East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS PUBLIC MEETING
12 NOVEMBER 2019, 10.15am
LECTURE THEATRE, SPENCER WING ENTRANCE, QEQM, CT9 4AN

This meeting will be conducted in line with the Trust Values below:

People feel **cared** for as individuals

People feel **safe**, reassured and involved

People feel teamwork, trust and **respect** sit at the heart of everything we do

People feel confident we are **making a difference**

AGENDA

Please note that this meeting will be preceded by an Extraordinary Meeting of the Council in Closed session at 9.00am, with an informal meeting of Council following on.
Refreshments will be available for all meetings and the venue open from 8.30.

Reference 19/ **Paper CoG 19/**

	HOUSEKEEPING			
36.	**Chair's introductions**	To note	10.15 (05)	*Stephen Smith Trust Chair*
37.	**Apologies for Absence and Declarations of Interest**	To note		*Stephen Smith Trust Chair*
38.	**Minutes from the last Council of Governors' Public meeting held on 5 August 2019**	To agree 038		*Stephen Smith Trust Chair*
39.	**Matters arising**	To agree 039		*Stephen Smith Trust Chair*
	BUSINESS			
40.	Chair's report	To discuss 040	10.20 (10)	*Stephen Smith Trust Chair*
41.	Chief Executive Officer's Report	To discuss Verbal	10.30 (20)	*Susan Acott CEO*
42.	Board of Directors' Quality Committee Chair's Report	To discuss 042	10.50 (20)	*Wendy Cookson NED Chair*

We care

43.	Board of Directors Integrated Audit and Governance Committee Report	To discuss 043	11.10 (20)	*Barry Wilding* *NED, Chair*
44.	Council of Governors Membership Engagement and Communication Committee report	To discuss 044	11.30 (15)	*Nick Wells* *Partner Governor, MECC Chair*
45.	Council of Governors Audit and Governance Committee Report	To discuss 045	11.45 (15)	*John East* *Public Governor, Dover* *AGC Chair*
46.	Meeting Schedule 2019 2021	To agree 046	12.00 (10)	*Alison Fox* *Group Company Secretary*
CLOSE				
47.	**ANY OTHER BUSINESS** Please notify Committee Secretary of matters to be raised deadline 48 hours before the meeting.		12.10 (5) End: 12.15	*Stephen Smith* *Trust Chair*
48.	**QUESTIONS FROM THE PUBLIC**			*Stephen Smith* *Trust Chair*
49.	**DATE OF NEXT PUBLIC MEETING** See below			*Stephen Smith* *Trust Chair*

RESOLUTION TO MOVE INTO PRIVATE SESSION FOLLOWING A 15 BREAK
That pursuant to the Trust s Constitution the Council of Governors is moving into closed session. All members of the public, including press, are to be excluded due to the confidential nature of the business to be discussed concerning contracts, negotiations and staff.

Dates of future meetings: as currently planned, may change after this meeting

DATE	DAY	TIME	TYPE	VENUE
2020				
21 January	Tuesday	09.00	Strategy meeting	WHH Boardroom
27 February	Thursday	All day	Informal, Public & closed - morning Joint with NEDs - afternoon	TBC
21 May	Thursday	09.00 (13.00 Estimate)	Informal, Public & Closed	TBC
13 July	Tuesday	All day	Training	TBC
3 August	Monday	09.00 (13.00 Estimate)	Informal, Public & Closed	TBC
September			AMM details TBC	
26 November	Thursday	09.00 (13.00 Estimate)	Informal, Public & Closed	TBC
2021				
25 January	Monday	09.00	Strategy meeting	TBC
23 February	Tuesday	All day	Informal, Public & closed - morning Joint with NEDs - afternoon	TBC

UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS MEETING
5 AUGUST 2019, 10.15am
BOARDROOM, WILLIAM HARVEY HOSPITAL, TN24 0LZ

PRESENT:

Stephen Smith	Trust Chair (Chairman)	StS
Sarah Andrews	Elected Governor Dover	SAn
Julie Barker	Elected Governor Rest of England	JBa
Robert Bayford	Partner Governor Local Authorities	RB
David Bogard	Elected Governor Staff	DBo
Mandy Carliell	Elected Governor Staff	MCa
Jenny Chittenden	Elected Governor Swale	JCh
	Up to item 15/19 Chair Appraisal & Objectives	
John East	Elected Governor Dover	JEa
Sharon Hatfield-Tugwell	Elected Governor Staff	SHT
Alex Lister	Elected Governor Canterbury	ALi
Ken Rogers	Elected Governor Swale	KRo
	Up to item 15/19 Chair Appraisal & Objectives	
John Sewell	Elected Governor Folkestone & Hythe	JSe
Marcela Warburton	Elected Governor Thanet	MWa
Nick Wells	Partnership Governor Volunteers	NWe
Junetta Whorwell	Elected Governor Ashford	JWh

IN ATTENDANCE:

Barry Wilding	Non-Executive Director	BW
Jane Ollis	Non-Executive Director	JO
	Up to and including item 26	
Nigel Mansley	Non-Executive Director	NM
Sunny Adeusi	Non-Executive Director	SA
Alison Fox	Trust Secretary	AF
Amanda Bedford	Committee Secretary (minutes)	AB
Philip Johnstone	KPMG, Director	PJ
	For item 30	

MINUTE NO. CoG/19/		ACTION
18.	**CHAIRMAN S WELCOME** The Chair welcomed Governors and Non-Executive Directors to the meeting and provided housekeeping information.	
19.	**APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Apologies were received from: Roy Dexter, Debra Towse and Philip Wells. There were no declarations of interest.	
20.	**MINUTES FROM THE LAST COUNCIL OF GOVERNORS MEETING HELD ON 24 MAY 2019** The minutes were confirmed as a correct record with the following amendment to the attendance record; Alex Lister had not been present at the meeting and should be added to the list of apologies.	

21.	**MATTERS ARISING** The updates on the outstanding actions were noted and all items closed, with one exception: 66/18(b) Midwives and overtime procedures: Council noted the update provided, requesting that the action remain open so that they continue to receive updates.	
22.	**PRESENTATION – KENT AND MEDWAY YOUTH FORUM** The presentation was given by the Co-Chair of the Kent and Medway Youth Forum, Johan Barrett – copy appended to papers. The following points were raised during the ensuring discussion; • the majority of forum members came from the Margate area, it was hoped to expand representation going forward; • the Council would welcome more engagement and involvement from younger members, recognising the challenges with meeting times falling on school days – the forum met at the weekend; • the Forum was in the early stages of development and would be exploring the direction it wanted to take when it re-convened after the summer break; • one of the Trust's aims was to encourage those living locally to train for careers in the health service and the forum was a good link for this; • NM said that he would pass on details of the Forum to the Director of Education for the Church of England Diocese Schools; • JEa noted that a meeting had already been arranged with the East Kent Colleges, who were keen to have a Forum presence on all three of their sites. • AF suggested that Governors might wish to explore options for having a young persons' representative on Council, as this may require a change in the constitution, it could be an issue that the Audit and Governance Committee could look at. **ACTIONS:** a) Pass details of the next forum meeting to NM and JEa to forward to the Church of England Diocese and the East Kent Colleges. b) CoG Audit and Governance Committee to look at options for a young persons' representation on Council.	AB AB - agenda
23.	**CHAIR'S REPORT** The following items were covered in the Chair's report. • The Chair was welcomed back following his period of sick leave. • Chair welcomed Councillor Bob Bayford to his first meeting as the Partner Governor for the Local Authorities. • It was noted that voting for the vacancies on Council would close on 19 September. • The Well Led Review has been completed and the draft report provided. It was good practice to have a review carried out by an independent organisation and the role of both Governors and Non-Executive Directors was included. The outcome would be shared with Council. • Sarah Andrews would be attending her first meeting of the Patient and Public Stakeholder Group for the Kent and Medway Pathology Programme on 29 August. • The Joint Site Visit programme continued to be welcomed by staff. There	

	was more work to do to complete the cycle and ensure that actions were taken in response to issues identified during the visits. • The next members meetings would be held in October. • There had been a very positive visit to the new Harmonia Village involving Board members and Governors.	
24.	**CEO'S REPORT** The verbal report was not provided as Liz Shutler, Deputy Chief Executive, had been called away at short notice.	
25.	**REPORT FROM THE BOARD OF DIRECTORS' FINANCE AND PERFORMANCE COMMITTEE (FPC)** SA introduced his report noting that the FPC were scheduled to meet the next day; the Month 2 figures had shown the Trust to be on track financially and agency costs were coming down. He invited questions. • SAn asked whether the Trust could deliver against its strategic plan within the finances available, taking into account the potential for extra funding from Government? SA acknowledged that it would be a challenge and it would be essential to monitor the costs of delivering the increased activity. • NWe asked what assurance the NEDs had received that quality of care would be maintained while costs were controlled. SA noted that all Cost Improvement Plans had to be submitted with a quality impact assessment which needed to be signed off by the Medical Director and Director of Nursing. Benchmarking the Trust against other organisations showed it to be quite competitive. • KRo asked whether the Trust was analysing DNA (did not attend) data and taking action. SAd said that he had confidence in the work that the Chief Operating Officer, Lee Martin, was leading, including the use of texting to encourage patients to attend appointments. • DBo noted that financial/budget training for managers was based on using the PbR model; were the NEDs assured that staff were receiving training to implement the new Aligned Incentives Contract (AIC) model? AF confirmed that training as being rolled out, although there was more to be done. DBo suggested that this might need to be accelerated given that a third of the year had passed. NM commented that the AIC model had been used in Northern Ireland for some time. He had questioned the plans and noted that the contract allowed for activity growth of 10% as long as operation was within the expected parameters of the contract. There was an emphasis on productivity so, as previously recognised, care had to be taken not to increase productivity at the expense of quality. In his view, if quality was maintained, then everything else would flow from it. SHT commented that it was difficult to see how already challenged and stressed staff could deliver more productivity. • There was general concern from Council that the success of the model depended on close and open partnership working within the health community. At present there was not much evidence of close integration between organisations; there were plans for the eight CCGs to merge at a time when primary care was failing for example, delayed transfers of care were increasing and GP appointments sometime took four weeks to set. As a consequence, more pressure was being placed on the acute Trusts, particularly the Emergency Departments. JSe	

