embedded with good patient clinical outcomes. DH suggested implementing in consultation with staff a model of values and behaviours that all staff were required to work to. Having these in place set the culture of the organisation and staff not adhering to these and presenting poor values and behaviour would be challenged and not tolerated.

In response to a question raised by the Chair regarding whether patients had been invited to join the LRC; DH confirmed that an invitation had been extended but at this sensitive time were unable to commit to be part of the Committee. It was noted that representatives from the Maternity Voices Partnership and Healthwatch were members of the LRC.

DH would be happy to have a discussion and engage with Dr Bill Kirkup who would be undertaking the Independent Review.

DH requested feedback from the Board regarding the frequency of progress reports to be presented and whether these should be monthly and the timescales and completion of the work of the LRC. WC commented whether advice could be sought from Dr Kirkup. SAc emphasised there were areas that were time critical where actions needed to be implemented at pace, such as the Coroner's recommendations. As well as reviewing the BESTT programme, its delivery and that this was being implemented appropriately. The LRC would provide assurance to the Board around the sustainability of the improvements and that the Trust's transformation programme was moving in the right direction and being delivered. She anticipated at the end of April the LRC would be in a position to provide an assessment of the work of the individual workstreams and their progress in respect of implementing and embedding actions.

DECISION: The Board discussed and noted the initial report from the Learning and Review Committee (Maternity) and **AGREED** monthly progress reports would be presented to the Board up to May 2020.

19/169 **QUALITY COMMITTEE (QC) – CHAIR REPORT**

- **MODERN SLAVERY STATEMENT**

WC reported the QC recommended for approval by the Board the Modern Slavery Statement. She confirmed assurance reports had been received on two of the maternity safety actions as detailed in the report, and would be liaising with DH with regards to how these aligned with the work of the LRC and the maternity improvements.

WC highlighted the Trust was performing well in respect of the key quality and safety metrics, namely pressure ulcers, falls and harm free care, particularly given the operational pressures through January 2020. It was important that this

improved performance was maintained. She emphasised that concern remained regarding medicines management and assurance was requested that actions were being progressed, the Committee would receive a report for focussed discussion at its next meeting. It was noted that crude mortality had breached the upper control limit, this metric needed to be reviewed over a longer time period and the Chief Medical Officer would review how this metric was reported and data contextualised going forward. RM stated that mortality information was processed using different national platforms and explained why the Trust showed differing metrics. The Trust would be reviewing the platform used against the CQC data processed using the Dr Foster system to enable the Trust understood these differences and addressed as appropriate. The Trust would be moving to use Dr Foster and for a short period there would be dual reporting. It was noted that all data was benchmarked.

WC reported the QC reviewed and discussed the principal mitigated risks, concerns remained regarding the lack of timely progress updates on risks. It was requested that a deep dive on risk CRR78: Risk of overcrowding in the Emergency Department (ED) compromising patient safety and patient experience be undertaken, and a report to be presented to the next Committee meeting as this risk was outside of the Trust's risk appetite.

NM raised point 3.7 in the report regarding the audit of WHO checklist data that had not been available for December and January, emphasising that this was a vital tool and metric in assessing quality. WC reiterated the QC had emphasised this was unacceptable and provided assurance that the Committee had requested this metric be reported at the next Committee meeting. She highlighted this was a vital metric that was required to be recorded and reported.

The Board noted that a senior representative from NHS Improvement (NHSI) providing oversight of the Trust had been in attendance at the March 2020 QC meeting and contributed to the discussions. This was welcomed by the Committee and the Trust and their advice and assurance proved very supportive and beneficial.

DECISION: The Board discussed and noted the QC Chair report and **APPROVED** the Modern Slavery Statement.

19/170 **CARE QUALITY COMMISSION (CQC) UPDATE**

RM stated the report presented provided an update in respect of engagement with the CQC and progress against the improvement action plans over the last month.

RM highlighted the planned engagement visit to the Trust's maternity services in January 2020 followed by unannounced inspections at the end of January and beginning of February. The CQC feedback from these inspections included how positively the staff engaged with the inspectors as well as staff being welcoming, open and honest. Data requests were received following the inspections for approximately 120 items and the information had been submitted. The CQC had advised the inspection approach in future would be more focussed, rather than bigger inspections of multiple core services.

RM confirmed the Trust had submitted all the required information in relation to the formal CQC Routine Provider Information Request (RPIR).

RM reported in respect of progress against the CQC improvement plans and against the total of 82 actions, 93% of these were complete, six actions were incomplete of which two were not yet due for completion and four that were overdue had mitigating actions in place. Progress against the paediatric improvement plan with 97% of actions complete, a total of 116 actions of which four were overdue with mitigating actions in place and work continued to complete and close these actions. RM advised that all actions were given a required completion date, with mitigating actions if not achieved. The Trust was focussed on ensuring the Must Do recommendations were implemented but due to the complexity around completing some actions a staged implementation plan was required with mitigating actions until these were in a position to be completed.

NM raised concern regarding the actions that were overdue and those due for completion by the end of the month and requested assurance that there was sufficient focus to ensure these were progressed and completed. WC advised progress was monitored by the QC and received assurance that work was underway to progress and achieve completion of these actions.

The Board discussed and **NOTED** the CQC update report.

19/171 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR REPORT**

- **RISK MANAGEMENT POLICY**
- **RISK MANAGEMENT STRATEGY 2020-22**
- **STANDING FINANCIAL INSTRUCTIONS (SFIS)**
- **BOARD ASSURANCE FRAMEWORK (BAF): PERFORMANCE AGAINST ANNUAL OBJECTIVES 2019/20**
- **TERMS OF REFERENCE (TOR)**

BW confirmed the items recommended by IAGC for approval by the Board, which included:

- Risk Management Policy;
- Risk Management Strategy 2020-22;
- SFIs;
- BAF: Performance against annual objectives 2019/20 quarter 3 report;
- ToR.

WC raised concern regarding the gaps in relation to updates within the progress notes in the BAF report. BW explained that the report appended covered the quarter 3 period and was not the current position as an updated version would be received by the IAGC at its next meeting covering the quarter 4 period.

BW stated following the annual review of the Risk Management Policy and SFIs these had been appropriately revised with only minor changes (as highlighted in the appendices). The Risk Management Strategy for 2020-22 had been developed to support the Risk Management Policy.

DECISION: The Board discussed the IAGC Chair report and **APPROVED**:

- the Board Assurance Framework (BAF) and Annual Objectives 2019/20 Quarter 3 report;
- the Risk Management Policy;
- the Risk Management Strategy 2020-22;
- the SFIs;
- the IAGC ToR.

19/174 **CORPORATE REPORTING:**

19/174.1 **INTEGRATED PERFORMANCE REPORT (IPR)**

SAc highlighted the key elements as noted below:

- A&E performance continued to remain under pressure as a result of winter pressures;
- Waiting lists backlog had been reduced with continued focus on prioritising and managing elective activity, particularly for ophthalmology that had seen a sustained reduction its in waiting lists backlog and anticipated to achieve the NHSI trajectory by the end of March;
- Improvement actions in place to reduce the four 52 week wait patients, these were complex and required treatment at other trusts and was working closely to progress the pathways for these patients and reduce their waits;
- Good performance against the cancer targets across the County, with positive collaboration from the tumour site lead clinicians across all the trusts working together to develop appropriate patient cancer pathways;
- Overperformance against the diagnostic standard;
- Positive metrics reported regarding patient experience and patient safety, particularly in relation to patient harm that continued to be reported as green with required focus to continue monitoring patient safety.

PC reported on the financial position for month 10, confirming the finance report had been reviewed in detail by the Finance and Performance Committee (FPC) the previous week. The Trust as a Group with its subsidiaries remained on target against its planned year end forecast of a consolidated deficit of £37.5m excluding technical adjustments. The challenging Cost Improvement Programme (CIP) target of £30m that was expected to be achieved at year-end. There had been overspends within two Care Groups, Women and Children's (W&C) and Urgent and Emergency Care (UEC), sufficient contingency had been factored into the annual plan supported by underspends within corporate budgets enabling overall management of the financial plan. Financial and operational performance was reviewed in detail and monitored at the Executive Performance Reviews (EPRs) with Care Groups challenged and escalation as and when required to the FPC. He highlighted the main financial pressure related to agency staff expenditure, confirming that this had been reduced significantly by £7m against the original expenditure of £30m but required further reduction and focus would continue. Pressures in year related to EU Exit planning and winter pressures. The Trust was submitting to NHSI a plan with details regarding additional costs and pressures associated with management of the Coronavirus in relation to additional support requirements in line with NHS emergency planning.

KP commented on the Trust's positive financial position highlighting the good news provided within the report and the robust annual planning.

AA highlighted progress in respect of the workforce and reducing agency costs with transferring doctors on to the direct engagement model resulting in increased fill rate on the staff bank with reduced costs as these were lower than agency. There had also been a reduction in the Trust's vacancy rate.

BW queried the impact over the next couple of months with regards to staff resources if some staff were unable to work due to Coronavirus. AA commented that it was unknown at the present the potential impact and the Trust was working with agencies in respect of future staffing support. She highlighted this would reflect a change in the metrics and enhanced reporting procedures were being introduced to record and report absences related to staff sickness and staff in isolation with Coronavirus to enable tracking metric changes.

NM raised the issue regarding the number of Delayed Transfers of Care (DTOC) and whether this would be negatively impacted as a result of Coronavirus in relation to limited capacity in the community to enable patients to be discharged from hospital. There was also the risk of this impacting patient flow through the hospital and what actions were in place to mitigate this. SAc reported the Trust continued to work with its NHS partners to progress the plans in place around sufficient staffing capacity in the community to support patients discharged from hospital, which was currently approximately 50 patients. Nursing homes had some capacity and discussions were on-going with Social Care regarding funding requirements. Contingency plans had been in place in respect of EU Exit planning in relation to operational issues for each of the hospitals that would be utilised in respect of management of Coronavirus.

CH queried how learning and development was being embedded throughout the organisation along with promoting the expected values and behaviours of staff. He congratulated the Trust with implementing the staff direct engagement model. AA confirmed this was in place with the RESPECT programme in relation to the values of the organisation cascaded to Care Groups. This supported the We Care programme around cultural change in alignment with the leadership workstream.

The Board discussed and **NOTED** the IPR report.

19/174.2 **FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**

SAc reported with regards to the Strategic Risk Register (SRR), there had been no changes to residual or target risk scores, no risks for closure and no new risks had been added. She confirmed that a new risk would be added in respect of Coronavirus and the risks presented currently to the Trust.

SAc advised the process for adding new risks was somewhat lengthy and the Group Company Secretary was looking at this to ensure new risks could be added promptly going forward. New risks added to the Corporate Risk Register would then be retrospectively calibrated to ensure they had been correctly risk scored.

WC raised the continuing issue regarding the lack of timely progress updates on risks, particularly with regards to SRR5: Failure to achieve financial plans as agreed by NHSI/E under the Financial Special Measures regime. She highlighted the first and second action points noting movement in the dates and no explanation

had been provided on the reasons for this, evidence was required before these could be agreed for closure. BW advised that the IAGC had raised concern regarding the lack of timely progress updates at its previous meeting and requested assurance that robust processes were in place to ensure this and if not the reasons for this. He emphasised that risk scores should also be changed in light of actions taken. Feedback would be provided to the Board as part of the next IAGC Chair report.

The Board discussed and **NOTED** the Risks report.

19/175 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR REPORT**

- **MONTH 10 FINANCE REPORT**

NM congratulated the Finance team and the Executive Directors for their robust and accurate budget planning as well as their continued support to ensure finances remained within the plan. Progress had already commenced in respect of the 2020/21 business planning process, he highlighted the major challenge area would be achievement of CIPs against the current target of £25m. CIP schemes were already being identified and worked up. Other challenges included reducing agency spend. SA questioned whether additional external support was required to assist the Trust with its CIP planning to enable it achieved this target, which PC agreed to review.

NM commented that a potential shortfall against the current year's £30m annual CIPs target with around £29.1m achieved at year-end, this would be balanced by the planned contingency and corporate underspends. This would not impact on the planned end of year deficit reported to NHSI at the beginning of this financial year and commended all Trust staff for their hard work and continued support in achieving this.

NM stated an update was received regarding the National Cost Collection (NCC) for 2018/19. This showed that the Trust was performing well against benchmarked trusts, performed better than the National average, was 2% more efficient but remained in FSM. He emphasised that focus on financial efficiency in no way had a negative impact on patient care and safety. PC reported it had been regularly fedback to the centre the Trust's Market Forces Factor (MFF) allocation was inadequate. He stated that discussions were taking place regarding how the Trust could exit FSM.

JO queried how the Board could support the provision of protected time particularly for front line staff to allow them to commit allocated time to work on the Trust's improvement programmes, e.g. Quality Improvement Programme. PC responded this had been incorporated within next year's business planning process with Care Groups, who had been requested to feedback what additional support they required for their staff in respect of performance to deliver quality and activity. The Executive Team in discussion with Care Groups would discuss and agree the priorities to be presented for consideration and approval by the Board, noting it was not possible to cover all items put forward. SAc commented this was an important area for consideration going forward in respect of providing allocated protected time for front line staff supporting them with regards to education, learning and development. The Board agreed the benefits of this for staff and the organisation and consideration of this invest to save initiative in the future

DECISION: The Board discussed and **APPROVED** the FPC Chair report.

19/176 **STRATEGIC WORKFORCE COMMITTEE (SWC) – CHAIR REPORT**

JO highlighted key points that included:

- Positive trend in the reduction of staff turnover, particularly with nurses and the many initiatives in place across the organisation to support nurses. The main challenge was around Healthcare Assistants (HCAs) and the early leavers rate of 60% of HCAs that leave within their first year. The Trust had investigated the reasons for this and what more could be done to retain and support these staff;
- Concern raised regarding the level of sickness absence that showed an upward trend, this had been analysed indicating the Trust was not an outlier. The HR Business Partners were aware of the hot spot areas for targeted focus to support staff;
- Staff survey results, good response rate and outcome, acknowledging and celebrating the positive improvements but recognising there still remained more improvement work to be done. An area of focus for improvement was communication and engagement between senior managers and staff, as well as ensuring staff felt more empowered;
- New starters averaged 300 per month.

DECISION: The Board discussed and **APPROVED** the SWC Chair report.

19/177 **ANNUAL OBJECTIVES: A GREAT PLACE TO WORK AND RIGHT SKILLS, RIGHT TIME, RIGHT PLACE 2019/20 PERFORMANCE AGAINST PRIORITIES**

AA reported the 'A Great Place to Work' objective was around feedback from the staff survey and all staff respecting each other and delivering service excellence. This included focussed work with the Care Groups in reviewing and taking forward the on-going action plan produced following the results of the survey. This was in respect of addressing the individual target areas within each Care Group with support provided by the HR Business Partners and Care Group triumvirates. The Trust recognised the importance of listening to staff and had introduced the RESPECT Café initiative along with RESPECT workshops. Work was also underway to improve the consistency with performance of completion of appraisals ensuring these were meaningful to staff, incorporated personal and career development focussing on better quality of patient care. She confirmed there had been improvements against all measures of bullying and harassment in this year's staff survey, with fewer reported incidents and staff felt confident to report such behaviours when they occurred.

AA highlighted staff retention and the continued steady improved position in respect of voluntary turnover that was now less than 12%. The Trust had taken action as a result of feedback from the staff survey in relation to improving staff areas, infrastructure and the hospital environment. Capital funding had been utilised and building improvement works carried out that had had a positive impact on staff morale.

AA emphasised the apprenticeship programme and the collaborative work with

schools, colleges and universities publicising this programme to attract staff who might not had traditionally considered a role in the NHS. She acknowledged the hard work of the HR team that had been recognised externally as the Trust had recently won the South East Public Sector Employer of the Year award for apprenticeships. Apprentices had reported positive feedback on their experience and were being fully supported by colleagues throughout the Trust.

AA commented on the 'Healthy Place to Work' objective and the initiatives in place as detailed in the report to improve the health and well-being of staff with positive results and feedback. A new Employee Assistance programme would be introduced the following month providing 24/7 cover for employees with additional support for mental, physical, counselling and a proactive occupational health well-being service. Noting there was still more areas that required focussed work.

The Board discussed and **NOTED** the Annual Objectives Performance Against Priorities report.

19/178 **HEALTH AND SAFETY (H&S) AND ESTATES STATUTORY COMPLIANCE REPORT**

LS reported good progress had been made in respect of H&S working closely with Care Groups to improve their compliance and performance against the Health and Safety Toolkit Audits (HASTA). Another area of improvement included Control of Substances Hazardous to Health (COSHH) that had been raised by the CQC and action taken was around increasing the provision of training with a significantly improved compliance position. There would be a continued focus on H&S as this remained an on-going issue with varying performance across the Care Groups. The W&C Care Group presented at the recent meeting of the IAGC explaining the improvement work they had implemented. Each Care Group now had in place a H&S Representative who was supporting embedding the importance of H&S and focussed work to sustain the improved compliance.

LS stated with regards to statutory compliance there had been a slight dip in compliance that was mainly due to documentation and 2gether Support Solutions (2gether) had introduced a centralised system resulting in an improvement. Funding of £800k had been allocated to address statutory compliance and these works were ongoing. The Trust had also been successful in receiving additional funding of £5m for the completion of fire related projects that would result in further improvements.

LS commented on completion of the 6 facet survey, this would clearly identify the areas of risk and the required prioritised programme of work for the next year. This survey and the risks identified in respect of backlog maintenance and statutory compliance would likely result in changes to the risks on the Trust's risk register.

The Board noted the report appended from the Trust's Internal Auditors detailing the outcome of their audit on H&S compliance and the improvements highlighted.

LS emphasised the success of the H&S team and the further work with Care Groups and staff embedding H&S and focus on culture and the importance of H&S would strengthen compliance and continue to ensure improvements were achieved.

The Board discussed and **NOTED** the H&S and Estates Statutory Compliance Report.

19/179 **ANY OTHER BUSINESS**

There were no other items of business raised for discussion.

19/180 **QUESTIONS FROM THE PUBLIC**

Mr Rogers requested that every effort was made to ensure that the risk register was as up to date and accurate as possible to ensure the Governors and the public were aware of the current position with regards to risks. The Chair commented on the discussions at the recent Council of Governors (CoG) meetings in respect of the relationship and interaction between Governors and Board Committees with regards to oversight. As well as communications and discussions regarding data and key documents, i.e. IPR, risk register. Noting there would be further discussions on how this would be taken forward.

Ms Chittenden visited the Queen Elizabeth the Queen Mother Hospital the previous day highlighting the lack of signage directing people to access the Coronavirus POD adjacent to the A&E department. She also raised concern that part of the disabled car park had been reduced for the provision of this POD, noting disabled car parking bays were already very limited with no concessions in the main visitor parking area. She commented there had been no one available at the POD and someone wishing to access this had been given conflicting confusing advice to telephone a number and when called were then told to call 111. LS reported following discussions the previous day there would be an immediate major signage rollout in line with the National signage guidance that would be clearly visible. As well as signage promoting the use of hand gels. LS would ensure discussions with the car parking attendants in relation to blue badge holders unable to park in the disabled bays and flexibility and allowance be given for disabled parking in the visitor car parks. It was noted that the current guidance was for those with potential Coronavirus to call 111.

The Chair extended thanks to all the Trust staff for their continued support and hard work during this unprecedented time in managing the Coronavirus appreciating the current pressures particularly for those on the front line.

The Chair closed the meeting at 12.20 pm.

Date of next meeting in public: Thursday 16 April 2020 in the Board Room, William Harvey Hospital, Ashford.

Signature _____

Date _____

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**16 APRIL 2020**
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 12 MARCH 2020**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: PUBLIC BoD ACTION LOG**

BACKGROUND AND EXECUTIVE SUMMARY

An open action log is maintained of all actions arising or pending from each of the previous meetings of the BoDs. This is to ensure actions are followed through and implemented within the agreed timescales.

The Board is required to be updated on progress of open actions and to approve the closing of implemented actions.

The Board is asked to consider and note the updates on the actions appended.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Board may lose sight of progress of key actions if the action list is not properly updated and maintained. The Trust Secretariat ensures there is an efficient process for maintaining the action list.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None

East Kent Hospitals University NHS Foundation Trust

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the progress updates on open actions.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - PUBLIC BOARD								
Action No.	**Date of Meeting**	**Min No.**	**Item**	**Action**	**Target date**	**Action owner**	**Status**	**Progress Note (to include the date of the meeting the action was closed)**
B/043/19	12.12.19	19/138.2	Full Corporte/Highest Mitigated Strategic Risks Report	Confirm the date for completion of the 6 facet survey to enable this risk to be recalibrated and have a discussion with SAc regarding what further actions could be undertaken to mitigate this risk.	~~Mar-20/ Apr-20~~ May-20	LS	Open	Survey due for completion in March 2020 and on completion survey results will be evaluated and risk appropriately recalibrated. **Action for future Board meeting.**
B/044/19	12.12.19	19/138.2	Full Corporte/Highest Mitigated Strategic Risks Report	Ensure the risk SRR4: Estate condition was recalibrated on completion of the 6 facet survey against the outcome.	~~Mar-20/ Apr-20~~ May-20	AH	Open	Survey due for completion in March 2020 and on completion survey results will be evaluated and risk appropriately recalibrated. **Action for future Board meeting.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**16 APRIL 2020**
REPORT TITLE:	**CHAIR'S REPORT**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Introduction

The purpose of this report is to:

- Report any decisions taken by the Board of Directors outside of its meeting cycle;
- Update the Board on the activities of the Council of Governors; and
- To bring any other significant items of note to the Board's attention.

Key Events:

1. COVID-19

1.1 Given the understandable concern about COVID-19, the Trust is ensuring regular updates are provided on the home page of the Trust's website. To reassure patients and members of the public, the Trust continues caring for patients with COVID-19 with the right infection prevention and control measures in place.

1.2 Thank you to all the Trust's staff as always during these unprecedented times for their continued hard work, support and dedication, also thanks to everyone involved in testing and caring for patients in a calm, professional and compassionate way keeping our services running.

2. Board Virtual Decision

2.1 The Board meet virtually and approved the move of Stroke Services. This was in response to managing the COVID-19 pandemic to create capacity in the acute hospital space. This is around managing acutely unwell patients who are COVID-19 positive on acute hospital sites to temporarily relocate to a less acute site. The temporary relocation was approved of stroke services from Queen Elizabeth the Queen Mother Hospital (QEQMH) and William Harvey Hospital (WHH) to be based at the Kent & Canterbury Hospital (K&CH) site. This will be reviewed following a four month period and as part of the wider pandemic response.

2.2 This proposal was discussed with local acute trusts, NHS England (NHSE), specialist commissioning and the Kent & Medway commissioning Stroke team.

3. Nominations and Remuneration Committee (NRC) Virtual Decision

3.1 The NRC approved virtually the proposal from its subsidiary Spencer Private Hospitals (SPH) to recruit an Independent Non-Executive Director with commercial and business development experience to its Board.

4. Artificial Intelligence (AI) research

4.1 The Trust has been part of a successful bid to carry out research using AI in our hospitals. This project will provide the Trust with the capabilities to develop, test and use AIs in clinical practice. AI has the potential to revolutionise the speed and accuracy of medical diagnosis and improving patient experience and patient clinical outcomes. As well as providing evidence for the benefits of AI during MRI and ultrasound scanning, such as faster and better-quality imaging.

Non-Executive Directors' (NEDs) Commitments:

A brief outline of the Non-Executive Directors' commitments are noted below:

Chair	16 March 2020 – Use of Resources Assessment 30 March 2020 – Kent & Medway Sustainability and Transformation Partnership (K&M STP) NED Briefing Council of Governors Briefings
Non-Executive Directors	26 March 2020 – Learning and Review Committee meeting (Maternity Support Programme) Weekly Board and NED Briefings

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE	None

East Kent Hospitals University NHS Foundation Trust

CONSIDERED THIS REPORT	
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **NOTE** the Chair's report.

East Kent Hospitals University NHS Foundation Trust

Board of Directors
COVID-19 Update

16 April 2020

We care

Agenda

East Kent Hospitals University NHS Foundation Trust

- Covid Update
- Capital Programme 2019/20
- Income & Expenditure (I&E) Performance 2019/20
- Debt Write Off 2020/21
- Covid-19 Finance Update
- Workforce Update

We care

Covid-19 Response Update

NHS
East Kent Hospitals University
NHS Foundation Trust

- Response Management
  - Trust has moved to a Gold control room now supported by dedicated site teams.
  - The team consists of Medical Director, Operational Director, 2 Executives and Deputy Chief Nurse.
  - Daily phone calls for the Covid Gold team and then Executive update each evening.
  - Additionally daily health economy calls and weekly regional calls.

- Clinical Response
  - Surge plan is well advanced on all sites with ITU capacity up to circa 87 beds.
  - Estate/Clinical teams are ensuring appropriate levels of oxygen are available although emerging risk.
  - Director of Pharmacy has raised a risk relating to the supply of ITU drugs because of the international supply chain demand.
  - Teams moved to full shifts, expected 24/7 on site anaesthetist cover.
  - Patients streamed into respiratory and non-respiratory patients.
  - Stroke and Cancer services within EKHUFT have moved to create capacity for Covid-19 patients, pathways have been separated..

- Other updates (non-finance/workforce)
  - Risk register continues to pick up all Covid-19 related risks and managed weekly through the Executive Management Team (EMT).
  - Personal Protective Equipment (PPE) and stock continues to be managed on a daily basis to maintain levels of equipment for our staff. PPE added to risk register, including the risk around gowns.
  - PPE and other resources are managed by senior members of site teams and PPE guidance reviewed as national guidance released. Corporate teams have switched roles and are supporting the distribution of stock.
  - Awaiting Department of Health allocation for Ventilators .
  - Staff swabbing is increasing with a county wide plan and response. IT have created an online portal to access the onsite drive through(s).
  - Work continues to ensure appropriate staffing levels across the sites.

We care

Capital Programme 2019/20

East Kent Hospitals University NHS Foundation Trust

	Plan/ Forecast £'000	Actual spend £'000	Accruals £'000	Final Outturn £'000	Variance £'000
Medical Equipment replacement (MDG)	3,588	3,692		3,692	(104)
Backlog maintenance/ patient environment (PEIC)	2,200	2,317		2,317	(117)
IT/ Systems replacement (IDG)	1,800	1,865		1,865	(65)
Electronic Medical Record (T3 system)	1,243	2,260		2,260	(1,017)
Harmonia Village - Clinical facilities for dementia patients	2,059	1,808		1,808	251
Replacement of Gamma cameras (CT SPECT)	2,690	2,374		2,374	316
Medical equipment - prior year deferrals/ VAT reclaim	178	440		440	(262)
Additional Mortuary space QEQM	232	259		259	(27)
East Kent Transformation Programme	200	220		220	(20)
2gether equipment	865	664		664	201
Trust Offices refurbishment	400	257	85	342	58
Staff accomodation refurbishment	25	28		28	(3)
Lithotripsy machine	361	361		361	0
Donated Assets	566	550		550	16
Energy Performance Contract (Breathe)	3,347	3,523		3,523	(176)
NEEF Lighting Retrofit	1,254	1,159		1,159	95
Winter Funding - Internal works schemes	2,384	1,957	175	2,132	252
UTCs	1,049	987		987	62
Canope area - QEQM	225	0		0	225
Diagnostic equipment replacement - CT K&C/ MRI QEQM	1,792	1,784		1,784	8
Elective Orthopaedics centre (Pilot) - Build	3,175	2,005		2,005	1,170
Portakabin	500	138	387	525	(25)
Fire safety works - QEQM	1,195	734	505	1,239	(44)
Fire safety works - K&C	2,054	1,668	513	2,181	(127)
Fire safety works - WHH	968	313	597	910	58
Fire safety works - All sites	793	428	112	540	253
IT bids/ Additional schemes	515	941		941	(426)
2019/20 Total	35,658	32,732	2,374	35,106	552

- Overall programme underspend of £0.5m, but actual spend £9.2m over original £23.6m plan.
- £13m of additional Emergency capital funding from NHS Improvement/NHS England (NHSI/E) secured in Q4 2019/20 for Emergency Department (ED) Winter, Elective Orthopaedics, Fire safety and IT infrastructure.
- Shortfall against plan driven predominantly by supply chain issues due to Covid-19.
- Capital has been closely monitored/controlled by the Capital Programme Board and Strategic Investment Group (SIG) all year.