	noted that evaluation of the pilot projects, such as Estuary View, were not showing that they were delivering as anticipated. As ever, there was risk that the Trust would be impacted by other organisations running out of funds before the year end. • The Chair confirmed that the CEO recognised the concerns that Council had identified and was raising them within the health community. As yet, re-assurance had not been provided that movement was in the right direction and the Board remained concerned. • SHT noted that the Trust had now employed an organisation, Lightfoot, which was seen as an exemplar for making a success of implementing integrated care into a community. As an experienced ED nurse, she could see where changes could be made and was interested to see what Lightfoot would bring to the situation. They had sophisticated modelling for predicting activity so staffing could be adjusted to match. • JO commented that the joint appointment of Sheila O'Riordan as the Director of Frailty had been very positive and there were some excellent steps being taken.	
26.	**REPORT FROM THE BOARD OF DIRECTORS' STRATEGIC WORKFORCE COMMITTEE (SWC)** JO presented the report noting that the Trust employs 7350 staff of which 1000 were new in year; there had been 123 new starters in June with 670 vacancies open. She commented that stability was developing in turnover, with a drop in vacancy rates. The two areas of most concern to the SWC were sickness absence and reports of harassment and bullying. The SWC was undertaking a deep dive on the issue of sickness at their next meeting as levels were steadily increasing with small monthly rises. The Committee would be looking for assurance that the Trust was being pro-active in providing support for those on long term sickness and that managers were being supported to manage the situation. Bullying and harassment had been identified as a concern via the staff survey and the Trust's figures were higher in comparison to other Kent trusts. The Trust had re-launched the Values & Respect programme and the Board had included a session on the programme at their Development Day – it was essential that Board members demonstrate the values themselves. With a large workforce getting to the point where everyone displays the preferred behaviours would take time, however, it must start with the Board. The following points were noted in the discussion: • There was a link between staffing capacity issues and increases in staff on stress related sick leave. • Staffing capacity was a complex issue with financial elements. For example, overtime had been stopped when the Trust went into financial special measures with shifts filled via NHS P. However, staff gained higher rates working via NHS P for other Trusts in the area. • DBo noted that most staff in the NHS worked unpaid overtime, often by working through lunch. Overtime was not available to administrative staff. • The Chair commented that staff in the health service did work 'above and beyond'. There should not be pressure applied for staff to undertake unpaid work. JO noted that the staff survey showed a small	

	increase in reporting that this was happening and it must be addressed. • ALi suggested that one way to handle the situation was to improve communications, identifying the problem areas and what has been done to tackle it. It should be measured more frequently than once a year via the staff survey to show what was happening in the interim. • SAn noted that there was information available to Governors via the reports to Council and Board from the SWC. AF commented that governors could raise questions to her in between formal meetings. • JO confirmed that metrics could be used to monitor progress with the Values & Respect programme; ultimately, improvement in the staff survey was the major indicator of overall progress. • The Chair summarised: bullying and harassment was recognised as a significant issue and a series of measures to address this had been taken. While it was too early to say if these were having an effect, Council should expect to see an improvement and to hold NEDs to account on this.`1` • JO commented that stress was not cited often during exit interviews. SHT felt that this might reflect staff protecting themselves. In her view the environment staff were working in was the most challenging she had experienced. She felt that this was linked to pressures to meet targets teams were less inclined to work well together, focussing instead on meeting their own internal targets. • AF noted that exit interviews could be done on line without involving line manager. The Trust operated a flexible working policy and phased back to work for those returning from sick leave where needed. • SHT noted that there was now a three week wait for occupational health appointments. • KR commented that in the past work surveys carried out by the Council with staff had provided a different picture to that seen by the Board. The Chair thanked governors for their contribution to the discussion. He concluded that the results of the next national staff survey would be the key indicator of the progress made.	
27.	**REPORT FROM CoG MEMBERSHIP COMMUNICATION AND ENGAGEMENT COMMITTEE (MECC)** NWe presented the report noting that the Committee had not seen anything significant when reviewing the membership feedback. NWe said that during the meeting ALi had raised two points: one involved the timing of meetings, which was being considered at this meeting under AOB; and the other related to his concerns about communications in the Trust. He invited ALi to speak. ALi said that while all could agree that there was good work being done in the Trust, he considered that there were problems with both the internal and external Trust communication and he was concerned that the Council was not operating effectively as a governing body. Over the last 18 months he had raised a number of issues and nothing had been done in response. There had been seven communication targets in the Trust objectives for 2018/19 and five of this had been missed this had not been included in the Governors commentary on the Trust's Quality Report, although he had requested that it should. He had also requested that the	

	Trust take some measure of wider public perception, which had not happened. The Trust needed to get good news stories out and not be seen to brush bad news under the carpet it should be proactive, open and transparent. He felt that there were problems with the whole of the Communications strategy. The media were not publishing the right stories, which suggested that the wrong ones were being sent out or the team did not have the right contacts. ALi said that he was asking in the strongest possible terms that there be a formal approach to appraising whether the Trust is doing a good job of tackling the PR problems. This was his profession field and, in his view, the Trust was not doing a good job of communications and Council should take significant action if it was not satisfied. The following points were noted in the discussion. • KRo was unsure whether ALi was referring to governors not being aware of what was happening in reality or if they were not connected with the public. If the latter, then he would agree. He felt that in general the Communications team did a good job. • JWh noted that when the CQC inspection report had noted the Trust had improved and lifted special measures, this was reported in the press. • The Chair observed that the Trust was the fourth most improved trust in the country ALi wondered whether this was being adequately communicated to the media. • BBo said that there were parallels between health care and Local Authorities good news was rarely taken up by the press. The NHS was a highly political issue and as such it was easy for the perception to be overly negative. JCh agreed that the press only picked up on bad news. • KRo said that if announcements were made by the Chair or the CEO then the press would pick them up. ALi noted that the CEO had refused an interview request from the Canterbury News. • DBo said there had been a lot of good publicity when the Trust was Dr Foster's Trust of the year. He would broadly agree that communications could be better and felt that internal communications was seen to be poor from the staffs' perspective. There had been some good discussions at the informal meeting and there needed to be a mechanism to capture any actions from these meetings and make sure that they are taken forward by a named individual. **ACTION: establish a mechanism to take forward any actions noted at the informal meeting between governors and the Chair.** • NM commented that there was a clear distinction between the PR and Communications functions. ALi agreed noting that in organisations the size of the Trust it was normally undertaken by one department. • NWe commented that this was a huge area and needed to be broken down into steps if progress was to be made. As engagement was critical to the Council's work there was a vested interest in making sure that it was done well and everyone was clear about their roles. • AF noted that the CQC report from the September 2018 visit had commended the Trust for its internal communications and the recent Well Led review by Deloittes also commented the communications team. The Chair concluded this item noting that the Non-Executive Directors	AB

	present had heard the views of the Council and would need to take these back to their colleagues.	
28.	**MEMBERS AND MEMBERSHIP ENGAGEMENT STRATEGY 2019/22** NWe explained that the draft of the document presented to the meeting was the culmination of many months of work by the Committee with earlier iterations going to the Council for comment and governors views sought on priorities for engagement. He drew attention to pages 6 and 7 of the draft which identified four principle engagement activities with two pilots also proposed. If successful and if resources were available, the list could be increased. NWe stressed that for success, all governors needed to commit to the programme. NWe explained that ALi had made strong representation to the MECC that Council should adopt a different method of working and that this should be included in the strategy. The Committee had agreed that ALi should raise this issue with the full Council and invited him to present. ALi explained that in his view it was important that the public were able to see that the Council was actually making a difference and that issues raised by members were acted upon. He was proposing a system which mirrored the way local authority Councils worked in that governors would be able to raise issues, or ask questions, which were then discussed and a vote taken. This would be a litmus test for how council feels and votes would be open so members could see how their governor voted, making governors more accountable. At present he felt that the minutes only recorded the view of the last person who spoke. AF had told him that the constitution did not preclude this approach. In discussion the following points were noted. • BBa noted that in local authority. • The Chair noted that there was a careful balance to be kept, remembering that the role of the Council was to hold the NEDs to account. AF reminded Council that they had the right to request an Executive director to attend a meeting. • SAn said that she did not see that this issue pertains to the engagement strategy. ALi said that it was appropriate as communications underpinned all the that the Council does • AF noted that the issues raised would have to be linked to a statutory duty; engagement was a statutory duty so the issues would be those raised by constituents or the public. There were already a number of processes in place for bringing public feedback to Council for consideration; these could perhaps be better used. • NWe commented that ALi s point was important; Council needed to be able to make strong and effective challenge. There was a mechanism for challenge raising the issue with the NEDs attending Council, listening to the response and if Council was not happy with the answer requesting further assurance. • AF suggested that Council should pause at the end of each item and agree if answers or assurance had been provided to issues raised and, if not, agree the action to take. This could be fed into the Governor newsletter to inform members. The Chair said that he would take this step at the end of this meeting.	

	• KRo concurred, adding that this would be a decision making process and, if needed, there could be a vote. NWe added that the discussions could also inform future agenda setting. The Chair said that further thought would be given to the process to follow. The Council **RATIFIED** draft Members and Membership Engagement Strategy without change.	
29.	**EFFECTIVENESS SURVEY ANALYSIS** AF presented the paper noting that the following themes had come through: • Council not being seen as making a difference; • Engagement with members could be improved; and • Improving working with the Board. and that she had suggested in the paper four possible questions for the Council to consider to framework their discussions. The following points were noted in the discussion. • JEa said that he had previously suggested that the Council break into smaller groups and each receive regular updates and meet with a named NED; they could then provide feedback to Council. The response had been that this had been tried in the past without success; he thought it merited consideration. • KRo commented that governors had to have regular interaction with the NEDs as Council has a key role in NED appraisal. A joint meeting to look at the Trust's future would be good. If there was to be a public consultation then the governors needed to be versed in what to say. • JCh said that there needed to be more opportunities to engage informally with the NEDs. It should also be clear what could be expected at the various Council meetings and making sure that access was equal for all governors. The situation at the Margate strategy meeting had been isolating as her mobility problems meant that she could not join in properly during the lunch break. • NM supported the idea of having opportunities for informal sessions between NEDs and Governors; time before the Annual Members Meeting would be a possibility. • MWa commented that the Joint Site Visits provided a good opportunity for governors and NEDs to work together and to observe the NEDs. A balance needs to be reached to ensure that NED time is spent to the best effect; time with governors should not detract from their other work. She felt that an annual meeting would be good. • AF noted that the support team had tried to arrange dates for an informal meeting but that had not worked. • JWh said that it was also important for NEDs to understand the governors' backgrounds.	