We care

I&E Performance 2019/20

East Kent Hospitals University NHS Foundation Trust

- Overall Summary Group has hit its £36.6m target (draft figures)
  - 2gether Support Solutions (2gether) has generated a surplus of £1.2m (after corporation tax).
  - Spencer Private Hospitals has generated a surplus of £0.2m (after corporation tax).

- Key Highlights
  - Finance team have collated all figures and accounts remotely.
  - The year end valuation of assets created an impairment of £11.2m which will be reflected in the accounts but is allowable against the finance target for the year. The main driver being a reduction in value to capital expenditure in 2018/19 such as the observation bays.
  - The M12 position included £2.3m of Covid-19 related costs and expenditure.
  - Full accounts now to be completed by 27 April 2020, with audited accounts due 25 June 2020.
  - Audit is now expected to be carried out remotely by Grant Thornton, there will be no quality account audit and IFRS 16 impact has been delayed one year.

- Work Still to be completed/Risks
  - Full group accounts still to be consolidated.
  - Public Dividend Capital (PDC) calculation can only be done once full balance sheet completed and could be an upside.

We care

Debt Write off

East Kent Hospitals University NHS Foundation Trust

- On 2 April 2020 Government announced the write off of NHS debt.
- We had already been informed of the draft planning guidance.
- This is the conversion of debt (Working Capital Loans) into a PDC entry on the balance sheet (shareholders equity).
- Broadly as interest is charged at 3.5% and PDC dividend is charged at 3.5% we are not expecting a material movement (circa £500k cost pressure) however, any movement will be reflected in our control total.
- In total the Trust has Loans of £133.8m, this is split:
  - Running Cost (Working Capital) Loans £124.9m at a rate of 3.5%.
  - Capital Loans £8.9m:
    - Fire Investment £4.95m at 0.79%;
    - Elective Orthopaedic Centre (EOC) £3.95m at 0.31%;
    - Salix Energy £7.7m 0.0%.

- Post conversion the following loans will still exist:
  - Running Cost (Working Capital) Loans £0m, removed;
  - Capital Loan £8.9m;
  - Salix Energy £7.7m.

We care

Finance/Governance Update

East Kent Hospitals University NHS Foundation Trust

- Financial Year (FY21) Planning
  - Planning and contracting have been suspended across the NHS for the foreseeable future.
  - Trust and subsidiaries will receive block cash payments to cover costs based on historic trend.
  - The Trust will receive two block payments in April to ensure strong cash flow to pay suppliers on time.

- Covid-19 Costs
  - All Covid-19 costs must be recorded and all reasonable costs will be covered by NHSE.
  - For FY20 the Trust has submitted a bid for £2.4m revenue support.
  - For FY21 the costs are still being assessed but are likely to be at least £2.5m per month.
  - For capital items the Trust has on order circa £4m (ex-VAT of equipment), mainly ventilators.
  - Costs are being authorised by the Executive Team and verified by the Chief Executive Officer (CEO)/Director of Finance (DoF).

- Standing Financial Instructions (SFIs)
  - The Chairman of the Trust Board, Integrated Audit and Governance Committee (IAGC) and Finance and Performance Committee (FPC) agreed to amend the SFIs to ensure the CEO/DoF can sign-off Covid-19 costs up to £2.5m of revenue and £2.5m of capital to ensure speed of decision making.
  - The costs are already encroaching £2.5m in both categories and it is suggested that the Board delegates authority to the FPC Chairman/CEO/DoF to spend above this value. Assurance will be given through a weekly update of the financial impact.

We care

Workforce Update

East Kent Hospitals University NHS Foundation Trust

- **Staff Welfare**
  - Regular ward walks across the sites by Execs for conversation/Q&A sessions
  - Free parking implemented
  - Free lunch grab bags and some hot food available for all staff
  - Employee Assistance Programme (EAP) WEF 1.4.20
  - 'Take 5 Rooms' - safe space for staff
  - Showers Available/ Rest Areas created
- **Sickness Impact**
  - Trust has amended staff roster to capture COVID related reasons for absence
  - Staff swabbing implemented and increasing
  - Daily Sit Reps required across the Trust
  - Circa 90 clinical / medical staff recorded sick, 134 medical / clinical staff self isolating
- **Recruitment**
  - National and local programme of returners via dedicated e mail to recruitment
  - Fast track recruitment for workers and volunteers in place
  - Long lines of work agreed with two agencies. Accommodation provided to draft in out of area
  - Specialist nurses and managers with clinical back ground being refresher trained and deployed to frontline.
  - **Returning Consultants / Doctors, 25 including anaesthetics, paediatrics, stroke, microbiology**
  - **38 "returners"** being processed inc Nurses, Physios, OTs and Radiographers
  - Advert responses in last 24 hours being processed (**48 general clinical applications, 20 critical care skills enquiries, 13 support staff**)
  - **HCA** virtual assessment centre **61** offers made
  - **22 Honorary contracts** being issued (Benenden)
  - Letters sent out to K&M STP partners and other identified business

We care

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**16 APRIL 2020**
REPORT TITLE:	**HIGHEST MITIGATED STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY AND PATIENT EXPERIENCE**
PAPER AUTHOR:	**RISK MANAGER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: HIGHEST MITIGATED STRATEGIC RISKS DATED 6 APRIL 2020** **APPENDIX 2: CORPORATE RISK REGISTER (RISKS OUTSIDE OF RISK APPETITE) DATED 9 APRIL 2020**

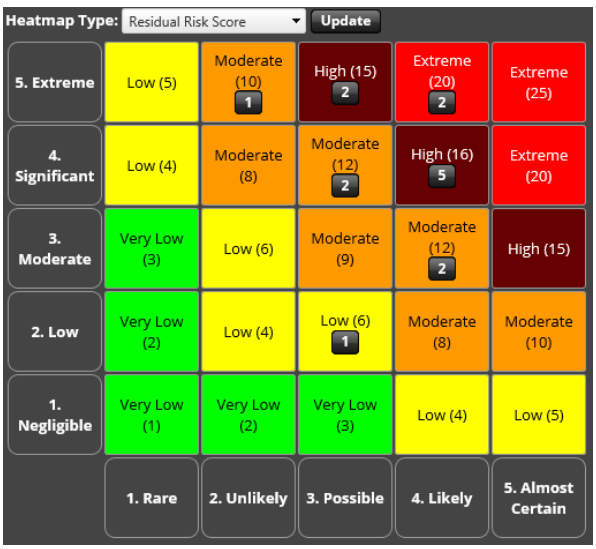
BACKGROUND AND EXECUTIVE SUMMARY

This report provides the Board of Directors with an update of the Highest Mitigated Strategic Risks. The risks rated as "high" post mitigation (residual) on the Strategic and the full Corporate Risk Register were last reviewed by the Board on 12 March 2020. The highest mitigated risks on the Strategic and Corporate Risk Registers were last reviewed by the Integrated Audit and Governance Committee (IAGC) on 25 February 2020.

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.

Current Risk Register Heat Map (by Residual risk score)

Strategic Risks (15)



Corporate Risks (24)

East Kent Hospitals University NHS Foundation Trust

Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register
Changes to residual risk scores

1 There have been no changes to residual scores in the last month. The target score for SRR 22 – Urgent Treatment Centre may not be established and may result in increased demand to the Emergency Department (ED) has been reduced from moderate (12) to moderate (9).

Risks approved for closure on the Strategic Risk Register

2 There was one risk closed due to sustained compliance with the standard. SRR 20 - The specialty may not meet the two week wait standard and be able to see the patient within 14 days due to potential unpredictable increase in the number of referrals.

New risks added to the Strategic Risk Register

3 There were no new risks added to the Strategic Risk Register.

Corporate Risk Register
Changes to residual risk scores

4 There have been no changes to residual or target risk scores in the last month.

Risks approved for closure on the Corporate Risk Register

5 There were no risks proposed for closure on the Corporate Risk Register.

New Corporate Risks added to the Corporate Risk Register

6 There were three new risks added to the Corporate Risk Register in March.

- CRR 79 – Risk to service delivery due to COVID-19 pandemic;
- CRR 80 – Risk of patient harm due to forced closure of Nuclear Medicine Imaging service at Kent & Canterbury Hospital (K&CH);
- CRR 81 – Current CT and MRI reporting backlog presents a clinical risk.

Risks outside of Trust risk appetite

7 There are three risks on the Corporate Risk Register that are outside of the Trust's risk appetite.

- CRR 68 - Risk to the delivery of the operational constitutional standards and undertakings;
- CRR 78 - Risk of overcrowding in ED compromising patient safety and patient experience;
- CRR 79 – Risk to service delivery due to COVID-19 pandemic.

Key issues for the Board of Directors attention and/or discussion

8 There are no further issues for the Board of Directors attention and/or discussion.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	As outlined in the appendix attached.
LINKS TO STRATEGIC OBJECTIVES:	The corporate and strategic risks align to all of the Strategic Objectives: • **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the Strategic Risks to the Trust and the risks on the Corporate Risk Register that sit outside the Trust's risk appetite.
RESOURCE IMPLICATIONS:	None specifically identified other than in the Risk Registers.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Clinical Executive Management Group
SUBSIDIARY IMPLICATIONS:	This paper does not have an impact on the business of any of the Trust Subsidiary Companies. The companies manage their risks separately to the Trust.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to:

1. Review the Strategic Risk Report and the Corporate Risks Report that are appended; and
2. Consider the sufficiency of the corrective actions identified in relation to the risks and provide positive challenge where necessary.

Strategic Risks Report (By Residual Risk Ranking)

Report Date	06 Apr 2020
Comparison Date	In the past 30 Day(s)

Strategic Risks 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
SRR 22	Urgent Treatment Centre may not become established and result in increased demand to ED **Risk Owner:** Lee Martin **Delegated Risk Owner:** Matthew Pomeroy **Last Updated:** 01 Apr 2020 **Latest Review Date:** 01 Apr 2020 **Latest Review By:** Matthew Pomeroy **Latest Review Comments:** Updated. Target dates updated due to delay in go live of UTC's due to Covid-19.	07 Jun 2019	**Cause** Lack of engagement between the CCG, GP colleagues and EKHUFT clinicians Lack of appropriate accommodation at the acute hospital site **Effect** Increased demand to ED Delivery of the 4 hour Emergency Access Standard Reduced workforce in ED Increased cost of service provision Increased attendance across the health economy	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 5 L = 4 Extreme (20)	A&E Delivery Board, attended by the CEO and senior Executives from whole health economy have agreed to support the development of UTC **Control Owner:** Lee Martin	Adequate	I = 5 L = 4 Extreme (20)	Pathways are being developed to maximise integration of primary and secondary care staff **Person Responsible:** Matthew Pomeroy **To be implemented by:** 29 May 2020	Not Set	**17 Mar 2020** COVID-19 pandemic is delaying the development of the pathways. Operations Director spending the majority of their role on mobilisation.	I = 3 L = 3 Moderate (9)
						Clinicians from Primary Care and EKHUFT have been meeting for over a year to build strong working relationships and a commitment to develop an integrated UTC **Control Owner:** Lee Martin	Adequate					
						ED Improvement Plan in place **Control Owner:** Lee Martin	Limited					
						Senior management support has been identified to support the project **Control Owner:** Lee Martin	Adequate					
						The project is being monitored monthly through the Local Care implementation group meetings **Control Owner:** Lee Martin	Adequate					

Strategic Risks 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
SRR 5	Failure to achieve financial plans as agreed by NHSI and E under the Financial Special Measures regime **Risk Owner:** Philip Cave **Delegated Risk Owner:** **Last Updated:** 23 Sep 2019 **Latest Review Date:** 09 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** At month 10, the Trust has a deficit of £29.3million and plans to hit the £36.5million deficit plan by year end.	20 Jan 2016	**Cause** Due to: * Failure to reduce the run rate * Poor planning * Poor recurrent CIP delivery * Political climate (EU Exit) and price inflation *Inability to secure external support for key projects *Demand from CCGs higher or lower than annual plan *EPR governance support delivery of plan *Negative impact of the new EMR implementation *Lack of clear workforce document outlining vacancies and future needs and a recruitment plan by Care Group *Failure to fully utilise all national benchmarking tools available *Lack of robust temporary staffing policy and implementation *Lack of 100% effective rostering for nursing *Lack of effective rostering for medical staffing *Lack of financial understanding across the Trust **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	Healthy Finances - Having healthy finances by providing better, more effective patient care that makes resources go further	I = 5 L = 5 Extreme (25)	Aligned Incentive Contract in place **Control Owner:** Philip Cave	Adequate	I = 5 L = 4 Extreme (20)	Full implementation of HealthRoster for nursing and demonstrate 100% sign off within 6 weeks **Person Responsible:** Amanda Hallums **To be implemented by:** 29 Nov 2019	Not Set	**09 Mar 2020** Approximately 85% sign off within 6 weeks for nusing	I = 5 L = 3 High (15)
						Clinically led business planning process embedded. **Control Owner:** Philip Cave	Adequate					
						Contracted ex-Chief Executive to provide challenge to the Care Groups and Executives **Control Owner:** Susan Acott	Substantial		Full implementation of rostering for medical staffing and demonstrate 100% compliance on usage **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2020	Not Set	**08 Mar 2020** A pilot is shortly completing in radiology following which the programme will be rolled out but the date for completion (31/3/2020) will not be met.	
						Cost Improvement Plan for 2019/20 developed and targets in place with workstream in support **Control Owner:** Philip Cave	Adequate		Care Groups to work with the PMO to identify 100% green CIPs for 2019/20 **Person Responsible:** Bernard Pope **To be implemented by:** 31 Mar 2020	Not Set	**09 Mar 2020** At month 10 green or delivered CIP is at 94%	
						Financial Annual Plan for 2019/20 in place **Control Owner:** Philip Cave	Substantial		Proposal to be developed to FPC on training for the Trust on budget management **Person Responsible:** Guy Dentith **To be implemented by:** 29 May 2020	Not Set	**09 Mar 2020** Paper to be presented to FPC in May 2020 outlining budget management training strategy and implementation	
						Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Philip Cave	Adequate		Implement plan for financial budget management training **Person Responsible:** Guy Dentith **To be implemented by:** 30 Jun 2020	Not Set	**09 Mar 2020** Training is currently available for different levels. A strategy and training needs analysis is being developed to identify gaps.	
						Fortnightly confirm and challenge meetings with the Care Groups (including Corporate) **Control Owner:** Philip Cave	Adequate		Ensure budget holders have read and accepted the Standing Financial Instructions **Person Responsible:** Guy Dentith **To be implemented by:** 30 Jun 2020	Not Set	**09 Mar 2020** Action considered by the Senior Finance team but given the size and scope of the SFI's it is considered an unreasonable expectation for all to read & accept. A summary guide has been created and a questionnaire will be developed to evidence understanding by budget holders.	
						HFMA training available for staff across the Trust **Control Owner:** Andrea Ashman	Limited					
						Improved Business Planning process in place for 2019/20 **Control Owner:** Philip Cave	Adequate					
						Local Vacancy Control Panel in place **Control Owner:** Philip Cave	Adequate					
						Process in place for managing decline in financial performance of Care Groups **Control Owner:** Philip Cave	Adequate					
						Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Philip Cave	Adequate					
						Programme Management Office (PMO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Philip Cave	Adequate					
						Regular reporting on the Trust's Financial position to the Trust Board and senior management team (including ensuring the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood). **Control Owner:** Philip Cave	Adequate					

Strategic Risks 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
						Workforce and Agency Control Group in place **Control Owner:** Andrea Ashman	Limited					
SRR 16	Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes **Risk Owner:** Susan Acott **Delegated Risk Owner:** Simon Hayward **Last Updated:** 25 Jul 2019 **Latest Review Date:** 23 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk to be reviewed and revised in light of new transformational programmes being implemented.	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 improvements * Mechanism / governance structures for Transformation is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to deliver the transformation required to meet Trust objectives * Licence restrictions *Regulatory concerns * Reputational damage	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 4 L = 5 Extreme (20)	Care Group Performance Meetings in place to monitor progress against transformational programmes **Control Owner:** Lee Martin	Adequate	I = 4 L = 4 High (16)	**Person Responsible:** **To be implemented by:**			I = 4 L = 2 Moderate (8)
						Implementation team in place for the Transformation Programme **Control Owner:** Simon Hayward	Adequate					
						Mark Hackett engaged by the Trust to review quarterly performance and provide external independent feedback to the Chief Executive and Director of Finance on maintaining the financial improvements **Control Owner:** Philip Cave	Substantial					
						Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Andrea Ashman	Adequate					
						Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS hospitals **Control Owner:** Elizabeth Shutler	Adequate					
						Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	Adequate					
						Transformation Improvement Group is in place to ensure programme is delivered **Control Owner:** Susan Acott	Adequate					

Strategic Risks 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
SRR 27	If there are multiple change programmes ongoing there is a risk that the Trust will not have the capacity to successfully deliver the T3 programme **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Andy Barker **Last Updated:** 26 Nov 2019 **Latest Review Date:** 19 Mar 2020 **Latest Review By:** Robert Nelson **Latest Review Comments:** Additional priorities in relation to business continuity support (COVID 19) are creating pressure but are being managed through increased resourcing and response meetings. A revised go-live date for T3 is currently the subject of contractual negotiations with the supplier.	10 Jun 2019	**Cause** Multiple change programmes **Effect** Staff time and capacity to focus on all projects	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 4 L = 4 High (16)	East Kent Digital Strategy Group chaired by Director of IT **Control Owner:** Andy Barker	Adequate	I = 4 L = 4 High (16)	Escalate any identified implementation conflict initially at SMT. This is an ongoing action leading up to T3 go live. **Person Responsible:** Andy Barker **To be implemented by:** 31 Mar 2020	Not Set	**19 Mar 2020** A revised go-live date for T3 is currently the subject of contractual negotiations with the supplier. Additional priorities in relation to business continuity support (COVID 19) are creating additional pressure but are being managed through increased resourcing and response meetings.	I = 2 L = 2 Low (4)
						External audit of capacity and capability undertaken **Control Owner:** Elizabeth Shutler	Substantial					
						Governance sign off by Finance and Performance Committee and Trust Board **Control Owner:** Elizabeth Shutler	Adequate					
						IDG Oversite of whole IT Programme **Control Owner:** Andy Barker						
						Internal T3 Programme Board with Executive membership **Control Owner:** Elizabeth Shutler	Adequate					
						T3 clinical group **Control Owner:** Paul Stevens	Adequate					
						T3 Programme governance structure in place reporting to CEMG **Control Owner:** Elizabeth Shutler	Adequate					
SRR 29	If the Trust does not develop a positive and inclusive culture this will impact its ability to recruit and retain staff with the right skills **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** **Last Updated:** 24 Feb 2020 **Latest Review Date:** 17 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Implemented for operational leadership and tactical competencies	10 Jun 2019	**Cause** Changes in structures and processes Lack of training and development for new leaders Values not sufficiently well embedded over a period of some years **Effect** Staff are disaffected and disengaged and seek alternative employment	Right skills, right time, right place - Developing teams with the right skills to provide care at the right time, in the right place and achieve the best outcomes for patients	I = 4 L = 4 High (16)	Ambassadors for Freedom to Speak Up **Control Owner:** Michelle Webb	Adequate	I = 4 L = 4 High (16)	Source and implement a cultural change programme **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2020	Not Set	**17 Mar 2020** This is currently being implemented.	I = 4 L = 2 Moderate (8)
						Annual Staff Survey **Control Owner:** Andrea Ashman	Substantial					
						Leadership development programme in place **Control Owner:** Andrea Ashman	Adequate		Raising the profile of workforce equality, diversity and inclusion **Person Responsible:** Bruce Campion -Smith **To be implemented by:** 31 Mar 2020	Not Set	**09 Mar 2020** The Equality, Diversity and Inclusion Staff Conference took place on 24 February 2020. Number of charities and external agencies attended.	
						Occupational Health service provide one to one support **Control Owner:** Andrea Ashman	Adequate					
						Refresh and relaunch of Trust Respect programme incorporating Equality, diversity and inclusion as a key element during 2019 **Control Owner:** Andrea Ashman	Adequate		Delivery of We Care cultural change programme at Care Group level **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2021	Not Set	**20 Mar 2020** Action updated to reflect new cultural change programme	
						Staff Networks in place **Control Owner:** Andrea Ashman	Limited					
						WRES, WDES and BAME nurse and midwifery progression action plans which we engage staff and our diversity networks in developing and share these via our intranet. **Control Owner:** Andrea Ashman	Adequate					

Strategic Risks 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
SRR 24	If leadership and management is not effective staff may not be engaged to deliver a high quality, caring service **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** **Last Updated:** 30 Sep 2019 **Latest Review Date:** 17 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Director of Human Resources and action closed.	10 Jun 2019	**Cause** Insufficient targeted/specific learning and development for new managers Changes to Care Group structures have produced able people new to management positions **Effect** Poor standard of care High turnover Poor recruitment Lack of staff engagement	A great place to work - Making the Trust a great place to work for our current and future staff	I = 4 L = 4 High (16)	Freedom to speak up guardians available **Control Owner:** Andrea Ashman	Adequate	I = 4 L = 4 High (16)	To finalise the Trust-wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme. **Person Responsible:** Jane Waters **To be implemented by:** 31 Dec 2019	Not Set	**06 Mar 2020** Framework updated to align with We Care and is ready to launch to support the approach	I = 2 L = 2 Low (4)
						Guidance and toolkits **Control Owner:** Andrea Ashman	Adequate					
						Leadership Development Plans and targeted development plans for individuals in place **Control Owner:** Andrea Ashman	Adequate		Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2020	Not Set	**06 Mar 2020** Leadership Development across the Trust currently being reviewed to identify gaps and ensure integration across the programmes. All programmes will be promoted through the Leadership Framework portal	
						Leadership diagnostics **Control Owner:** Andrea Ashman	Adequate					
						Staff Survey local action plans **Control Owner:** Andrea Ashman	Adequate					
						Team Talk sessions **Control Owner:** Andrea Ashman	Adequate					
SRR 4	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 30 Jul 2019 **Latest Review Date:** 22 Oct 2019 **Latest Review By:** Nicky Bentley **Latest Review Comments:** PCBC on track to be submitted in November 2019.	20 Jan 2016	**Cause** - Backlog of work (£71 million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 4 L = 5 Extreme (20)	An assessment of the maintenance required has been undertaken to understand the overall position. The Trust has commissioned a 6 facet estates survey to be undertaken in 2019/20 which will be used as a benchmark to prioritise backlog maintenance requirements in the future. **Control Owner:** Elizabeth Shutler	Adequate	I = 4 L = 4 High (16)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee **Person Responsible:** Nicky Bentley **To be implemented by:** 29 Nov 2019	High	**18 Feb 2020** Following review by the SE Clinical Senate on 27th November and an informal review by NHSE/I, the PCBC is being updated to incorporate comments and additional information. The latest draft PCBC is being considered via the East Kent Transformation Programme Governance structure and will be presented to the EK System Board and Joint Committee of the CCGs in February and March. The PCBC is on track to be submitted to in line with the NHSE/I timetable.	I = 4 L = 2 Moderate (8)
						Interim Estates Strategy in place **Control Owner:** Elizabeth Shutler	Adequate					
						Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Adequate					
						Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2019/20. **Control Owner:** Elizabeth Shutler	Adequate					
						Risk assessed condition survey carried out every 5 years (rolling interim plan every 18months) **Control Owner:** Elizabeth Shutler	Adequate					
						Statutory Compliance dashboard in place **Control Owner:** Elizabeth Shutler	Adequate					

Strategic Risks 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
SRR 26	The Trust will be unable to make the changes to services needed if the Pre-Consultation Business Case (PCBC) is not signed off by external bodies **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 26 Nov 2019 **Latest Review Date:** 18 Feb 2020 **Latest Review By:** Nicky Bentley **Latest Review Comments:** PCBC is currently being finalised and will be considered by the EK System Board and Joint Committee of the CCGs in February 2020. Discussions continue with NHSE/I to ensure that the EK position is clearly articulated and understood.	10 Jun 2019	**Cause** Requirement for the PCBC to be signed off by external bodies **Effect** The Trust will not be able to make changes due to lack of capital	Delivering our future - Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services	I = 5 L = 4 Extreme (20)	STP Governance Process **Control Owner:** Elizabeth Shutler STP system leaders group **Control Owner:** Elizabeth Shutler	Adequate Adequate	I = 5 L = 3 High (15)	Influence CCG through STP Governance Process **Person Responsible:** Nicky Bentley **To be implemented by:** 31 Mar 2020 Lobbying of external bodies by Chief Executive and Chairman **Person Responsible:** Susan Acott **To be implemented by:** 31 Mar 2020	Not Set Not Set	**18 Feb 2020** Continued engagement at all levels within the System Governance process and the East Kent Transformation Programme. Consistent engagement and attendance at the EK System Board, the EK Transformation Delivery Board, the EK Clinical Models Group, the EK Commercial Group, the EK Finance and Activity Modelling Group and the EK Joint Committee of the CCGs. The draft PCBC was considered by the Clinical Senate which was attended by a team from the Trust. The PCBC is on track to be submitted in line with the NHSE/I required timetable. **18 Feb 2020** EKHUFT CEO and CCG Managing Director meeting with Anne Eden and Amanda Pritchard from NHSE/I in February and March to continue to update on progress with the PCBC and Clinical Strategy and to continue to articulate the case for change across East Kent.	I = 5 L = 2 Moderate (10)