	The Chair thanked governors for their contributions to the discussions, which would be taken into account when planning meetings moving forward.	
30.	**ANNUAL GOVERNANCE DOCUMENTS** Philip Johnstone, from the Trust's external auditors KPMG, joined the meeting. AF relayed apologies from Amanda Hallums (AH), Chief Nurse and Director of Quality, who had been scheduled to join the meeting for this item but was unwell. PJ explained that the Auditors had three tasks: to audit the Trust's financial statements; confirm that there were proper arrangements in place to ensure Value for Money (VFM); and look at the Trust's Quality Report and audit the two national indicators and the Governors' Indicator. PJ noted that an unqualified opinion had been issued on 24 May for the accounts. The quality of the papers had been high, which was of particular note as there had been changes in the senior team during the duration of the annual audit. A material uncertainty had been highlighted in that the Trust was forecasting a £37.5M deficit which in part was dependent on cash support from the Department of Health. In previous years there had been clear agreement that this support would be provided, this year there was less certainty. PJ emphasised that the Trust was not in a unique position nationally. A qualified opinion had been issued in relation to VFM, mainly as the Trust was still in financial special measures. The content of the Quality report met the proscribed format and was in line with requirements, so a clean opinion was given. There were good systems in place in relation to the national indicators: A&E waits and 2 day cancer targets. The situation with respect to the Governor Indicator, auditing of the use of SBAR tool (Situation, Background, Assessment and Recommendation) was found to be well below standard. Information was found to be inaccurate and in some cases important data was missing. The system for recording this had worsened since the same audit had been done the previous year. The following points were noted in the discussion. • PJ said that the response from the Board had been clear dissatisfaction with the situation and a determination to improve it moving forward. • AF said that AH had confirmed that she and the Deputy Medical Director were taking this forward personally. Additional auditing was in place and performance would be monitored by the Quality Committee. • The Chair said that it was important to note the other two indicator audits on indicators had been commended.	
31.	**COUNCIL OF GOVERNORS AUDIT AND GOVERNANCE COMMITTEE (AGC) UPDATE** JEa reminded the meeting of the process the AGC followed in producing a draft for the Governor Commentary on the Trust's Annual Report. The Committee were limited to looking at quality issues as this was a commentary on the Quality Report. The Committee had raised concerns	

	about the quality data for 2018/19 directly with the Chair of the Board's Quality Committee during this process and this had worked well; he hoped to follow that pattern again in the coming year. The next meeting of the Committee was scheduled for 15 August when the will look at the Quarter 1 performance data for 2019/20 and consider the governor indicator for the year end audit. The plan was that the Committee would be regularly looking at the performance date through the year and therefore be in a better position to draft an informed commentary. AF commented that the quarterly Board Assurance Framework (BAF) would be going to each AGC meeting so the milestones could be tracked through the year. She noted that AH had aligned the quality strategy with the trust's objectives so this would work well.	
32.	**COUNCIL MEETINGS SCHEDULE FOR 2020/21** The paper was noted with no comment.	
33.	**ANY OTHER BUSINESS** <u>For the Governor Newsletter</u> The following items were identified for inclusion in the Governor Newsletter. • The importance of the Trust having good dialogue with partners to reduce unnecessary attendances. • Assurance that the staff survey results had been noted and that there was recognition of the issues relating to bullying. The Board had assured the Council that action was being taken and governors would be looking at the results of the next survey to see that there was improvement. • The discussions around making the Council more effective. <u>Timing of meetings</u> ALi proposed to Council that all meetings, including CoG Committee meetings, should be held in the evening. Holding meetings during the day discriminated against those who were working and meant that the population was not properly represented on Council. Local Councils held their meetings in the evening, so it could be done. ALi said that he had had to take about a third of his annual leave in order to attend meetings. He recognised that the support staff would need to work in the evenings, however, this should be covered via overtime or time off in lieu. He recognised that this might be more difficult for those who had carer responsibilities as they would need to find cover which is more difficult in evening hours. JCh said that she understood the point being made about representation, however, she was concerned that there would not be enough time to cover the required business in an evening meeting. Today had started at 9am and was scheduled to finish at 3pm; this would mean a midnight finish for a meeting starting at 6pm. JWh commented that there were also safety issues to consider, both for staff and governors attending the meetings. Those with carer responsibilities were unlikely to be able to attend and evening meetings would extend the working day significantly for the support team, Trust staff attending and Staff	

	Governors. KRo noted that there were no members of the public in attendance at the meeting and it would be sensible to look at what could be done to encourage attendance. Timing of the meeting would be one factor; perhaps once a year there could be a later meeting with the bigger agenda items. AF said that there could be shorter meetings in the evening focussed on core business. The Chair said that he had some sympathy with the proposal that meetings take place in the evening. ALi commented that there were few people at the table who were under 40 and employed. The Chair noted that this was a reflection of the demographic of the local population. It was **AGREED** that a task and finish group would be convened to look at meeting arrangements, including ways to improve public attendance at meetings. **ACTION: set up a task and finish group to look at meeting arrangements, including ways to improve public attendance**.	
34.	**QUESTIONS FROM THE PUBLIC** There were no members of the public present.	
35.	**DATE OF NEXT PUBLIC MEETING** 12 November 2019, QEQM.	

The meeting closed at 13.00

RESOLUTION TO MOVE INTO PRIVATE SESSION
Pursuant to the Trust's Constitution the Council of Governors moved into closed session. All members of the public, including press, were excluded due to the confidential nature of the business to be discussed concerning contracts, negotiations and staff.

Future meetings

DATE	DAY	TYPE	TIME	LOCATION
2019				
5 August	Monday	Closed and Public Council	0930 – 1300	WHH
September	TBC	Annual Members Meeting	TBC	TBC
12 November	Tuesday	Closed and Public Council	0930 – 1300	QEQM
2020				
24 January	Thursday	Strategy development	0930 – 1230	WHH
27 February	Thursday	Closed and Public Council Joint meeting with NEDs	0930 – 1600	TBC

Signed _____

Chair's initials .....

Date _____

CoG 19/39
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - COUNCIL OF GOVERNORS, PUBLIC

Action No.	Date of Meeting	Min No.	Item	Action	Target date	Action owner	Progress Note (to include the date of the meeting the action was closed)
66/18 (b)	14.02.19	66/18	Finance and Performance Report	Further clarification to be sought regarding midwives and overtime procedures		AB	24.05.19: Overtime spend in Maternity has historically been very high and the Care Group are taking action to reduce and control this. At the time of the last Council meeting the Management team were having pre-thought sessions with staff about encouraging them to work overtime via the NHS Professionals bank. This would help improve control of overtime and is cost effective. There are clear escalation processes in place to ensure safe staffing levels and overtime is agreed as needed. The Care Group has an objective to have nil spend on overtime; in future it will all be undertaken on a time in lieu basis. This is a change and the staff are going through an adaptation process. **Udate 05.08.19: controlling overtime is part of the action being taken to reduce agency spend. The aim is to move to a position of no overtime with additional hours being worked via the Bank. Work is also being done on looking at Bank staff pay rates. This work will be ongoing for some time and is also an element of the work on culture change.** **12.11.19: held open pending Council's satisfaction that the impact of overtime arrangements on staff has been resolved.**
22a/19	05.08.19	22/19	Presentation	Pass on details of the next forum meeting to Nigel Mansley and John East to be forwarded to the Church of England Diocese and East Kent Colleges.		AB	**12.11.19: as yet the date of the next forum meeting has not been set.**
22b/19	05.08.19	22/19	Presentation	CoG Audit and Governance Committee to look at options for a young persons representation on Council.		AB	**12.11.19: on the agenda for meeting on 9 December 2019.** **Propose close action.**
27/19	05.08.19	22/19	MECC Report	Establish a mechanism to take forward any actions noted at the informal meeting between governors and the Chair.		AB	**12.11.19: for further consideration**

33/19	05.08.19	22/19	AOB: meeting arrangements	Set up a task and finish group to look at meeting arrangements, including ways to improve public attendance.		AB	**12.11.19: to be convened early next year.**

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**12 NOVEMBER 2019**
REPORT TITLE:	**TRUST CHAIR S REPORT**
PAPER AUTHOR:	**TRUST CHAIR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

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

Background

Open Evenings

I was pleased to host the Open Evening at the WHH on 22 October where staff from the Surgical and Anaesthetics Care Group spoke with passion and enthusiasm about their work to improve patient pathways for elective surgical patients. This was an ongoing theme throughout the three evenings and we had a very positive reception from the members of the public who attended. I am grateful to Jane Ollis for stepping in at short notice to host the other two events when my diary changed.

It was very striking to see how changes made by individual teams in the care group are linking together to make significant impacts on the patient. For example, changes made by the pre-assessment team ensure that patients are seen as soon as possible once scheduled for a procedure which means that their bloods are taken and, if their haemoglobin levels are low, they will receive early treatment thereby improving the outcome of their procedure.

Council tasks forward plan

Governors will be aware that Amanda began planning for a Task and Finish group to work on Council meeting arrangements following discussions at the last Council meeting, and had hoped to report to this meeting. However, there was limited interest expressed in joining this group and, in the event, the suggested timeframe proved to be ambitious given the other time pressures on the support team. I have suggested that the action be held in abeyance until early next year when the Council membership changes and the group can include new governors.

This is also an opportune moment to remind Council that the elections for lead governor will be held at the start of March. The annual re-fresh of Council Committee membership will take place in February when governors will be asked to express a preference for the committee on which they wish to sit and complete a skills form to assist Alison and Amanda to formulate the starter for 10 committee membership proposal which will be brought to the February meeting of Council.

Elections for the vacancies which will arise in the Ashford and Folkestone & Hythe constituencies will start before the end of the year. The successful candidate in the recent elections for the latter constituency has had to withdraw. The timing of the elections is being confirmed at present to ensure that purdah arrangements are not breached.

October Council Session

I was pleased to meet a number of the governors due to start on 1 March next year at the

training session on 3 October, together with current governors. This was a valuable opportunity for those who will be leaving the Council in February to share their experience with incoming governors.