Strategic Risks 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
SRR 8	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** Louise Goldup **Last Updated:** 30 Sep 2019 **Latest Review Date:** 17 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Director of HR and actions updated.	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 (exit interview suggests retirement accounts for 25% of turnover figures) * Uncertainty due to the STP plans * Increase in service demand * Potential negative impact that may arise from the publication of the Staff Survey Results. * Reputation of some medical specialties * Split site organisation increases the intensity of on call rotas **Effect** * Potential negative impact on patient outcomes and experience * High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups * Patient safety * Service delivery * Turnover * Unsafe staffing * Overtime * Withdrawal of GMC support	A great place to work - Making the Trust a great place to work for our current and future staff	I = 5 L = 5 Extreme (25)	The Trust has a plan in place that supports the retention of newly qualified nursing staff locally. **Control Owner:** Amanda Hallums	Adequate	I = 5 L = 3 High (15)	Revise and implement Care Group Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 31 Dec 2019	High	**06 Mar 2020** All CGs have been provided with their 2019 staff survey results and are in the process of developing actions related to key areas of focus	I = 4 L = 2 Moderate (8)
						Care Group Great Place to Work Action Plans in place **Control Owner:** Jane Waters	Adequate					
						Hard to recruit plan in place and being implemented **Control Owner:** Louise Goldup	Adequate		Engage with medical school to promote and support opportunities for partnership working and joint appointments **Person Responsible:** Andrea Ashman **To be implemented by:** 30 Sep 2020	Not Set	**17 Mar 2020** Director of HR meeting with Chris Holland regarding joint contracts, joint appointments and research opportunities	
						Implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Adequate					
						Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Substantial		Pursue streamlining and passporting opportunities for new appointments across the STP **Person Responsible:** Lindsey Shorter **To be implemented by:** 31 Mar 2021	Not Set	**17 Mar 2020** The Trust is signing off on passporting	
						Revised recruitment process has been implemented **Control Owner:** Andrea Ashman	Adequate					
						Staff Performance Appraisals in place **Control Owner:** Jane Waters	Adequate					
						STP Recruitment & Retention Working Group **Control Owner:** Louise Goldup						
						Training plans in place in each Care Group / corporate area that supports staff development. **Control Owner:** Andrea Ashman	Adequate					
SRR 25	If staff are not involved in meaningful appraisals they may not feel valued by the Trust resulting in increase in turnover / lack of pride in doing their job **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** **Last Updated:** 01 Oct 2019 **Latest Review Date:** 17 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed with Director of HR	10 Jun 2019	**Cause** Time not built in t undertake the appraisals Lack of engagement in the process **Effect** demotivated staff increased turnover	A great place to work - Making the Trust a great place to work for our current and future staff	I = 3 L = 4 Moderate (12)	Annual reports produced and presented to the Strategic Workforce Committee detailing both appraisal compliance and the results of any quality audits **Control Owner:** Andrea Ashman	Adequate	I = 3 L = 4 Moderate (12)	Conduct a quality audit of 2018/19 appraisals **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2020	Not Set	**17 Mar 2020** A quality audit of 2018/19 appraisals has been undertaken and was presented to the IAGC in February 2020.	I = 3 L = 2 Low (6)
						Appraisal policies in place for all staff **Control Owner:** Andrea Ashman	Adequate					
						Appraisal section including FAQ and Toolkit on Staff Zone available for all staff **Control Owner:** Andrea Ashman	Adequate					
						Appraisal training in place for all staff **Control Owner:** Andrea Ashman	Adequate					

Strategic Risks 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
SRR 17	Risk to safety, quality and experience as a result of not achieving the strategic objectives **Risk Owner:** Rebecca Martin **Delegated Risk Owner:** Paul Stevens **Last Updated:** 08 Mar 2020 **Latest Review Date:** 08 Mar 2020 **Latest Review By:** Paul Stevens **Latest Review Comments:** Progress in the 4 main areas (deteriorating patient, pressure ulcers, falls rate and medicines related incidents) is being made. VitalPac monitoring is now present in all clinical areas; the fall in missed doses of critical medicines to below the national average has been sustained for 6 months; falls rates are below the national average for acute Trusts and PU rates have also improved. However, the improvements have not completely met our internal stretch targets	06 Jun 2019	**Cause** Due to a lack of resources, skills deficit, engagement and appropriate systems **Effect** Patient harm from failure to deliver the improvement trajectories in relation to pressure ulcers, falls, deteriorating patients and medicines optimisation	Getting to good - Improve quality, safety and experience, resulting in Good and then Outstanding Care	I = 4 L = 4 High (16)	Agreed Improvement Plan in place with supporting Care Group Plans **Control Owner:** Amanda Hallums	Adequate	I = 4 L = 3 Moderate (12)	Establish a working group to embed NICE fluid management guidance **Person Responsible:** Mansoor Akhtar **To be implemented by:** 31 Dec 2019	Not Set	**08 Mar 2020** Awaiting the return to work of one of the key members of the group to drive this	I = 4 L = 2 Moderate (8)
						Appropriate policies, procedures, guidelines and protocols in place **Control Owner:** Paul Stevens	Adequate		Improve support for staff involved in medication incidents and develop a positive hospital culture around medication error reporting **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2020	Not Set	**16 Dec 2019** There now appears to be a good level of incident reporting where medication related incidents occur	
						Audit regime in place **Control Owner:** Amanda Hallums	Adequate		Continue to support workstreams to improve care of patients at risk of hypercapnoea (embedding NEWS2 pathway and oxygen wristband pilot). **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2020	Not Set		
						Benchmarking in place to assess performance against peers **Control Owner:** Lee Martin	Adequate		Improve support for managing difficult intravenous access out of hours **Person Responsible:** Gemma Oliver **To be implemented by:** 31 Mar 2020	Not Set	**10 Mar 2020** A business case has been submitted to business planning. Awaiting outcome as to whether this was successful.	
						Coordination of information from Trust systems in a central information repository linking into Careflow as a vehicle to deliver targetted alerts **Control Owner:** Michael Bedford	Adequate		Introduce gate keeping and an absolute requirement for cohorting and nursing NIV patients in designated beds **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2020	Not Set	**16 Dec 2019** Until we have access to more actual space on the emergency floors it will be difficult to complete this action	
						Pressure ulcers, falls, medicines optimisation and the deteriorating patient are the 4 agreed quality areas for focus **Control Owner:** Paul Stevens	Limited		Review and improve education and training of existing and new staff, student practitioners and doctors with regards medication safety **Person Responsible:** Michael Jenkinson **To be implemented by:** 31 Mar 2020	Not Set	**16 Dec 2019** Update on behalf of Michael Jenkinson - This action is in progress.	
						QII hubs **Control Owner:** Amanda Hallums	Adequate		Implement ReSPECT **Person Responsible:** Judith Banks **To be implemented by:** 30 Jun 2020	Not Set	**18 Mar 2020** Consideration is being given to the appropriateness of implementation during the COVID-19 pandemic.	
						Recording of data against the Patient Safety Thermometer across all Trust inpatient areas **Control Owner:** Jackie Shaba	Adequate		Ensure consistency in adherence to Vital Pac protocol across the organisation **Person Responsible:** Amanda Hallums **To be implemented by:** 30 Jun 2020	Not Set	**09 Mar 2020** This action is ongoing in order to ensure key components are being acted upon e.g. MUST scoring	
						Skilled personnel and leadership in the areas of tissue viability, falls management, medicines optimisation and deteriorating patient **Control Owner:** Amanda Hallums	Adequate		Evaluate where technology can reduce the risk of medication errors in prescribing and administration as well as the identification of high risk situations and patient groups **Person Responsible:** Will Willson **To be implemented by:** 30 Nov 2020	Not Set	**16 Dec 2019** Essentially this action depends on the introduction of electronic prescribing which will be in Autumn 2020	
						Training and support **Control Owner:** Amanda Hallums	Adequate					

Strategic Risks 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
SRR 18	Integrated respiratory pathways will not be developed to enable patients to be managed in the community setting **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 25 Jul 2019 **Latest Review Date:** 20 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** This risk will increase due to the vulnerability of respiratory patients to the new coronavirus COVID-19	07 Jun 2019	**Cause** Potential lack of engagement from primary and secondary care clinicians (GP/Respiratory CNS/EKHUFT Consultant and Specialist nurses) **Effect** Patients with a respiratory condition presenting to the ED and putting deliver of the 4 hour Emergency Access Standard at risk and increasing the risk of admission Risk to patient of contracting a hospital acquired infection or deconditioning resulting in increased length of stay.	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 3 L = 4 Moderate (12)	Local care plan is an integrated plan which includes an integrated respiratory pathway which has been signed up to by the local health economy and led by the CCG **Control Owner:** Lee Martin	Adequate	I = 3 L = 4 Moderate (12)	A QIPP for respiratory, which the Acute and Specialist Medicine Care Group lead on will support and enhance the development of integrated optimal respiratory pathways **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2020	Not Set	**27 Sep 2019** Steering Group established; action plan being developed. Lightfoot data shared across acute and community care teams	I = 3 L = 2 Low (6)
SRR 21	Due to lack of capacity in tertiary centre patients may breach the 62 day standard waiting on diagnostic or treatment **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 12 Aug 2019 **Latest Review Date:** 20 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed by Deputy COO and Director of Performance. Risk remains due to lack of capacity in tertiary centres.	07 Jun 2019	**Cause** Lack of capacity Consultant based decision Availability of high tech interventions **Effect** Patients wait longer for diagnostics and treatment plan	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 4 L = 4 High (16)	Business case approved by Finance and Performance Committee **Control Owner:** Sarah Collins	Adequate	I = 4 L = 3 Moderate (12)	Implement business case as approved by FPC **Person Responsible:** Sarah Collins **To be implemented by:** 28 Feb 2020	Not Set		I = 4 L = 2 Moderate (8)
						Cancer Improvement Plan in place **Control Owner:** Sarah Collins	Adequate					
						Daily performance telephone call with Operations Director for Cancer Services, Out Patient booking managers and General Managers to monitor and resolve any capacity issues **Control Owner:** Sarah Collins	Adequate					
						Director of Operations or COO to expedite patient's treatment where necessary **Control Owner:** Sarah Collins						
						Track patients through their pathway to ensure there are no internal delays and the pathway is optimal **Control Owner:** Sarah Collins	Adequate					
						Weekly call with Maidstone and Tunbridge Well NHS Trust **Control Owner:** Sarah Collins	Adequate					
						Weekly cancer PTL meeting to monitor all cancer standards **Control Owner:** Karen Rowland	Adequate					
						Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Operations Directors and General Managers **Control Owner:** Karen Rowland	Adequate					
						Weekly tertiary centre PTL to escalate any patients of concern **Control Owner:** Sarah Collins	Adequate					

Strategic Risks 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
SRR 23	Integrated frailty pathways cannot be agreed resulting in patients being treated in a traditional hopsital based service **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 15 Nov 2019 **Latest Review Date:** 20 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Frailty pathways in but there is more work to do. Executive Lead is reviewing the terms of reference for the steering group to ensure standardisation and delivery. Increase the numbers of patients going through a frailty pathway.	10 Jun 2019	**Cause** Consultant geriatrician vacancies Lack of consultant engagement **Effect** Patients will be admitted and risk decompensating rather than have access to integrated ambulatory and community pathways Adding pressure to bed base Patients decompensating	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 5 L = 3 High (15)	A joint clinical lead has been appointed to lead the service **Control Owner:** Lee Martin	Adequate	I = 5 L = 2 Moderate (10)	Pathways are being developed to maximise integration of primary and secondary care staff **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2020	Not Set	**20 Mar 2020** Frailty pathways in but there is more work to do. Executive Lead is reviewing the terms of reference for the steering group to ensure standardisation and delivery. Increase the numbers of patients going through a frailty pathway.	I = 5 L = 1 Low (5)
						A&E Delivery Board, attended by the CEO and senior Executives from whole health economy have agreed to support the development of UTC **Control Owner:** Lee Martin	Adequate					
						Clinicians from Primary Care and EKHUFT have been meeting for over a year to build strong working relationships and a commitment to develop an integrated frailty service. **Control Owner:** Lee Martin	Adequate					
						Length of Stay (LOS) Improvement Plan in place **Control Owner:** Lee Martin	Adequate					
						Monthly steering group in place **Control Owner:** Natalie Acheson	Adequate					
						Senior management support has been identified to support the project **Control Owner:** Lee Martin	Adequate					
						The project is being monitored monthly through the Local Care implementation group meetings **Control Owner:** Elizabeth Shutler	Adequate					

Strategic Risks 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
SRR 19	Patients may decline a date within breach and choose to delay their treatment until after their 52 week breach date **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 12 Aug 2019 **Latest Review Date:** 20 Mar 2020 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Patients at 52 weeks may not be urgent and government advice is to cancel those patients not urgent at this present. Each Care Group receives a list of patients over 30 weeks, asking each clinician to review the pathway to determine whether patient is clinically urgent or not.	07 Jun 2019	**Cause** The potential number of patients who have waited over 18 weeks for treatment **Effect** £2,500 fine for the Trust and a £2,500 fine for the CCG for each month each individual patient breaches	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 4 L = 4 High (16)	52ww - Monthly monitoring via the Executive Performance Reviews **Control Owner:** Lee Martin	Adequate	I = 2 L = 3 Low (6)	Internal discussion to be undertaken about those patients that don't want to attend the hospital due to COVID-19 pandemic. Ensure effective communication between patient and clinician and determine whether patients could be managed effectively by their local care provider. **Person Responsible:** Christine Hudson **To be implemented by:** 29 May 2020	Not Set		I = 2 L = 2 Low (4)
						Clinical review of patient risk conducted by the Care Groups **Control Owner:** Lee Martin	Adequate					
						Daily performance reporting via the Planned Care Report, which is sent to the COO, Deputy COO, Director of Performance and all Operational Directors, General Managers, Service Managers **Control Owner:** Karen Rowland	Adequate		Internal discussion to be undertaken about those patients that don't want to attend the hospital due to COVID-19 pandemic. Ensure effective communication between patient and clinician and determine whether patients could be managed effectively by their local care provider. **Person Responsible:** Sarah Hyett **To be implemented by:** 29 May 2020	Not Set		
						Live reporting via RTT App on all Directors and General Managers telephone and is also available on iPads, laptop and desktop computers **Control Owner:** Lee Martin	Adequate					
						Weekly monitoring at the PTL meeting which is Chaired by the Chief Operating Officer and attended by the Deputy COO for Elective Care, Director of Performance and the Operations Directors and their General Managers **Control Owner:** Lee Martin	Adequate		Internal discussion to be undertaken about those patients that don't want to attend the hospital due to COVID-19 pandemic. Ensure effective communication between patient and clinician and determine whether patients could be managed effectively by their local care provider. **Person Responsible:** Sarah Collins **To be implemented by:** 29 May 2020	Not Set		
									Internal discussion to be undertaken about those patients that don't want to attend the hospital due to COVID-19 pandemic. Ensure effective communication between patient and clinician and determine whether patients could be managed effectively by their local care provider. **Person Responsible:** Karen Costelloe **To be implemented by:** 29 May 2020	Not Set		