The afternoon session, attended only by current Council members, began a very useful discussion on the role of Council during a public consultation and the type of support that governors will need during this time. This is subject which we will return to.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to note the contents of the report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**6 JUNE 2019**
REPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

MEETING HELD ON 29 MAY 2019

1. Quality, Risk and Governance Care Group:

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

General and Specialist Medicine

1.1 The structured judgment reviews (SJRs) had identified 2 cases of poor care and it was confirmed that there are actions in place to focus on ensuring escalation is appropriate in terms of the deteriorating patient and the Board will receive an update on this at the meeting in June;

1.2 Harm free care continued to report positively for the Care Group;

1.3 In response to concern about embedding a health and safety culture, champions had been identified for each site;

1.4 Concern was highlighted about a transfer of a patient from Queen Elizabeth the Queen Mother Hospital (QEQMH) to Kent & Canterbury Hospital (K&CH) and a SJR will be undertaken

Urgent and Emergency Care

1.5 Safeguarding adults training was 68% across the Care Group and a trajectory for improvement has been agreed with the Chief Nurse to reach the required standards by August;

1.6 Hand hygiene was improving but remained a challenge

Clinical Support Services Care

1.7 There was a United Kingdom Accreditation Service (UKAS) visit in pathology and the outcome will be reported at the June meeting but there were no major concerns

reported. A Quality Assurance visit in cervical screening took place, this was a main agenda item and will be covered in more detail;

1.8 A number of scanning days had been lost due to the MRI downtime and it was agreed to write to the radiology team to thank them for their work in ensuring patient safety was maintained during the failure;

1.9 Venous thromboembolism (VTE) compliance had fallen sharply and this was being investigated, an update will be provided to the Committee in June 2019;

1.10 Pharmacy Ward audit shows a decline in performance in April and an analysis was being undertaken and would be included in the Care Group pack in June 2019; and

1.11 Therapist are supporting patients to be more mobile and implementing actions to reduce the number of falls.

Committee general feedback:

1.12 Harm free care (new) remained positive across the Trust although there was concern about an increase in falls and pressure ulcers during April 2019; the Chief Nurse confirmed actions were in place; and

1.13 Going forward all Care Groups will include a slide on complaint themes and the learning taken from these.

2. Principal Mitigated Quality Risks

The Committee received the report and ask the Board to note the following:

2.1 A number of risks have merged and new risks added about the delivery of the constitutional standards (Emergency Department (ED) performance; Referral to Treatment (RTT) and Cancer) this was to make them more specific and visible;

2.2 Concern was raised in relation to the implementation date for actions where these had been constantly moved due to non-delivery / slippages and action updates not being timely; and

2.3 It was agreed to undertake a deep dive into risk CRR28 - Lack of timely recognition of serious illness in patients presenting to the Emergency Departments.

3. Integrated Performance Report Quality, Safety, Experience, Effectiveness:

The Committee received and discussed the report, and asks the Board to note:

3.1 Mixed Sex Accommodation (MSA) breaches have reduced significantly to 3 registering amber in April (compared with 8 in March; 21 in February and 34 in January 2019). The Improvement Plan is monitored through Patient Experience Committee;

3.2 Pressure ulcers have increased; recovery focuses on action to improve the documentation of prevention strategies and appropriate deployment of medical devices. This has been added to the Bristol Safety Check List to ensure appropriate assessment is undertaken; and

3.3 The number of falls reported has increased significantly in April. The rate per 1000 bed days was 5.68 in April compared with 4.95 in March. Falls has been identified as one of the Trust Improvement priorities for the forthcoming year and the Steering Group will be overseeing the improvements.

4. Care Quality Commission (CQC) Update:

The Committee received the Care Quality Commission Update.

4.1 The Chief Nurse and Director of Quality provided re-assurance that the RAG Ratings showing against the actions, a number of those rated as Red are awaiting confirmation of evidence;

4.2 The Committee will be receiving the evidence in relation to the actions in the Paediatric Care Quality Commission (CQC) Plan actions 22 and 23; and

4.3 The Committee heard that the establishment of the Regulatory Compliance Committee

would be tasked with reviewing the evidence against action plans to support independent sign off.

5. Patient Safety Committee (PSC):

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

5.1 Within the minutes it is highlighted that staff felt under pressure not to raise incidents. This is not reflective of the strategy which is to build a reporting culture; the Care Group's provided reassurance that they had seen good levels of reporting. It is thought that this is a due to small pockets, nationally we report as expected. The action is to continue to encourage reporting and develop the culture.

6. NICE / Clinical Audit and Effectiveness Committee:

The Committee received the report and supported the derogation against recommendation 1.4.6 of NG89.

7. Cervical Screening Quality Assurance Visit:

The Committee received the report and associated action plan; assurance was given that the actions were either completed or not yet due for completion. An update will be brought back to the September meeting when all actions should have been completed.

8. 7 Day Services Board Assurance Framework:

The Committee received the report and asks the Board to note:

8.1 All Trusts should be compliant with the 4 standards by April 2020;

8.2 An action to review what steps the Trust can take to move towards 7 day services is to be brought back for discussion in June 2019; and

8.3 An analysis of 30 day readmissions was presented as part of the report and as a result the Committee has asked for a review to clarify the data.

The Committee also received and discussed the following reports.

- Never Event Action Plan Update/Learning from Never Events Annual Report.
- Quarterly Integrated Incidents, Patient Experience and Claims Report.
- Research and Innovation Committee Report and Minutes.
- Clinical Audit Programme.
- Quality Committee Work Plan.
- Care Group Quality and Risk Packs for:
    - Surgery Head Neck, Breast and Dermatology.
    - Surgery and Anaesthetics.
    - Cancer, Clinical Haematology and Haemophilia.
    - Women's and Children's.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to **APPROVE** the Quality Committee Chair Report

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: DEEP DIVE RISK CRR 28**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

MEETING HELD ON 25 JUNE 2019

1. Care Group Quality, Risk and Governance Reports

The Care Groups presented their key points and the Committee asks the Board to note the following:

Women and Children's

1.1 There has been improvement in Venous Thromboembolism (VTE) assessment compliance within gynaecology now reporting green at 97.7%. Overall compliance is 91.83%. Obstetrics is red at 88.59%. The Care Group continues with focussed work with the teams to ensure compliance improves, highlighting this is an essential part of the initial patient assessments that is required to be appropriately documented;

1.2 Following the Healthcare Safety Investigation Branch (HSIB) inspection and publication of the final report, the Head of Midwifery, Chief Executive and Medical Director met with HSIB representatives;

1.3 HSIB identified a number of cases in relation to babies being cooled. The Trust has a level 3 unit and there is a lower threshold for neonatologists for cooling babies, research also advises the cooling of babies as soon as possible. The Trust will be carrying out a deep dive looking at and identifying any themes, as well as reviewing and learning from processes followed in other trusts. The outcome of this deep dive will be reported to the Committee in October.

Cancer, Clinical Haematology and Haemophilia

2.1 Positive compliance against VTE assessment at 99.95%;
2.2 A reduced achievement of 74% against policy and audits for 2019/20 to date;
2.3 Full compliance of 100% regarding neutropenic sepsis prescription, in relation to improving the needle time for patients requiring antibiotics within an hour;
2.4 Harm free care positive at 100%;
2.5 The development of a cancer app for patients for chemotherapy and also for breast;
2.6 The Care Group had a highly successful haemophilia peer review and received excellent feedback. The review acknowledged the haemophilia unit's physiotherapy research commenting that this was world class.

Urgent and Emergency Care

3.1 Friends and Family Test (FFT) compliance improved from 79% to 84%;
3.2 Hand hygiene audits remained poor at 58%. There were no themes identified. The Care Group is focussed on raising staff awareness along with support to improve compliance around staff training, and any non-compliance is addressed with individual staff;
3.3 Compliance with the Bristol safety checklist is poor at 43%. Corrective action is in place to address this, which includes staff training, setting standards that are required to be met, completion of daily spot checks and managing individual staff for non-compliance.

General and Specialist Medicine

4.1 There were 14 wards that had gained 100% recommended, in relation to the FFT responses;
4.2 Compliance regarding Duty of Candour (DoC) letter, was significantly variable, 91% at the William Harvey Hospital, 58% at the Queen Elizabeth the Queen Mother Hospital and 47% at the Kent & Canterbury Hospital. This is being monitored weekly by the Clinical Governance Team;
4.3 The Care Group has challenges around carrying out Structured Judgement Reviews (SJRs) and sufficient time to be able to focus on these, which is being addressed through a Trust-wide business case already approved by the Strategic Investment Group;
4.4 The Care Group has introduced a carer passport. This was a direct action following a complaint from a patient's relative around the lack of access outside of visiting hours.

5 Principal Mitigated Quality Risks

The Committee received the report and ask the Board to note the following:

5.1 Three new risks have been added to the Corporate Risk Register as noted below:
- 5.1.1 CRR 69: Detriment to patients with a disability as we are non-compliant with the statutory Accessible Information standards;
- 5.1.2 CRR 70: Patients may not receive optimal care based on a clearly articulated clinical plan due to the requirement to maintain patient flow on a site;
- 5.1.3 CRR 71: Patients may be harmed if there is non-compliance with indicators within the medication safety thermometer, the Medicines Policy and national best practice. This risk is presented in Appendix 1, however, is currently under review to ensure that all relevant controls and mitigating actions are described. The risk name has been shortened to Patients may be harmed through poor medicines management.

5.2 The deep dive into risk CRR28: Lack of timely recognition of serious illness in patients presenting to the Emergency Departments (EDs) was discussed and is appended (Appendix 1) for the Board to discuss and note.

6 Infection Control

The Committee received and discussed the report, and asks the Board to note:

6.1 The significantly high flu activity currently circulating in Australia. This is not necessarily a predictor of the UK's flu season but provides a warning of the potential risk for the UK. The flu vaccination campaign will be launched later in the year highlighting the importance that those eligible take up the offer of a vaccination. The Trust will continue to ensure good uptake and encourage frontline workers to be vaccinated ;

6.2 There has been no methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias up to 25 June;

6.3 There has been seven methicillin-sensitive Staphylococcus aureus (MSSA) bacteramias, an average rate comparative to other trusts in the South of England;

6.4 The Trust took immediate action following advice from Public Health England (PHE) in relation to the confirmed cases of Listeriosis, withdrawing all sandwiches and reverting to onsite production of sandwiches. A review of the Trust's food handling processes was also undertaken, verifying that all appropriate processes were and are being followed.

7 Integrated Performance Report – Quality, Safety, Experience, Effectiveness

The Committee received and discussed the report, and asks the Board to note:

7.1 Positive performance in relation to Harm Free Care (new harms) remains green, FFT inpatient satisfaction rate remains green at 96%, falls continue to remain below the national average for acute hospitals;

7.2 Performance for complaints has reduced to amber reporting 84.9% from green the previous three consecutive months;

7.3 Areas of concern include VTE assessment that remains red at 93.7%, confirmed grade 2 and above pressure ulcers (PUs) is 59. In month there have been 2 confirmed category 3 PUs and no category 4 PUs. Targeted actions are in place to address these issues. Although C. difficile is red rated this is because of the change in the counting system introduced this year, C. difficile counts are below trajectory;

7.4 Two never events were reported but one has since been down-graded to a near miss (which is actually positive);

7.5 There were 18 reported Serious Incidents (SIs);

7.6 The Trust's overall fill rate of 101.9% is misleading because the calculation is based on a lower bed base than actual, challenges remain within some areas particularly those with high vacancies. Action is being taken to address the staffing establishment with support around focussing on recruiting to substantive funded posts, movement of staff across the wards and flexing of ward staffing profiles according to patient need.

8 Care Quality Commission (CQC) Update:

The Committee received the CQC Update and asks the Board to note:

8.1 Good progress is being made on the improvement plans;

8.2 Assurance was provided regarding the review process developed and implemented regarding evidence, to ensure that each piece of evidence is examined for assurance purposes, and actions only closed when sufficient assurance is provided.

The Committee also received and discussed the following reports.

- Patient Safety Committee (PSC), which included the complete resolution of the 18 month stoma reversal waiting list (a previous outlier on the National Bowel Cancer Audit).
- Patient Experience Committee (PEC).

- NICE/Clinical Audit and Effectiveness Committee.
- Progress update regarding the Getting it Right First Time (GIRFT) plan and actions.
- Update on the ophthalmology backlog.
- Quality Committee Work Plan.
- Care Group Quality and Risk Packs for:
    - Surgery Head, Neck and Breast.
    - Surgery and Anaesthetics.
    - Clinical Support Services.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to **APPROVE** the Quality Committee Chair Report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**12 SEPTEMBER 2019**
REPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

MEETING HELD IN AUGUST 2019 MEETING

1. **Surgery, Head, Neck, Breast and Dermatology Care Group**
   1.1. Ophthalmology transformation backlog will be cleared by December 2019, the transformation programme will tackle the multiple pathways, include workforce changes to support to patient experience and ensure quality of care.

2. **Surgery and Anaesthetics**
   2.1. There were concerns around the safeguarding training compliance but this is being progressed and monitored;
   2.2. Cancer pathway is blocked at a number of points that delay the patient pathway there are robust plans in place but does need escalation to NHS Improvement (NHSI);
   2.3. Venous thromboembolism (VTE) compliance is good; and
   2.4. Reassurance was provided in relation to the learning from the mismatched prosthesis never event.

3. **Principal Mitigated Quality Risks**
   3.1. There were a number of concerns regarding the contents of the risk register and these will be raised, discussed and actioned through the Integrated Audit and Governance Committee

4. **Integrated Performance Report**
   4.1. Venous thromboembolism (VTE) was static, incidences of pulmonary embolism are higher than expected and a focus to reinvigorate performance was agreed;
   4.2. Serious incidents were breaching control limits and an action to investigate this and report back to the Committee was taken;
   4.3. Complaints response time had deteriorated potentially due to trying to increase quality so returners should reduce;
   4.4. The Nurse in charge metric had deteriorated and a deep dive was in progress;
   4.5. It was noted that mixed sex in Intensive Therapy Unit (ITU) was not being reported in relation to fit for discharge to ward and this was being instigated; and
   4.6. The Board should note that discharges continue to hinder patient flow and any opportunities to raise this with partners should be taken.

5. NICE / Clinical Audit and Effectiveness Committee (CAEC):

5.1. Concerns were identified in relation to the Urgent and Emergency Care Group audit plan;

5.2. When there are outliers in national audits this will be discussed at NICE / CAEC with a view to providing assurance that actions are being delivered.

6. Mortality Report

6.1. Crude mortality has reduced but adjusted mortality is being impacted by coding concerns and therefore there is an unclear picture. Electronic patient record will support improving this but this is 12 months away;

6.2. Resource is required for structured judgment reviews (SJRs) and there is a business case to enable this to be added to job planning; this will increase SJRs from 5% to 60%; and

6.3. The report identifies the need for a focus on stroke mortality and this will be progressed through the Mortality and Morbidity Group.

7. Quarterly Report on Claims, Concerns and Incidents

7.1. The Chief Nurse had highlighted that improvement plans were not always robust. The focus will move from creating linear assurance driven actions to a recognition that practice and solutions required are complicated and complex. A methodology to monitor improvement will be brought back to the November meeting.

8. Central Alerts System (CAS) Alerts

8.1. It was agreed to raise the process for managing CAS alerts for medical devices with the 2gether Board through the Board Chair meetings.

9. Human Tissue Authority (HTA)

9.1. The Committee supported the Medical Director and Care Groups view that relinquishing the United Kingdom Accreditation Service (UKAS) accreditation to focus on compliance with HTA was sensible; and

9.2. The Committee Chair took an action to speak to 2gether to request prioritisation of the business case for additional capacity and the incidents relating to harm to deceased patients.

The Committee also reviewed the following reports:

- Board Assurance Framework and Progress against Annual Objectives for Quarter 1;
- Clinical Negligence Scheme for NHS Trusts (CNST) Maternity Incentive Scheme Safety Actions;
- Patient Safety Committee;
- Patient Experience Committee;
- Care Quality Commission Update;
- Care Group Quality and Risk Packs for:
    - Clinical Support Services;
    - Cancer, Clinical Haematology and Haemophilia;
    - Women's and Children's;
    - General and Specialist Medicine;
    - Urgent and Emergency Care.

MEETING HELD IN SEPTEMBER 2019

1. Quality, Risk and Governance Care Group:

The Care Groups presented their key points and the Committee asks the Board to note the following:

Clinical Support Services

1.1. Positive performance in relation to patient experience and health and safety;

1.2. VTE there was focussed work with the Interventional Radiology team to ensure compliance;

1.3. At the next Care Group business meeting each service area will be presenting their position in relation to delivery of the Care Quality Commission (CQC) action plans; many required evidence before turning Blue; and
1.4. Wireless monitoring of locked fridges will support improvement in this area.

Urgent and Emergency Care

1.5. Hand hygiene was a concern and use of technology, strategic placement of hand gels and auditing is being reviewed to support improvement;
1.6. Falls was identified as an area of focus and work with the Falls Team was crucial;
1.7. The Care Group is reviewing the evidence to support the closure of the CQC actions which will reduce the number of outstanding;
1.8. The HR Business Partner is supporting an improved position in relation to appraisals;
1.9. Safeguarding was a focus and the Care Group was gathering evidence to support the levels of attendance;
1.10. Bristol Safety Checklist audit score is low and the Care Group is keen to increase its use. Changes are being made to the tool to help improve compliance; and
1.11. Ambulance handovers are significantly improving.

Committee general feedback:

1.12. Medicines incidents seem more prevalent, the Chair of Drugs and Therapeutics Committee assessed the First Year doctors and Registered Medical Officers but this training starts at medical school. Medicines Matrons visit outlier wards to provide support; and
1.13. Both Care Groups raised provision of evidence to close CQC actions as an issue. Reassurance was provided that the evidence is available and it was down to resourcing.

2. Principal Mitigated Quality Risks

The Committee received the report and ask the Board to note the following:

2.1. The Integrated Audit and Governance Committee (IAGC) requested a review of the report to ensure it is focussed on risks and not issues and this action is underway;
2.2. Limited assurance could be taken from the content of the risk register;
2.3. The Duty of Candour risk was presented for downgrading but given the recent partial assurance internal audit and current reporting the Committee recommended that this risk is reviewed and the score not reduced at this time.

3. Integrated Performance Report Quality, Safety, Experience, Effectiveness:

The Committee received and discussed the report, and asks the Board to note:

3.1. Sickness is increasing and is being investigated through Strategic Workforce Committee;
3.2. Work is taking place in relation to the falls metric to make it more meaningful;
3.3. An improvement plan is being developed internally through review of the root cause analysis from pressure ulcers, there is some indication that the increase in numbers of patients coming through the Emergency Department (ED). However, nationally the Trust is performing well. A system quality meeting is being set up and this should enable a joint action plan to be developed; and
3.4. Care hours per patient triggered the lower control limit (negative) and it is anticipated that this will improve after the summer holidays.

4. Care Quality Commission (CQC) Update:

The Committee received the Care Quality Commission Update.

4.1. The CQC has asked to see the latest action plans; and
4.2. There is an internal Quality Review visit across Child Services planned to assess improvement;
4.3. Good progress on delivery of the overarching CQC plan is good; and
4.4. The October report will identify any actions outstanding that may require further focus and discussion about deliverability.

5. Patient Safety Committee (PSC) / Patient Experience Committee (PEC) NICE / Clinical Audit and Effectiveness Committee (CAEC):

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

5.1. There is a general concern in relation to quoracy for these committees. The Committee received assurance that this will be addressed and the Committee will keep a watching brief;

5.2. NICE / CAEC the mechanism for receiving feedback presentations on key issues is not working as anticipated and the Medical Director will monitor this; and

5.3. The Care Groups were actioned with ensuring attendance at these meetings.

6. Getting it Right First Time:

The Committee did not obtain assurance from this report as it was unclear as to the status of the actions plans including their implementation. The Chief Executive has asked for the action plans to be a standing item on the Clinical Executive Management Group before onward escalation / assurance to Quality Committee. This should rectify this issue.

7. Progress against the annual objectives: Medicines Optimisation and Deteriorating Patient

7.1. The Committee has asked for a more forward looking view for this item to ensure that the agreed plans will be delivered and achieved and any risks identified and mitigated.

8. Quality Strategy 2019-22:

The Committee received the report and asks the Board to note:

8.1. Further work is required to ensure the corporate strategies align and all aspects are measurable. The core membership of the Committee will discuss this to ensure the document clearly outlines the focus.

9. Readmission Rates:

9.1. The paper clarified the position on readmissions following a previous report and showed the expected position in terms of the difference between weekday and non-week day;

9.2. A new model for frailty was being designed to support this and would be in place from mid-October; and

9.3. 7 day working will be on the Committee agenda over the next few months.

The Committee also received and discussed the following reports.

- Quality Committee Work Plan;
- Care Group Quality and Risk Packs for:
  - Surgery Head Neck, Breast and Dermatology;
  - Surgery and Anaesthetics;
  - Cancer, Clinical Haematology and Haemophilia;
  - Women's and Children's;
  - General and Specialist Medicine.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to **APPROVE** the Quality Committee Chair report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**10 OCTOBER 2019**
REPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: GETTING IT RIGHT FIRST TIME (GIRFT) SLIDE ON ACUTE HOSPITAL PERFORMANCE INDICATORS**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

1. Strategic Objectives: Pressure Ulcers and Falls

The Committee reviews 2 of the strategic objective on a monthly rotational basis but receives a report quarterly on all the quality strategic objectives, this month the focus is pressure ulcers and falls.