Risk Ref	Created Date	Risk Title	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 68	10/05/2019	Risk to the delivery of the operational constitutional standards and undertakings Risk Owner: Lee Martin Delegated Risk Owner: Last Updated: 26 Jun 2019 Latest Review Date: 20 Mar 2020 Latest Review By: Rhiannon Adey Latest Review Comments: Constitutional targets are at risk due to COVID-19 pandemic, specifically RTT due to the cancellation of electives. There is also a risk of maintaining DM01 and cancer targets as the demographic of patients over 70 and patients may choose to cancel due to government advice or their own fears.	Cause: Inability of organisation to meet constitutional standards due to unplanned demand, workforce or infrastructure availability including equipment failure Effect: Patients are delayed in their pathway Possible harm to patients There is non-compliance against access standards and our agreed trajectories Negative impact on workforce Reputational damage Greater overview and scrutiny by regulators/MP's Financial impact Wider health economy implications	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 5 L = 5 Extreme (25)	Agreed trajectories with CCG and NHSI Control Owner: Lee Martin	Adequate	I = 5 L = 4 Extreme (20)	Recruitment of acute physicians and specialty doctors establishment Person Responsible: Andrew Mortimer To be implemented by: 30 Sep 2019	**23 Mar 2020** Increased short term staffing gaps likely due to current coronavirus pandemic. May result in significant staffing gaps during periods of extreme pressure on the department as staff are either unwell, undergoing self-isolation or due to care needs of children. Will attempt to mitigate by asking staff to be as flexible as possible. Coronavirus screening of staff to reduce impact of self isolation has been suggested as a measure to mitigate impact but not feasible until testing capacity within trust available.	I = 4 L = 2 Moderate (8)
						Business Continuity Plans in place Control Owner: Sarah Hyett	Adequate				
						Business Continuity Plans in place Control Owner: Matthew Pomeroy	Limited				
						Business Continuity Plans in place Control Owner: Sarah Collins	Limited				
						Business Continuity Plans in place Control Owner: Victoria Harrison	Limited				
						Business Continuity Plans in place Control Owner: Natalie Acheson	Limited		Oversee cancer improvement plan to delivery Person Responsible: Sarah Collins To be implemented by: 23 Dec 2019	**09 Mar 2020** Update on behalf of Sarah Collins - Improvement Plan reviewed and updated in February2020 to enable the Trust to achieve 82% trajectory	
						Business Continuity Plans in place Control Owner: Christine Hudson	Adequate		Review Access Policy Person Responsible: Karen Rowland To be implemented by: 31 Jan 2020	**20 Mar 2020** Access Policy to be transferred to the current policy format and then submitted to the Policy Authorisation Group for approval.	
						Business Plans Control Owner: Lesley White	Adequate		Implement and deliver the new 28 day faster diagnostic standard Person Responsible: Sarah Collins To be implemented by: 31 Mar 2020	**09 Mar 2020** Update on behalf of Sarah Collins - Plan above includes 28 day faster diagnostic standard – with detailed action plan for all care groups.	
						Care Group production plans Control Owner: Lesley White	Adequate		Deputy Chief Operating Officer to monitor and challenge the plans for all patients over 30 weeks and agree an improvement trajectory for each specialty as appropriate Person Responsible: Karen Rowland To be implemented by: 31 Mar 2020	**20 Mar 2020** A risk assessment view will need to be undertaken of how we manage these patients in the current pandemic	
						Escalation processes in place Control Owner: Lee Martin	Adequate				
						Improvement plan for Cancer Control Owner: Sarah Collins	Adequate				
						Improvement plan for ED Control Owner: Matthew Pomeroy	Adequate				
						Improvement plan for Outpatients Control Owner: Christine Hudson	Adequate				
						Improvement plan for Radiology Control Owner: Christine Hudson	Adequate				
						Improvement plan for RTT Control Owner: Victoria Harrison	Adequate				
						Improvement plan for RTT Control Owner: Natalie Acheson	Adequate				
						Improvement plan for RTT Control Owner: Sarah Collins	Adequate				
						Improvement plan for RTT Control Owner: Sarah Hyett	Adequate				

						Live reporting via RTT App on all Directors and General Managers telephone and is also available on iPads, laptop and desktop computers Control Owner: Lee Martin	Adequate				
						Local equipment libraries Control Owner: Finbarr Murray	Adequate				
						Monthly monitoring via the Executive Performance Reviews Control Owner: Lee Martin	Adequate				
						Technicians on site that regularly calibrate and test equipment Control Owner: Finbarr Murray	Adequate				
						Track patients through their pathway to ensure there are no internal delays and the pathway is optimal Control Owner: Sarah Collins	Limited				
						Weekly monitoring at the PTL meeting which is chaired by the COO and attended by the Deputy COO for Elective Care, Director of Performance and the Operations Directors and their General Managers Control Owner: Karen Rowland	Adequate				
						Weekly tertiary centre PTL to escalate any patients of concern Control Owner: Sarah Collins	Adequate				
CRR 78	14/01/2020	Risk of overcrowding in ED compromising patient safety and patient experience Risk Owner: Lee Martin Delegated Risk Owner: Last Updated: 21 Jan 2020 Latest Review Date: 20 Mar 2020 Latest Review By: Rhiannon Adey Latest Review Comments: With the current COVID-19 pandemic the number of patients attending ED has reduced, however, as the virus spreads this is likely to increase.	Cause: 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 Lack of availability of GP at the front door Failure of the NHS 111 to provide appropriate advice Surge resilience plans do not meet unprecedented demand Failure to respond appropriately to the Operational Pressure Escalation Framework Not enough capacity in the system Effect: Poor Patient experience Harm to Patients Staff morale Patients getting lost in flow Privacy and dignity Infection control issues	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 4 L = 5 Extreme (20)	A&E improvement plan in place with work streams for Admission Avoidance, A&E Streaming, Improved Flow, Discharges and Workforce Control Owner: Lee Martin	Limited	I = 4 L = 5 Extreme (20)	Develop a plan to build staff competencies in communication between paediatrics and adult emergency departments Person Responsible: Lee Martin To be implemented by: 28 Feb 2020	**20 Mar 2020** There is a 9.30 phone call every day between paeds ed and the wards.	I = 4 L = 2 Moderate (8)
						Accident and Emergency Delivery Board in place Control Owner: Susan Acott	Limited		Reduction in the number of medically optimised patients awaiting discharge by 25% over the next 3 months and 50% over the next 6 months Person Responsible: Lee Martin To be implemented by: 31 Mar 2020	**09 Mar 2020** Update on behalf of Lesley White - Long LOS >21 days are monitored weekly via national and internal EMT report. Weekly internal >21 day board rounds established to monitor and progress patient pathways.	
						Acute Medical Model in place Control Owner: Andrew Mortimer	Limited				
						Daily intensive review/bed matching for emergency admissions not placed at time of review Control Owner: Lee Martin	Adequate				
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework Control Owner: Lee Martin	Limited		Develop integrated frailty pathways with primary and secondary care Person Responsible: Lee Martin To be implemented by: 01 Apr 2020	**09 Mar 2020** Update on behalf of Lesley White - Frailty model implemented at WHH and QEQMH. Frailty steering group with whole system engagement has been implemented and continues to refine and monitor the model.	
						Escalation protocols developed and agreed with Care Groups	Limited				

										Control Owner: Lee Martin					
										Health Economy Plan in place. Intensive work on relationship management and lateral integrations and partnership working. Control Owner: Lee Martin	Limited				
										Increased acute medical bed capacity through moving the cardiology ward to the Arundel suite as part of creating a cardiology inpatient area including CCU and general cardiology beds. Vacated space becomes an acute medical area Control Owner: Lesley White	Adequate				
										Increased opening hours of the surgical emergency assessment unit Control Owner: Victoria Harrison	Adequate				
										Introduction of Bristol safety checklist in the EDs Control Owner: Elisa Steele	Adequate				
										Medical assessment areas are now in place as part of the emergency floor at both QEQMH and WHH. Control Owner: Matthew Pomeroy	Adequate				
										Primary care service in place at QEQMH and WHH for a minimum of 12 hours per day, Control Owner: Andrew Mortimer	Adequate				
										Review of Emergency Care Pathway and revised Improvement Plan Control Owner: Lee Martin	Adequate				
										Weekly site based meetings in place designed to improve ownership of the emergency care pathway and reduce overcrowding in the emergency department Control Owner: Andrew Mortimer	Adequate				
													Build plans for converting admin areas to clinical Person Responsible: Lee Martin To be implemented by: 30 Jun 2020	**20 Mar 2020** Works have started at QEQM to convert admin areas to clinical	
													Implement Urgent Treatment Centres at four sites Person Responsible: Lee Martin To be implemented by: 30 Jun 2020		
													Develop integrated optimal respiratory pathways with partners Person Responsible: Lee Martin To be implemented by: 30 Jun 2020	**09 Mar 2020** Update on behalf of Lesley White - Integrated programme in place and progressing	
													Scope ambulatory care Person Responsible: Lee Martin To be implemented by: 31 Dec 2020	**20 Mar 2020** Ambulatory care has moved to a new unit. Need is likely to increase with COVID-19.	
													Increase space for paediatric emergency departments Person Responsible: Lee Martin To be implemented by: 31 Dec 2020		

CRR 79	16/03/2020	Risk to service delivery from COVID-19 pandemic Risk Owner: Susan Acott Delegated Risk Owner: Last Updated: 24 Mar 2020 Latest Review Date: 08 Apr 2020 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by EMT, additional action added	Cause: •COVID-19 and the requirement to isolate Effect: •An increased demand on critical services (such as increasing presentations in ED, increase testing workload affecting Virology and potentially critical care if patients are admitted) •Disruption to routine/elective healthcare outpatient clinics. •Cancellation of elective and outpatients procedures/tests for an unknown period of time •Impact on staffing levels as a result of increased staff sickness. •Inability of the Trust to comply with national guidelines and targets for patient treatment.	Higher standards for patients - Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times	I = 5 L = 4 Extreme (20)	Cease planned care with exceptions (Trauma, Emergency, Cancer) Control Owner: Lee Martin Central Response Team established Control Owner: Lee Martin COVID-19 Gold Group established to coordinate the response Control Owner: Susan Acott Limited visiting in place within the hospitals Control Owner: Lee Martin Local COVID-19 testing developed Control Owner: Sally-Ann Hall Outpatients team and clinicians providing outpatient appointments by virtual clinics or telephone consultations if not needed in the front line Control Owner: Christine Hudson		I = 5 L = 4 Extreme (20)	Capacity maps to be agreed to allow plans for rotas Person Responsible: Lee Martin To be implemented by: 27 Mar 2020 Transfer certain cancer services to K&CH and private hospitals Person Responsible: Sarah Hyett To be implemented by: 03 Apr 2020 Agree staff welfare plans Person Responsible: Lee Martin To be implemented by: 03 Apr 2020 Consider COVID-19 phone line for triage Person Responsible: Amanda Hallums To be implemented by: 17 Apr 2020 Information team breaking down outpatients appointments being delivered by virtual clinics or telephone consultations to identify sub specialties and the number of appointments delivered in order to identify the backlog following the pandemic. Person Responsible: Philip Cave To be implemented by: 22 May 2020		I = 5 L = 2 Moderate (10)

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**16 APRIL 2020**
REPORT TITLE:	**SECOND REPORT FROM THE LEARNING AND REVIEW COMMITTEE (LRC) - MATERNITY**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**INDEPENDENT CHAIR – LRC**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: LRC SECOND REPORT**

BACKGROUND AND EXECUTIVE SUMMARY

This the second report to Trust Board from the Learning and Review Committee.

The Trust replied to Her Majesty's Coroner's (HMC) prevention of future deaths notice within the prescribed timeframe. It has stated it has or will comply with all HMC recommendations following the death of baby Harry Richford. For every recommendation, and every statement of compliance the group identified the evidence that would need to be collected and demonstrated so that the Board can have assurance that changes have been made and are being sustained. Most of the actions and deliverables are appropriate for audit, and these audits must become part of the Women's and Children's care group audit plan. It was agreed that initially the Board, or its sub-committee should see the audits frequently, to ensure that the changes have been made, as some new practices (e.g. in relation to employment and induction of locums) require all members of some professional groups to work differently. It is the recommendation of the LRC that when new practice is embedded the audits are maintained with lower frequency for continued assurance.

An initial gap analysis has suggested that most of the recommendations from the 2016 Royal College of Obstetrics and Gynaecology report have been implemented and has offered the evidence for each. As stated at the last Trust Board the LRC believes that some of the cultural and behavioural issues have not been fully addressed and persist. This is to be tackled with the help of Dr Rebecca Martin (Chief Medical Officer (CMO)) stating her expectations going forward and could be supported by work focused on values and consequent behaviours.

The Birthing Excellence Success Through Teamwork (BESTT) improvement programme has delivered a lot of improvement work and has made key recommendations to the LRC involving an expansion of resource and investment. The leaders of the programme are not clear whether BESTT is the acknowledged programme for delivering the care group's strategy. It is important that the programme achieves clarity on this and that the care group, and the Executive own the prioritisation of effort and investment that will be required to deliver stated outcomes. This will form the basis of future LRC work. It is also important that this programme, or the improvement work the care group and Executive agree to deliver takes account of the findings of the future Independent Review and has the input of service users.

The LRC agrees with the BESTT programme lead that incidents should be investigated and managed with a methodology like that used by the Healthcare Safety Investigation Branch (HSIB). This classification system of themes helps with subsequent improvement and helps to demonstrate learning.

Matthew Jolly, National Clinical Director for Maternity is working with NHS Digital on a modern dashboard for maternity which will feature outcome measures and soft intelligence. With the challenge of COVID-19 this work is on hold, but when it resumes EKUHFT might consider being a pilot site for its development in practice.