1.1. The Trust reported an average falls rate of 4.84 per 1000 patients for July and August. This represents 5.14 year to date. Progress is on track to achieve green rag rating for quarter 2. It was agreed to split falls recording to 'falls' and 'falls with moderate or severe harm'.
1.2. August pressure ulcer performance was 0.858 per 1000 bed days (year to date) against a milestone of 0.84 per 1000 bed days but it is an improving position. Performance in April and May had been poor and root cause analysis had identified they issues in relation to overcrowding and flow. External support from ECIST will help identify actions to reduce overcrowding in the Emergency Department supporting improvements in pressure ulcers numbers.
1.3. In respect of the other strategic objectives, medicines optimisation and the deteriorating patient are improving for quarter 2; and
1.4. The Chief Nurse has confidence that the strategic objectives will be met for the year.

2. Integrated Performance Report

2.1. Staffing levels were lower compared with last month and it was reassuring that the wards with staffing concerns were not seeing an increase in quality or safety issues;
2.2. Friends and Family test trends were being addressed with a focus on staff training, a robust training package for overseas nurses, recruitment and retention. It was also highlighted that there had been vacancies in the senior leadership for Urgent and Emergency Care but these posts had now been filled and will support improvements;
2.3. The Medical Director raised a concern about the downward trend in the inpatient survey with respect to the nurse in charge metric which had breached the lower control limit. This will be Patient Experience Committee which reports to the Quality Committee;
2.4. It was noted that mixed sex breaches reporting will extend to areas from 1 October 2019;

2.5. It was noted that performance for VTE within General and Specialist Medicine was poor and this was a focus for the Care Group;
2.6. Discharges before midday remained a concern as did the flat-lining of the 4 hour performance in the Emergency Department. The Clinical Director for Clinical Support outlined a number of initiatives to reduce admissions and support discharges. The Medical Director produced a slide that showed the significant difference between the Trust and the national picture for patients being in hospital that were not awaiting further acute care (attached); and
2.7. RIDDORs were highlighted as an outlier and it was agreed that an update would be presented at Board.

3. Principal Mitigated Risks

3.1. Patient safety and experience risks in relation to the EU Exit were discussed and the Committee received assurance from the Executive Directors and Care Groups as to the mitigations in place empowerment of the staff during this period to act with some increased autonomy was crucial;
3.2. A high level review of the risk registers is being undertaken during September and October in order to have improved clarity of actual risk, mitigations and progress toward target scores;
3.3. The following risks were agreed by the Clinical Executive Management Group
3.3.1. CRR28 - Lack of timely recognition of serious illness in patients presenting to the Emergency Departments The likelihood of this risk occurring has been reduced due to a decreasing number of incidents where serious illness is not identified in a timely manner; and
3.3.2. CRR47 - Inability to prevent deterioration in the number of healthcare associated infections The likelihood of this risk occurring has been reduced as year to date the C. diff rate is below trajectory, there have been no MRSA bacteraemias and the rate of MSSA is below the regional average.
3.4. A new corporate risk is proposed: Pennine Ryles Tubes, used for drainage of gastric contents, have been replaced by dual licensed Enteral drainage/feeding tubes which do not drain as well vomiting could occur with the potential risk of inhalation in those patients with compromised air, escalated from the Clinical Quality and Patient Safety risk register;
3.5. It was confirmed that a new risk strategy will be presented to the November 2019 Integrated Audit and Governance Committee.

4. Care Quality Commission Update

4.1. Concern was raised in respect of the statement that there is no formal Trust framework for sharing lessons and learning from events, and Care Groups are at different levels of sophistication in how they do this. Reassurance was received that there is learning between the Care Groups on how they share learning and Women s and Children s Care Group had a well embedded process. The Director of Pharmacy highlighted Risk Wise and Medicines Wise in terms of sharing learning;
4.2. The Chief Nurse confirmed there will be a zero tolerance for failure to provide evidence and complete actions on time in relation to the CQC improvement plans; and
4.3. reassurance was received that engagement with the improvement plans across the Trust was significantly improved and whilst not all the actions were complete staff understood the implementation plans and could communicate these well.

5. Patient Safety Committee

5.1. A report of the Trust paediatric allergy services against NICE Quality Standards for paediatric allergy was presented. The Trust is not currently able to meet NICE recommended standards in terms of staffing and this is largely driven through the rise in allergy prevalence. The report recommended investment in a 2nd Consultant Paediatrician with interest in Allergy and 3 Paediatric Allergy Nurses Specialists. Separately a business case for an immunologist with a clinical interest in allergy has already been approved;
5.2. An assessment against the recommendation from this National Confidential Enquiry into Patient Outcome & Death (NCEPOD) report was presented by the paediatric

oncology lead clinician with recommendations for improvement; and

5.3. Opiate prescribing was being reviewed across the health economy.

6. Patient Experience Committee

6.1. Complaints performance has deteriorated because there was a reduced tolerance for granting extensions to respond to complaints.

7. Medicines Storage

7.1. Currently the pharmacy team audit 132 areas out of the 502 areas across the Trust and without additional resources undertaking these audits will take around 3 months;

7.2. There was a definite and sustained improvement in the safe and secure storage of medicines between March 2019 June 2019 but there had been deterioration across the Trust in August 2019 in the following audits:

7.2.1. Fridge temperatures monitored (83.8%)
7.2.2. Drug fridges locked (79.3%)
7.2.3. Medicine cupboards locked (83.3%)
7.2.4. IV fluids stored in a locked area (87.8%)
7.2.5. Ambient temperature monitored (82.5%)

The Chair requested the Director of Pharmacy and Medical Director highlight this to the Committee if this remains a problem for September and identify whether additional actions / resources are required.

The Committee also reviewed the following reports and made the following comments:

- Quality Impact Assessment review assurance was sought from the Medical Director and Chief Nurse that they did not feel under pressure to sign these off and that was confirmed;
- Concerns were raised at the lack of 7 day services strategy for the Trust; the Medical Director will be reporting to the Committee and then Board next month;
- Quoracy of the key safety and experience committees reporting to Quality Committee was a major concern and an action was taken to review the amount and timing of the committees executives, senior clinicians and nurses in the Care Groups had to attend.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to **APPROVE** the Quality Committee Chair report.

Extracts from the confirmed minutes of the Board of Directors

6 June 2019

19/44 **QUALITY COMMITTEE (QC) CHAIR REPORT**

BW reported that the new format of the QC meetings continued to work well and at each meeting there was a focussed discussion on either three or four of the Care Group Quality and Risk reports rather than all seven.

WC raised the format in which the risk register report was currently presented to the QC, which was not reflective of the work being done around risk management throughout the Trust. It was noted that there had been significant work undertaken to revise the format of future reports and that this would be presented in August.

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

4 July 2019

19/61 **QUALITY COMMITTEE (QC) CHAIR REPORT:**

- **DEEP DIVE RISK CRR28: LACK OF TIMELY RECOGNITION OF SERIOUS ILLNESS IN PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENTS (EDs)**

BW reported that future QC meetings would be chaired by WC. The Committee had discussed the deep dive into risk CRR28 and the format of the meeting had been further amended around feedback from the Care Groups, their key specific issues and the actions in place to address these. The new format was working well that was resulting in positive and constructive discussions.

In response to a question raised by SA regarding any correlation between Care Groups that were potentially entering into Financial Special Measures (FSM) and impact on quality and resulting in quality issues. BW stated that a consistent improvement in quality was being seen, focus continued on maintaining these improvements and highlighting those Care Groups that were underperforming. The format of these meetings was an on-going development and would ensure areas of risk and deterioration of quality standards to be identified and escalated. LM confirmed that this correlation was covered within the Executive Performance Reviews (EPRs) within the performance framework and triangulating any issues within the Integrated Performance Report (IPR).

ACTION: Board discussion regarding impact of finance, quality and workforce around triangulating any issues with quality of care and performance in relation to financial challenges.

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

12 September 2019

19/79 **QUALITY COMMITTEE (QC) CHAIR REPORT**

WC reported that the QC were monitoring performance within the Integrated Performance Report (IPR), as performance against some of the standards had remained static. Serious Incidents (SIs) were breaching the upper control limits. These areas were being reviewed regarding whether this identified anything indicative that needed to be addressed.

It was noted that Mixed Sex Accommodation (MSA) breaches may increase in line with the policy that all breaches within the Medical Assessment Unit (MAU) and Intensive Therapy Unit (ITU) were recorded. These were justifiable breaches based on clinical need and every effort was made to ensure privacy and dignity. This information had been reported to NHS England.

The QC received a report on the Human Tissue Authority (HTA). WC confirmed that the QC was fully supportive of the view from the Medical Director and Care Groups to relinquish the United Kingdom Accreditation Service (UKAS) accreditation to focus on compliance with the Human Tissue Authority (HTA). As the HTA process was more robust.

WC stated that the Urgent Emergency Care Group had previously reported limited governance resources and now had full governance support. The QC expected to see improvements as a result.

The QC had agreed to retain the residual risk score for Duty of Candour (DoC) and not to downgrade this due to the recent partial assurance internal audit report received. As this was a vital area and it was important to maintain focus to improve compliance.

WC reported that AH had been tasked with progressing the necessary actions to ensure positive improvements in relation to the Care Quality Commission (CQC) improvement action plan and the paediatrics action plan. With the view of moving all actions to complete (blue) within the next couple of months, as it was important that the Trust was as good as it could be.

DECISION: The Board discussed and **APPROVED** the QC report.

10 October 2019

These minutes will be confirmed at the Board meeting on 14 November. The unconfirmed minutes will be in the Board meeting papers.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**12 November 2019**
REPORT TITLE:	**Report from the Chair of the Board of Directors Quality Committee**
PAPER AUTHOR:	**Chair, Board of Directors Quality Committee** **Wendy Cookson**
PURPOSE:	**DISCUSSION**
APPENDICES:	**Annex A** Report from Chair of Quality Committee to June Board meeting **Annex B** Report from Chair of Quality Committee to July Board meeting **Annex C** Report from Chair of Quality Committee to September Board meeting **Annex D** Report from Chair of Quality Committee to October Board meeting **Annex E** Summary of Confirmed Board minutes relating to the Quality Reports

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

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

Background

I have been a member of the Board's Quality Committee since I commenced as a NED in 2017 and my nursing background qualifies me well for the role. In August this year I took on the chairmanship of the Committee and will have chaired three meetings by the time I attend Council.

My priorities are to ensure we support our clinical teams through our Executive colleagues, to truly be a learning organisation to attain clinical excellence and a outstanding experience for our patients and staff. We also look forward to two new key substantive appointments to the Trust in Amanda as our Chief Nurse and Director of Quality and, once approved, an external candidate to the Chief Medical Officer post.

In his reports to Council Barry Wilding, the previous Chair, made reference to the changes to the way which the Committee engages with the senior team in the Care Groups as advised in our Deloitte Well-Led review. We no longer have a regular programme of attendance by the Care Groups, instead we call them to attend when there is a particular issue we wish to address. This is working well and also ensures that the time of the senior teams is not wasted. The same system is followed by the Board's Finance and Performance Committee.

The report from Deloitte also highlighted some development areas in relation to the way the Board and Board Committees work. As a Board we will be looking at this in more detail at the meeting on 14 November and I anticipate that this will feed through into the way the Quality Committee operates in the future.

Governors are able to track the work of the Committee through the Chair's reports to Board of Directors meetings and the minutes of those meetings; these documents are all in the public domain. For ease of reference, Annexes A D are the reports from the Chair of the

Committee to the Trust Board meetings since the last report to Council. Annex E reproduces the relevant sections of the confirmed minutes of the Board meeting where Quality Committee Chair reports were discussed.

The following are some of the areas which I believe are of key significance and which the Quality Committee needs to remain sighted upon:

- Monitoring performance against the CQC action plan and quality visits
- The strategic objectives for this year, which the Chief Nurse believes will be met this year
- Mixed sex breaches as reporting will extend to HDU and ICU areas from 1 October 2019
- A continued move towards closing the loop in learning from incidents and complaints with the arrival of our new Deputy Director of Risk, Governance and Patient Safety Elizabeth Coles
- Medicine management including storage the Trust has 502 areas to audit, which will be completed by end January 2020

I was particularly pleased with the action that arose out of the discussions at the July Board meeting for a Board discussion regarding impact of finance, quality and workforce around triangulating any issues with quality of care and performance in relation to financial challenges. This focussed attention on the importance of ensuring that the outcomes from the Board Quality, Finance & Performance and Strategic Workforce Committees are considered as a whole and co-ordinated action taken where needed.

I look forward to discussing this report with the Council and hearing Governors views.

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

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to note this report and use the item as an opportunity to fulfil their statutory duty in holding the NEDs to account for the performance of the Board.

It is also an opportunity to share with the Non-Executive Directors present intelligence arising from Governors engagement with FT members and the public relevant to the work of the Committee.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**12 November 2019**
REPORT TITLE:	**Report from the Chair of the Board of Integrated Audit and Governance Committee**
PAPER AUTHOR:	**Chair, Board of Directors Integrated Audit and Governance Committee** **Barry Wilding**
PURPOSE:	**DISCUSSION**
APPENDICES:	**Annex A**: IAGC Chair's report to September board **Annex B:** Appendix 1 to Annex A BAF and Progress against the priorities **Annex C:** BAF (Board Assurance Framework) **Annex D:** Annual Objectives milestones **Annex E:** Extract from confirmed September Board minutes

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

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

Background

Governors are able to track the work of the Committee through the Chair's reports to Board of Directors meetings and the minutes of those meetings; these documents are all in the public domain. It is worth re-iterating that the role of the IAGC is in reviewing the Trust's systems of governance, risk management, and internal control. This includes ensuing that the way that the Quality, Finance & Performance and Strategic Workforce Committees work is fit for purpose;

This Committee does not re-visit the detailed work of looking at performance and planning in these areas; that is the role of those committees. The papers provided to the IAGC are, however, a good source of data for the Council in its role of holding the NEDs to account.

For ease of reference, the report to the September Board meeting is at Annex A, and its three appendices at Annex B – D. The confirmed minutes from the Board meeting relating to this item are at Annex E.

I would like to draw the Council's attention to the following points.

- There are four risks on the strategic and corporate risk registers that are falling outside of the Trust's risk appetite. The IAGC reviewed the mitigations in place for each of these risks at the meeting.

    - SRR 5 – Failure to achieve financial plans as agreed by NHS Improvement (NHSI)/NHS England (NHSE) under the Financial Special Measures (FSM) regimes.
    - SRR 22 – Urgent Treatment Centre not being established.
    - CRR 28 – Lack of timely recognition of serious illness in patients presenting to the EDs.
    - CRR 68 – Risk to the delivery of the operational constitutional standards and

undertakings.

- The Committee is now working with the new auditors, Grant Thornton, and matters are progressing smoothly.
- The recent new appointments to the Chief Nurse and Deputy Director of Risk posts, and the pending appointment of Paul Steven's replacement, will support the Trust in taking risk management processes to the next level.

I look forward to discussing this report with the Council and hearing Governors' views.

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

RECOMMENDATIONS AND ACTION REQUIRED:
The Council is asked to note this report and use the item as an opportunity to fulfil their statutory duty in holding the NEDs to account for the performance of the Board.

It is also an opportunity to share with the Non-Executive Directors present intelligence arising from Governors' engagement with FT members and the public relevant to the work of the Committee.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**12 SEPTEMBER 2019**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)**
BOARD SPONSOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK (BAF) AND ANNUAL OBJECTIVES 2019/20 REPORT APPENDIX 2: BOARD ASSURANCE FRAMEWORK APPENDIX 3: ACHIEVEMENT AGAINST ANNUAL OBJECTIVES 2019-20 Q1**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

MEETING HELD ON 27 AUGUST 2019

Positive assurance was received in relation to:

1. The Committee received and discussed a quarterly Cost Improvement Programme (CIP) deep dive report that focussed on the schemes for Procurement, with a total value of £2.3m. The Committee was able to interrogate the live system and gain assurance that there was evidence and documentation to support this CIP. The Committee agreed this demonstrated a high level of assurance and a quarterly report was no longer required and would be moved to annual.

2. The Committee received and discussed a report on the Board's risk appetite, acknowledging the positive engagement work of the Trust around agreeing its risk appetite. It also noted and took assurance from the actions being taken to address the risks outside the Board's Risk Appetite:

   2.1 SRR 5 – Failure to achieve financial plans as agreed by NHS Improvement (NHSI)/NHS England (NHSE) under the Financial Special Measures (FSM); and CRR 68 – Risk to the delivery of the operational constitutional standards and undertakings. Progress against the actions to mitigate these risks is reviewed and

monitored by the Finance and Performance Committee (FPC) and any issues will be escalated to the Board via the FPC Chair report; and

2.2 SRR 22 – Urgent Treatment Centre may not become established and result in increased demand to the Emergency Department (ED); and CRR 28 – Lack of timely recognition of serious illness in patients presenting to the EDs. Progress against the actions to mitigate these risks is reviewed and monitored by the Quality Committee (QC) and any issues will be escalated to the Board via the QC Chair report.

3. The Committee received and discussed a risk briefing update report regarding window restrictors following a Root Cause Analysis (RCA) and the recommended actions identified. The Committee noted that EKHUFT's Policy had been reviewed and changes implemented. Further improvements were also being considered.

4. The Committee received and discussed an update report on risk CRR 34 – Inadequate Health & Safety (H&S) Systems Embedded within the Care Groups. The Committee acknowledged the significant progress that had been achieved, thanks to the excellent and hard work of the H&S Team and staff in the Care Groups. The Health and Safety Toolkit Audit (HASTA) scores year to date (YTD) for 2019/20 are much improved from the previous year's scores; 80%-100% compared to 40%-80% in 2018/19. The Committee will maintain a watching brief with regular updates until such times as progress is sustained.

Limited assurance was received in relation to:

5. The Committee received and discussed a report on the Highest Mitigated Risks (Strategic and Corporate Risk Registers), noting the changes that had been made to the risk register. The Committee took substantial assurance from the processes and framework in place in relation to the management of risks. There needed to be more work done around improving the flow of information and the level of assurance presented regarding the actions to mitigate the risks. The actions were being progressed but updates were not always reflected in the register. To strengthen and embed the process the Committee noted the following:

5.1 The Chief Nurse and Director of Quality and Patient Experience will join the monthly risk review meetings held by the Risk Manager with the Care Groups;

5.2 The new Deputy Director of Risk, Governance and Patient Safety will commence in post in September. This will provide the opportunity to undertake a review of the processes in place regarding the management of risks and the risk system, including how to manage 'issues', provision of support to the Care Groups to ensure timely updates on actions and also holding to account where there are any gaps;

5.3 The Committee noted that there had been no changes to the residual or target risk scores, which was disappointing as this indicated lack of proactive risk management.

6. The Committee received and discussed the Quarter 1 report on the Board Assurance Framework (BAF) and Annual Objectives 2019/20, recommending this for approval by the Board (Appendix 1). The Committee noted:

6.1 The Healthy Finances annual objective was outside of the EKHUFT's risk appetite. This would continue to be monitored throughout the year and was not a concern of the Committee at the current time;

6.2 The report as presented did not provide the required level of assurance that the work and actions were being actively progressed. It was acknowledged that the work was being carried out as regular meetings were held with the Executive

Director leads to provide updates on the current position. The Executive Directors are currently in the process of reviewing their individual areas. It was noted that the Committee at its next meeting will receive a much more robust report that will be fully populated with updates on the risks.

7. The Committee received and discussed a report on the annual review of Senior Managers Risk Management Training Compliance. The Committee noted:

   7.1 A concern was raised regarding the validity of the statutory and mandatory training data compliance for the Non-Executive Directors (NEDs). It was noted that the Board had previously agreed that not all of the mandatory training was relevant for the NEDs; this had been feedback to the Learning and Development (L&D) team. This will be picked up by the Group Company Secretary with the L&D Team;
   7.2 The Committee Chair requested an update from the Director of HR confirming the NEDs statutory training compliance rate.

8. The Committee received and discussed a report with regards to Partnership Shared Risk. This provided a progress update on the current state of thinking in relation to the governance and risk management process around the Sustainability and Transformation Partnership (STP) / Integrated Care Partnerships (ICP) and Aligned Incentive Contract (AIC). The Committee needed assurance that the appropriate processes are in place and that shared risks are being managed effectively. It was agreed that the Trusts Risk Manager will discuss and work with their counterparts at the CCGs/STP, with the aim or producing a high level risk register across the STP.

9. The Committee discussed an issue raised at the Quality Committee. This was regarding concern that a number of H&S Policies were out of date and that prompt action needed to be taken to address this and that these are reviewed and updated. The Policy Authorisation Group requested an action plan detailing the policies for review and updating along with confirmation of the dates when these will be presented to the group for consideration and approval. It was noted that the overarching H&S and Fire Policies were up to date. The Committee requested a briefing on the number of policies that are out of date, mitigating reasons why these had not been updated in a timely way. The Committee requested assurance that the Regulatory Compliance Committee, once in place, would ensure this did not happen going forward.