The LRC has met once since the last Trust Board and has two more meetings scheduled over the next two months. The commitment from the clinicians leading the workstreams has been maintained despite the huge operational pressures and new ways of working that COVID-19 has brought.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	CRR77: Women may receive sub-optimal quality of care and poor patient experience in our maternity services.
LINKS TO STRATEGIC OBJECTIVES:	**Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This is the second update of work conducted by the LRC relating to safety and quality concerns, public experience of care, and reputational risk in relation to maternity and neonatal services.
RESOURCE IMPLICATIONS:	It is likely there will be resource implications from the recommendations the Committee will make.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the report.

20/11 – APPENDIX 1

NHS
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East Kent Hospitals Maternity Learning and Review Committee

Report to Trust Board 16 April 2020

The reasons for setting up the Learning and Review Committee (LRC), its remit and membership were covered in its first report to the Board on 12 March 2020. Since that report the Committee has met for a third time with attendance in person or by dial in from its membership.

The following is an update on the various workstreams that come under the Committee:

Trust response to the prevention of Future Deaths Notice from Her Majesty's Coroner (HMC) (inquest considering the death of Harry Richford)

Dr Clare Redfern, consultant Obstetrician, led the work on the reply to HMC. There were 19 recommendations in the prevention of future death letter. Each was presented, as was the action that had been taken to comply, and the proposed response. Where appropriate the actions cross reference to more than one recommendation. The evidence that could be sought to demonstrate compliance with the action was also discussed for each.

For example, recommendations 2-3 relate to the employment and supervision of locum doctors. The actions taken include formal sign off of CV and references, a database of these, and a review of the shifts the doctor has worked, to be shared with the doctor and available to see when future work is undertaken. Locums are booked to work a day shift where their practice is more easily observed and assessed before they work any out of hours shifts. This change in practice requires both a lead consultant to review CVs, but also needs every consultant (as all could be on a shift with a locum) to work in a new way. All consultants have been written to and replied that they will work in this way.

Recommendation 4 referred to competence in knowing what to do when fetal heart monitoring is judged pathological. The actions relate to substantive staff but there is also new work for locums who will be sent training materials and be assessed as competent in their knowledge of local protocols on arrival. For these examples and for most of the other actions and changes in practice the evidence will be through audit.

The LRC recommends these audits are received frequently for a period of time so that progress can be monitored and acted on quickly.

The Trust was able to respond to HMC before the end of March deadline.

The Birthing Excellence Success Through Teamwork (BESTT) programme

BESTT began in 2017 following the Royal College of Obstetrics and Gynaecology (RCOG) report, General Medical Council (GMC) and staff surveys and in response to Care Quality Commission (CQC) reports. It has focused on a number of areas including reducing stillbirth and neonatal death, reducing perinatal damage and maternal birth injury, 24 hour midwifery triage and continuity of carer. Underpinning these themes are two additional programmes, digital tools to enable better care outcomes and education and learning through simulation, competency frameworks and case discussion.

The BESTT programme has used the LRC to ask for investment, including equipment and staffing. It sees the work it is doing as entering a second phase, with a timeline through until 2025, and an aim to deliver the local ambitions of the national programme of NHS England/NHS Improvement (NHSE/I) maternity transformation programme (safer, more personalised, kinder care where every woman has the information she needs to choose the care pathway that is right for her). The clinical leadership of the BESTT programme, specifically consultant Obstetrician, Mr Ciaran Crowe, is exploring a new methodology for investigating serious incidents, this could be based on that used by the Healthcare Safety Investigation Branch (HSIB) which was developed within the South East region and uses a classification of factors within an incident investigation that promotes more focused learning.

Royal College of Obstetrics and Gynaecology (RCOG) report

This workstream was established to review whether the actions of the RCOG report had been completed. The workstream reported that the majority of actions required by the authors of this report have been completed and the evidence to show this has been offered to the LRC and will be reviewed at its next meeting. The report's author and the wider LRC agree that some of the concerns relating to culture and behaviour had not been fully resolved, as was reported at the March Board meeting. The LRC felt that the arrival of a new Chief Medical Officer offered an opportunity to set expectations on behaviour going forward.

Data Workstream

This workstream has not presented to the LRC yet but has been analysing the Trust's outcomes in detail. Neonatal death (NND) and still births over a period of time appear in line with national norms. However, the Hypoxic-ischaemic encephalopathy (HIE) reported rates do require further detailed assessment. To this end, the National Neonatal data centres at Imperial has been commissioned to carry out a comparative analytical assessment for the Trust. Due to the current constraints caused by COVID-19, it is unclear how long this will now take.

Clinical Dashboard

This workstream has not yet presented at LRC. Matthew Jolly, National Clinical Director is working with NHS Digital on a new dashboard of information that maternity services could use to understand their performance and their level of risk. This work has paused during the COVID-19 pandemic. EKHUFT should consider volunteering to pilot and help develop this dashboard.

Conclusion

The work of the LRC continues despite the added pressures of the COVID-19 pandemic. Clinician and broader membership remain committed to the outcomes and a service offering to women and their babies and families that is safe and high quality and learns when things go wrong. Two more meetings will happen prior to the Trust Board in May and it is expected that the ongoing improvement plan will be prioritised and owned within the Trust's Women's and Children's Care Group, ensuring it is able to receive the findings of the Independent Review expected to start in April and modify or re-prioritise from the learning this work brings.

Dr Des Holden

11 April 2020

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**16 APRIL 2020**
REPORT TITLE:	**REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE (NRC)**
BOARD SPONSOR:	**WENDY COOKSON, ACTING CHAIR OF THE NRC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: NRC TERMS OF REFERENCE (TOR)**

BACKGROUND AND EXECUTIVE SUMMARY

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

The purpose of the committee will be to decide on the appropriate remuneration, allowances and terms of and conditions of service for the Chief Executive and other Executive Directors including:

(i) all aspects of salary (including performance related elements/bonuses).

(ii) provisions for other benefits, including pensions and cars.

(iii) arrangements for termination of employment and other contractual terms.

To appoint and set the terms and conditions for subsidiary Board members and review any Key Performance Indicators/performance bonus. Receive a recommendation from the subsidiary Board and Nominations and Remuneration Committee on achievement against these.

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

To agree and oversee, on behalf of the Board of Directors, performance management of the Executive Directors, including the Chief Executive.

The Trust Chairman and other Non-Executive Directors and Chief Executive (except in the case of the appointment of a Chief Executive) are responsible for deciding the appointment of Executive Directors.

The appointment of a Chief Executive requires the approval of the Council of Governors.

MEETING HELD ON 10 MARCH 2020

The Committee received and discussed the following reports:

1.1 **Executive Directors' Mid-Year Appraisals 2019/20**

The Committee received and discussed a report from the Chief Executive following the mid-year appraisals held with the Executive Directors in relation to performance against their annual objectives. The Committee provided feedback on the performance of the individual Executive Directors.

1.2 Chief Executive's Appraisal 2019/20

The Committee discussed the objectives and performance of the Chief Executive noting the additional key focus in supporting the maternity services improvement programme. There will be future consideration regarding whether there was a need for additional operational Executive level assistance to support the Chief Executive.

1.3 Board Skills, Experience and Competency Review

The Committee received and discussed a report on the outcome of the review of the Board skills, experience and competency. The Committee noted identified gaps in respect of Clinical Information Officer and legal support. Board clinical engagement had been increased with the appointment of the Dean of the Kent and Medway Medical School to the new Associate Non-Executive Director on the Board that is a non-voting Board member. The Committee discussed the potential additional support Non-Executive Directors could provide in relation to supporting the Chief Executive with regards to attendance at meetings with Council leaders and MPs. The Committee discussed the Board Development Sessions and consideration regarding inviting representatives from the mental health trust and secondary care to attend to present at future sessions.

1.4 Pension Recycling Applications and Employer Contribution Payment Scheme Policy

The Committee received and noted a report regarding the Employer Contribution Payment Scheme Policy and the nine applications that had been received and approved. This was in response to the impact of tapered tax relief and the value of the NHS defined benefits pension scheme resulting in many of the senior clinicians receiving significant tax bills when exceeding their annual allowance for pension relief. This has also supported the Trust in assisting with the management of consultant and senior staff availability.

1.5 National Position for Very Senior Managers (VSM) Pay Uplifts

The Committee received and approved to award an uplift of 2% to VSM/Executive staff appointed in year.

1.6 2gether Support Solutions (2gether)

The Committee received and considered a number of proposals from its subsidiary 2gether.

1.7 NRC TOR

The Committee received and discussed its annual effectiveness survey, agreed that a full extensive survey will be undertaken every three years and a brief survey undertaken annually. The Committee considered and approved its TOR and recommend these for approval by the Board (Appendix 1).

RECOMMENDATIONS AND ACTION REQUIRED:

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

- Nominations and Remuneration Committee Chair Report;
- Nominations and Remuneration Committee Terms of Reference.

East Kent Hospitals University NHS Foundation Trust

NOMINATIONS AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Board of Directors has established a committee of the Board known as the Nominations and Remuneration Committee. It is a Non-Executive committee and has no executive powers, other than those specifically delegated in these Terms of Reference. These Terms of Reference can only be amended with the approval of the Board of Directors.

2 PURPOSE

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

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

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

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

2.4 To appoint and set the terms and conditions for subsidiary Board members and review any Key Performance Indicators/performance bonus. Receive a recommendation from the subsidiary Board and Nominations and Remuneration Committee on achievement against these.

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

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

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

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

3. OBJECTIVES

The Nominations and Remuneration Committee is responsible for:

3.1 Establishing a process to identify suitable candidates to fill executive director vacancies as they arise and making recommendations to the chairman, the other non-executive directors and Chief Executive. Recommendations in relation to the Chief Executive position will be to Non-Executive Directors only.

3.2 Considering nominations for executive directors and chief executive positions.

3.3 To set the remuneration and terms of service for the chief executive and executive directors with the support of independent advice as appropriate.

3.4 To ensure that individual executive directors have performance objectives and personal development plans, that are reviewed twice yearly. The review will also consider the capability of the executives as a team as well as at the level of individuals identifying any team development needs.

3.5 To include in its decisions all aspects of salary (including any performance related elements) and provisions for other benefits (including pensions and cars).

3.6 To decide on the appropriate contractual arrangements for executive directors, including a proper calculation and scrutiny of termination payments, taking account of legislation and such national guidance as is appropriate.

3.7 To ensure the Trust achieves proper control of the total remuneration paid to the executive directors by developing appropriate pay and reward policies for these posts. The Committee will ensure it has a clear statement of the responsibilities of the individual posts and their accountabilities for meeting the objectives of the organisation, a person specification for each post, a means of assessing the comparative job “weight”, with comparative salary information from the NHS and other areas and criteria and mechanisms for assessing performance.

3.8 To ensure the publication, in annual reports, of the total remuneration from NHS sources of the chief executive and executive directors.

3.9 To recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose will be determined by the Board and described in the Pay Policy for Very Senior Managers.

3.10 To receive an annual report on the application of the Pay Policy for very Senior Managers from the chief executive

3.11 Approve any non-contractual termination payments to staff in-line with the Trust’s Special Severance Pay Policy.

3.12 Annually reviewing the structure, size and composition of the board of directors and to make recommendations for change, where appropriate.

3.13 Evaluating the balance of skills, knowledge and experience of the board of directors and, in the light of this evaluation, preparing a description of the role and capabilities required for the appointment of executive directors and the chief executive.

3.14 Ensuring that appointments to the board of directors are based on merit and objective criteria as well as meeting the "fit and proper" persons test described in the Provider Licence.

3.15 Appointing a shortlisting and appointments panel for the appointment of executive directors and the chief executive.

3.16 Succession planning, taking into account the future challenges, risks and opportunities facing the Trust and the skills and expertise required on the Board to meet them.

MEMBERSHIP AND ATTENDANCE

Members

4.1 The committee will be comprised of the non-executive directors, chairman and chief executive (except in the case of appointment of a chief executive). **Interview panel membership** will be determined by the Nominations and Remuneration Committee who will appoint from its members a selection panel, with the addition of the chief executive, where executive director appointments are being made. It may invite others as suitably qualified advisors as it sees fit.

Chair

4.2 The Chair of the committee will be the Trust chairman or non-executive director as determined by the Nominations and Remuneration Committee of the Board.

Attendees

4.3 The Director of Human Resources (or representative) will attend in an advisory capacity.

4.4 The Chief Executive will attend (except when their own post is under discussion) and should attend when executive directors remuneration is discussed.

Quorum

4.5 Business will only be conducted if the meeting is quorate. The Committee will be quorate with four Non-Executive Directors present. If the Chair is in attendance, this will count towards the quorum.

4.6 If the meeting is not quorate the meeting can progress if those present determine. However, no business decisions shall be transacted and items requiring approval may be submitted to the next Board of Directors meeting as an urgent item.

Attendance

4.7 The Chair, or their nominated deputy, of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings.

Attendance by Officers

4.8 The Committee will be open to the Trust Secretary to attend.

4.9 Other staff, or external advisors, may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis.

Voting

4.10 When a vote is requested, the question shall be determined by a majority of the votes of the members present. In the event of an equality of votes, the person presiding shall have a second or casting vote. Advisors to appointment panels do not have a vote.

5. FREQUENCY OF MEETINGS

5.1 Meetings of the Committee shall be generally held two times a year and up to four times a year, as determined by the work of the Committee. The likely timetable of meetings is as shown below:

Date	Purpose
End May	Sign off Executive Director performance appraisal for preceding financial year and performance objectives for current financial year. Identify personal and team development needs for the executives as individuals as team members. Review salaries of Executive Directors as appropriate.
Dec	Review mid-year performance of Executive Directors. Make a final decision on any appeals from Executive Directors on access to annual pay uplift Review progress against personal development plans where appropriate. Review policies for remuneration of Executive Directors and senior managers not covered by National terms and conditions.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of

staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 Reference should be made as appropriate, to the Standing Orders and Standing Financial Instructions of the Trust.

6.3 The committee may set up permanent groups or time limited working groups to deal with specific issues. Precise terms of reference for these shall be determined by the committee. However, Board Committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary or advantageous to its work.

7 SERVICING ARRANGEMENTS

7.1 A member of the Board Secretariat shall attend meetings and take minutes.

7.2 Agendas and papers shall be distributed in accordance with deadlines agreed with the Committee Chair.

7.3 Members will be encouraged to comment via correspondence between meetings as appropriate.

7.4 The Committee will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle. The planning of the meetings is the responsibility of the Chair.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9. RELATIONSHIPS WITH OTHER COMMITTEES

9.1 Council of Governors' Nominations and Remuneration Committee.

9.2 The Committee will receive Chair reports from the Board Committees as required. To review and consider findings of significant assurance functions and the implications for the governance of the organisation.

East Kent Hospitals University NHS Foundation Trust

10. MONITORING EFFECTIVENESS AND REVIEW

10.1 The Committee will provide an annual report outlining the activities it has undertaken throughout the year.

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

10.3 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.

10.4 The Committee will report on an annual basis to the Board of Directors on the work it has undertaken in the year and describe its work in the Annual Report.

Date Approved by Board:

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**16 APRIL 2020**
REPORT TITLE:	**CHARITABLE FUNDS COMMITTEE (CFC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR OF CFC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: CFC TERMS OF REFERENCE (TOR)**

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 key issues highlighted at the Charitable Funds Committee meeting held on 10 March 2020 are:

1. **Application for Grants**

1.1 The Committee received and approved an application for funding for Sentinel Node Sampling (Fluorescence Imaging Camera) at a cost of £103,000 and recommends this for approval by the Board.

1.2 The Committee noted that benefits to patients from provision of this equipment include speedy detection of sentinel lymph nodes, improved diagnosis, treatment and patient experience.

1.3 The Committee agreed an action to be taken forward by the Chief Medical Officer to liaise with the clinicians who put forward this funding application to confirm that this equipment and its technology are current, relevant and appropriate prior to allocation of Charity funding.

2. **Charitable Funds - Cazenove**

The Committee received annual presentation from Cazenove Capital regarding the position of the Charitable Funds' investment portfolio, potential income and planned expenditure. An investment strategy will be produced by Cazenove and submitted for approval by the Charity.

3. **Finance Report**

3.1 The Committee discussed and noted a report on the current financial position, income and expenditure of the East Kent Hospitals Charity. This included the following key elements (as at the end of January 2020):

3.1.1. Charity fund balances of £2.6m;
3.1.2. Cash position of £0.7m;
3.1.3. Investments (portfolio) of £2.3m;
3.1.4. Income for the period April 2019 to January 2020 of £0.5m;

3.1.5. Expenditure for the period April 2019 to January 2020 of £0.7m of which:
3.1.5.1 Grants to Trust April 2019 to January 2020 amounted to £0.5m with a further £0.7m committed.
3.1.6. Approval of the Charity costs and planned spend for 2020/21.

4. CFC TOR

4.1 The Committee received and discussed its annual effectiveness survey. It was agreed that a full extensive survey will be undertaken every three years and a brief survey undertaken on an annual basis. The Committee considered and approved its TOR and recommend these for approval by the Board (Appendix 1).

5. Audit update

5.1 The Committee considered an update report regarding the Charity's annual audit. It approved the option that an independent examination be undertaken and not a full audit. The Committee noted that under current regulations, the Charity meets the requirement set by The Charity Commission to have an independent examination. The Charity's Auditors, Grant Thornton, were supportive of this approach.

6. CFC Marketing update

6.1 The Committee received and noted an update report regarding future marketing activities to support fundraising for the Charity.

7. Charity Strategy 2019 - 2022

7.1 The Committee received and agreed the strategic aims and objectives of the Charity up to 2022.

8. CFC Fundraising Update

8.1 The Committee received and discussed an update report on current fundraising activities, key appeals and events of the Charity. Noting the success of The Garden of Light at Ashford McArthur Glen that to date has raised an impressive amount of be funds of almost £45,000.

8.2 The Fundraising and Development Officer will be liaising with the Chief Executive with regards to supporting the promotion of the fundraising work of the Charity and including this in the Chief Executive's blog.

9. Devereux Trust

9.1 The Committee received and discussed an update report on the Devereux Trust as well as the liability and responsibilities of its trustees; noting all decisions taken are in the best interests of the tenant.

9.2 The Committee noted the responsibilities of the Charity trustees, which included:

9.2.1 Liability for the maintenance of the property;
9.2.2 Evaluation of maintenance or other works required of the property, replacement of any fixtures and fittings that become beyond repair. Compliance with the conditions for use recommended or required by the manufacturer of any item forming part of the property. Enter into any contracts as may be reasonably necessary for the regular maintenance,

inspection and care and servicing of any items forming part of the property as shall require servicing. Pay for expenses incurred in respect of inspecting, cleaning, repairing, maintaining, altering, removing, renewing or carrying out other works to walls, fences, entrance ways, passage ways, roads, footpaths and other access ways to the property;

9.2.3 The statutory requirement that both the gas and electricity certificates are in date and the Committee received confirmation that these were in place;

9.2.4 The establishment of a robust routine maintenance review process ensuring the Charity responsibilities are met.

9.3 The Committee will receive an annual update report providing assurance that the Charity responsibilities are being met.

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. • **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	No
RESOURCE IMPLICATIONS:	Not applicable
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

East Kent Hospitals University NHS Foundation Trust

RECOMMENDATIONS AND ACTION REQUIRED:

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

- Charitable Funds Committee Chair Report;
- Charity funding application for Sentinel Node Sampling (Fluorescence Imaging Camera) at a cost of £103,000;
- Charitable Funds Committee Terms of Reference.

For NOTING: The Board is asked to **NOTE** its responsibilities in relation to the Devereux Trust.

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE

CHARITABLE FUNDS COMMITTEE

1. CONSTITUTION

1.1 The East Kent Hospitals University NHS Foundation Trust (the Trust) is the Corporate Trustee and holds assets belonging to the charity. In addition, Part 9 s177 of the Charities Act 2011 defines 'charity trustees' as 'the persons having the general control and management of the administration of the charity'. The directors of the Corporate Trustee are not Trustees; however, they act on behalf of the Corporate Trustee. The Charity is separate from the Trust and independent of it, but the Trustees always aim to work closely with the Trust. The Corporate Trustee can delegate certain powers to agents and/or employees but will always retain the ultimate responsibility for the management of the Charity.

1.2 The Board of Directors has set up a committee, to be known as the Charitable Funds Committee in accordance with its Standing Orders. The Charitable Funds Committee will oversee the charity's operation on behalf of the Corporate Trustee. The Committee will apply scrutiny and constructive challenge to the Charity's financial information and systems of control, including the Annual Accounts, to provide assurance to the Board of Directors that the administration of charitable funds is distinct from its exchequer funds and compliant with legislation and Charity objectives.

2. PURPOSE

2.1 The purpose of the Committee is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy, specifically:-

2.1.1 Develop the strategy and objectives for the charity for consideration by the Board of Directors

2.1.2 Oversee the implementation of an infrastructure appropriate to the efficient and effective running of the charity

2.1.3 Oversee the charity's expenditure

2.1.4 Oversee the charity's investment plans

2.1.5 Monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements

2.2 In order to comply with Charity Commission regulations the Committee can only act in an advisory capacity and cannot be an approving body. The Board of Directors must retain responsibility for strategic decisions and operational activities.[1] The practical application of this guidance is covered under section 6: Authority

3. OBJECTIVES

The Committee has the following specific duties and functions.

3.1 Develop the strategy and objectives for the charity for consideration by the Board of Directors

3.1.1 Monitor achievement of the Strategy and objectives. Consider annually whether any updating is to be recommended.

3.1.2 Ensure the Charity's strategy and objectives are consistent with the strategic direction of the Trust.

3.1.3 Review and submit the Annual Business plan and budget

3.1.4 Provide assurance that the activities of the Charity function do not cause conflict with those undertaken by others supporting East Kent Hospitals University NHS Foundation Trust, e.g. Leagues of Friends

3.2 Oversee the implementation of an infrastructure appropriate to the efficient and effective running of the charity

3.2.1 Agree and make recommendations for the establishment of an appropriate internal infrastructure for the charitable function including suitable office space; equipment; charity database; cash handling; banking ; insurance and legal services etc

3.2.2 Review the infrastructure and resourcing requirements as necessary

3.3 Oversee the development and delivery of the fundraising strategy

3.3.1 Agree and recommend any change to the Brand and logo of the Charity and sub branding for Major Appeals.

3.3.2 Agree and recommend a comprehensive 3 year Fundraising strategy to be incorporated within the Charity Strategy

3.3.3 Review and recommend all Fundraising policies and activities

[1] Charity Commission Guidance 86 B3 & Trustee Act 2000 Section 11

3.3.4 Review and approve marketing materials for both the external and internal market place.

3.3.5 Oversee the development of the Charity website for public access.

3.3.6 Oversee all projects for Major Appeals

3.4 Oversee the charity's expenditure

3.4.1 Review policies and procedures for the identification of projects for charitable funding

3.4.2 Review approval thresholds for expenditure from the Charity's funds

3.4.3 Receive and recommend proposals for major fundraising appeals

3.4.4 Oversee the rationalisation of existing funds

3.4.5 Review all expenditures to ensure these meet objectives of the Charity

3.4.6 Review proposals for annual commitments and capital projects for ratification by the Board of Directors

3.5 Oversee the charity's Investment Plans

3.5.1 Review investment strategies for the Charity's funds

3.5.2 Oversee the periodic retendering of the investment management contract in line with EU regulations.

3.5.3 Monitor investment data and make recommendations to ensure investment performance is maximised. Report on the performance of Investments

3.6 Monitor the performance of all aspects of the charity's activities and ensure it adheres to the principles of good governance and all relevant legal requirements

3.6.1 Monitor the effectiveness of fundraising spending and investment activities via a set of agreed metrics

3.6.2 Ensure implemented policies are consistent with Charity Law and the Department of Health legislation and guidelines.

3.6.3 Approve the annual report and accounts prior to Audit Committee approval and ratification by Board of Directors

4. MEMBERSHIP AND ATTENDANCE

Members

4.1 The membership of the Committee shall consist of three Non-Executive Directors, together with the Chief Executive, the Director of Finance and Performance, Director of Strategic Development and the Chief Medical Officer. The committee meetings shall be open to all members of the Board of Directors.

4.2 A Committee Member must make a declaration of interest at the start of meetings and must absent himself or herself from any discussions in which it is possible that a conflict may arise between his or her duty to act solely in the interests of the Charity and any personal interest (including but not limited to any personal financial interest).

4.3 The Chair of the Committee will be a Non-Executive Director appointed by the Board of Directors. If the Committee Chair is absent from the meeting, the directors present shall choose one of the other Non-Executive Director members to preside for that meeting.

Attendees

4.4 The Fundraising Manager and Charitable Funds Manager shall normally attend meetings of the committee. Others may be invited to attend meetings and or be co-opted onto the committee as and when the committee members feel it is necessary. Also the committee may invite specialist advisors such as the investment managers etc to attend meetings or parts of meetings, as deemed appropriate by the Chair.

Quorum

4.5 At any meeting of the Committee, at least two Non-Executive Directors and one Executive Director must be present. If the Chair is in attendance, this will count towards the quoracy.

Attendance by Members

4.6 The Chair or their nominated deputy of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 80% of all meetings and be allowed to send a Deputy to one meeting per annum.

Attendance by Officers

4.7 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad hoc basis

Voting

4.8 When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

5. FREQUENCY OF MEETINGS

5.1 Meetings of the Committee shall be held four times a year. The Chair may call additional meetings to ensure business is undertaken in a timely way.

6. AUTHORITY

6.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

6.2 The Committee is authorised by the Board to make decisions which are not of a significant nature. Reference should be made, as appropriate to the Standing Orders and Standing Financial Instructions of the Trust. In practice, what is significant will depend on the judgement of members but committees must refer the following types of issue to the Board of Directors:

6.2.1 Change the strategic direction of the Trust Charity.

6.2.2 Conflict with statutory obligations.

6.2.3 Contravene national policy decisions or governmental or Charity Commission directives.

6.2.4 Have significant revenue, capital or cash implications as determined by the Trust's Standing Financial Instructions.

6.2.5 Have significant governance implications.

6.2.6 Be likely to arouse significant public or media interest.

6.3 The Committee will review expenditure decisions made under delegated authority to officers, to ensure compliance with the charity's objectives and strategies.

6.2 A committee may set up permanent groups or time limited working groups to deal with specific areas of work or projects. Precise terms of reference for these shall be determined by the committee. However, Board committees are not entitled to further delegate their powers to other bodies, unless expressly authorised by the Trust Board (Standing Order 5.5 refers).

6.3 A special meeting may be called at any time by the person elected to chair meetings of the Trustees or by any two Trustees. Not less than four days' clear notice must be given to the other Trustees of the matters to be discussed at the meeting. A special meeting may be called to take place immediately after or before an ordinary meeting.

6.3 The Committee is authorised to investigate any activity within the terms of reference and to seek any information it requires from any employee and all employees are directed to co-operate with any request which in the opinion of the Chair of the Committee is properly made by the Committee.

6.4 The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary. Legal advice should normally be arranged through the Trust Secretary.

7. SERVICING ARRANGEMENTS

7.1 The Trust Board Secretary shall ensure an appropriate officer attends meetings to take minutes. Agendas and papers shall be distributed one week prior to the meeting.

8. ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

8.2 Chair reports will be provided to the Board of Directors to include: committee activity by exception; decisions made under its own delegated authority; any recommendations for decision; and any issues of significant concern.

8.3 Approved minutes will be circulated to the Board of Directors. Requests for copies of the minutes by a member of public or member of staff outside of the Committee membership will be considered in line with the Freedom of Information Act 2000.

9. MONITORING EFFECTIVENESS AND REVIEW

9.1 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

9.2 The terms of reference will be reviewed and approved by the Board of Directors on an annual basis.