Other reports received and discussed:

10. The Committee received and discussed a quarterly Freedom to Speak Up (FTSU) report providing an update on the activity of the FTSU Guardians in Q1, which was now beginning to get traction with positive outcomes around learning for the Trust. The following was noted:

    10.1 The Committee supported the request for a review of the required resourcing to enable all elements of the Guardian role to be delivered. The Interim Chief Nurse and Director of Quality will progress this through the appropriate governance route;
    10.2 The timeliness of progressing one investigation was raised. The Committee received reassurance that patient safety and health and safety issues were addressed immediately. The Committee requested an update on this investigation, the actions to mitigate the risks in the interim until the investigation is completed, the issues around this investigation and the reasons for the delay in completion; and
    10.3 The service was seeing an increase in the number of cases reported, which was positive as it showed an improved culture within the organisation that staff felt confident to raise issues to the Guardians.

11. The Committee received and discussed the first report presented by the Trust's new External Auditor, Grant Thornton. This provided an overview of their approach regarding the audit work along with the project plan for 2019/20.

12. The Committee approved the Policy on Procuring Non-Core Services from External Auditors.

13. The Committee received and discussed the Internal Audit progress report. Eight internal audit reports had been completed and were reported to the Committee. These included one substantial assurance, four reasonable assurance, two partial assurance and one advisory. The Committee noted the steady progress being made on the follow-up of management actions, of which there were 26 to be implemented, and to date 18 of these had been implemented and eight were being progressed. The substantial and partial assurance internal audit reports received are noted below:

    13.1 Risk Management – Substantial Assurance;
    13.2 Duty of Candour – Partial Assurance;
    13.3 Standards of Business Conduct – Partial Assurance.

14. The Committee received and discussed the Counter Fraud progress report, noting the following:

    14.1 The Annual Report providing a summary of Counter Fraud activity for 2018/19, which showed a positive compliance rating of green;
    14.2 The Counter Fraud Self-Assessment that measures Counter Fraud performance against the National Standards, which showed an overall score of green for EKHFT.

15. The Committee also received and noted the Quarter 4/Year End report on the Board Assurance Framework (BAF) and Annual Objectives 2018/19.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to:

1) Discuss the report;
2) Approve the Board Assurance Framework (BAF) and Annual Objectives 2019/20 Quarter 1 report.

East Kent Hospitals University NHS Foundation Trust

REPORT TITLE:	BOARD ASSURANCE FRAMEWORK AND ANNUAL OBJECTIVES 2019-20: QUARTER 1

BACKGROUND AND EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is the key document that records the Trust's strategic objectives, risks controls and assurances and the Quarter 1 position is provided as Appendix 1. The BAF has been completely reviewed and as a result there are some gaps in relation to assurance levels and in some cases more work on the controls is required.

The Board committees all reviewed their elements of the BAF at their August 2019 meetings. All risks except SRR5, Failure to achieve financial plans as agreed by NHS Improvement (NHSI) and NHS England (NHSE) under the Financial Special Measures regime, were within the Board's agreed risk appetite. It was agreed that the level of risk was appropriate given the current situation and a detailed activity based year-end forecast was requested as a further control. This will be presented in draft at the September Finance and Performance Committee meeting.

In terms of the first quarters' performance, all strategic objectives except Higher Standards for Patients (HSfP) were RAG rated as Green. The Finance and Performance Committee noted the continued improvement in delivering the HSfP objectives and noted the report on the actions being taken to improve. Each of the committees sought assurance on the sub-objectives where milestones had not been met and received assurance that corrective action should see them on track for Quarter 2.

The overall position is reflected below for ease. The colour coding for 'Performance' is 'green' majority on-track; 'red' majority off-track. The bracket in the Strategic Risk column indicates the Board's agreed risk appetite.

STRATEGIC OBJECTIVE	PERFORMANCE Aggregated	STRATEGIC RISK Aggregated	ASSURANCE Aggregated
Getting to Good	GREEN	MODERATE (HIGH)	ADEQUATE
Higher Standards for Patients	RED	MODERATE (HIGH)	ADEQUATE
Great Place to Work	GREEN	HIGH (SIGNIFICANT)	ADEQUATE
Delivering Our Future	GREEN	HIGH (SIGNIFICANT)	ADEQUATE
Right Skills, Right Time, Right Place	GREEN	HIGH (SIGNIFICANT)	NOT YET RATED
Healthy Finances	GREEN	SIGNIFICANT (HIGH)	ADEQUATE

The first quarter's report follows previous years' format but the Group Company Secretary is working with the Information Team to build reporting on the Annual Objectives, strategic risk and assurance into the Integrated Performance Report.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding**

East Kent Hospitals University NHS Foundation Trust

	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 report brings together the strategic risks that form the Board Assurance Framework as at 30 June 2019.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	All Board Committees have reviewed their elements.
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The IAGC is asked to:

- discuss the process and note the actions taken to address:
  - The gaps in assurance on the BAF;
  - The risk highlighted as being outside the Board's risk appetite;
  - The objective and sub-objectives where progress in Quarter 1 did not meet the milestone(s).
- Note the proposed change to the presentation of this report from Quarter 2 and highlight any concerns: and
- Suggest any changes to enhance the process.

Board Assurance Framework

Quality Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 17	The Care Groups may not deliver the improvement trajectories associated with the annual objectives **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 25 Jul 2019 **Latest Review Date:** 15 Jul 2019 **Latest Review By:** Paul Stevens **Latest Review Comments:** This is a relatively new risk and actions were reviewed last month. There is one outstanding action (launch of the Quality Strategy) which has effectively been completed	**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	I = 4 L = 4 High (16)	Agreed Improvement Plan in place with supporting Care Group Plans **Control Owner:** Amanda Hallums	Care Groups signed-off improvement plans which are monitored at their governance meetings	Quality and Risk Group (meetings monthly) oversees performance against quality standards. Quality Committee - receives the Care Group quality packs and on a quarterly basis Care Groups present their performance.		Adequate	Planned trajectories are on track in the majority of areas but some recovery work is planned on pressure ulcers and ward audits.	I = 4 L = 3 Moderate (12)	Launch of 2019/20 Quality Strategy **Person Responsible:** Amanda Hallums **To be implemented by:** 28 Jun 2019	**24 Jul 2019** **Alison Fox** Quality Strategy to be presented to the Clinical Executive Management Group on 14 August 2019	I = 4 L = 2 Moderate (8)
				Appropriate policies, procedures, guidelines and protocols in place **Control Owner:** Paul Stevens	Each policy has an assigned author who is responsible for the professional / clinical content of the policy.	The Policy Authorisation Group monitors out of date policies and highlights to the Clinical Executive Management Group where policies are out of date. They also ensure consistency of templates.		Adequate			Relaunch of Careflow system with the reintroduction of existing alerts **Person Responsible:** Michael Bedford **To be implemented by:** 31 Oct 2019	**15 Jul 2019** **Paul Stevens** All alerts are live in testing except for radiology alerts. Alerts are in the following broad categories: pathology out of range; patient admission eg transplant patients; VTE assessment recording; and EWS alerts from VitalPac	
				Audit regime in place **Control Owner:** Amanda Hallums	standardised electronic ward audits are in place.	Escalation / sign-off process in place to highlight non-compliance		Adequate	Completion of the implementation of the ward audits is end of July 2019				
				Benchmarking in place to assess performance against peers **Control Owner:** Lee Martin							Implement ReSPECT conditional on two requirements - adoption by Kent & Medway Sustainability and Transformation Partnership (STP) and an introduction of an electronic version of the tool **Person Responsible:** Michelle Webb **To be implemented by:** 29 Nov 2019		
				QII hubs **Control Owner:** Amanda Hallums	QI Hubs are overseen by the Quality Improvement team with a rolling programme of events / updates / training			Adequate			Establish a working group to embed NICE fluid management guidance **Person Responsible:** Michelle Webb **To be implemented by:** 31 Dec 2019		
				Skilled personnel and leadership in the areas of tissue viability, falls management, medicines optimisation and deteriorating patient **Control Owner:** Amanda Hallums	Skilled personnel have clear job descriptions and report through to an Executive Director to ensure there is professional leadership in the areas outlined.			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		

Board Assurance Framework

Quality Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
				Training and support **Control Owner:** Amanda Hallums	Essential role specific training is provided. The training needs analysis identifies clearly which staff need to complete relevant training. The training is provided by the "expert".	Quality and Risk Group / Executive Performance Reviews - oversee compliance with training. Quality Committee and Strategic Workforce Committee receive updates in relation to areas where there are concerns about completion of essential training.		Adequate			Improve support for managing difficult intravenous access out of hours **Person Responsible:** Gemma Oliver **To be implemented by:** 31 Mar 2020			
											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			
											Implement Medication Safety Thermometer **Person Responsible:** Jackie Shaba **To be implemented by:** 31 Mar 2020	**15 Jul 2019** **Jackie Shaba** The medication safety thermometer data is collected in a systematic format following a pharmacy driven SOP. The frequency of collection is related to performance around patients with a missed dose and continues to be facilitated by the pharmacy team with involvement from ward staff where applicable. Results are fedback to ward staff at the time and via monthly Care group reports.		
											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:** 31 Mar 2020			

Board Assurance Framework

Quality Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
											Roll out of Texas Safety Culture tool to assess safety culture **Person Responsible:** Michelle Webb **To be implemented by:** 31 Mar 2020			
											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			
											Utilise available tools more effectively to establish a baseline for current medicines safety **Person Responsible:** Will Willson **To be implemented by:** 31 Mar 2020			
											Agree timed audit programme in relation to pressure ulcers, falls, medicines optimisation and deteriorating patient **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2020			
											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			
											Ensure consistency in adherence to Vital Pac protocol across the organisation **Person Responsible:** Amanda Hallums **To be implemented by:** 31 Mar 2020			

Board Assurance Framework

Quality Committee														
Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
											Improve reporting of medication incidents and shared learning and feedback from individual medication incidents and re-occurring thematic trends identified within the MSG **Person Responsible:** Jackie Shaba **To be implemented by:** 31 Mar 2020	**15 Jul 2019** **Jackie Shaba** The reporting of medication incidents has improved as reported in the annual report to the PSC in June. The themes and more harmful incidents are reported to each Care group a as well as the Trust on a monthly basis, and Medicine Wise is published quarterly to share the learning with the wider clinical teams		

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	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:** 24 Jul 2019 **Latest Review By:** Alison Fox **Latest Review Comments:** Outstanding action is being progressed - as a result there is no change to the residual risk score.	**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.	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						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	**24 Jul 2019** **Alison Fox** Workshop held (8 July), data measures in place. Clinical redesign being tested	I = 3 L = 2 Low (6)	
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:** 25 Jul 2019 **Latest Review Date:** 08 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed by Deputy COO, requested for closure at July CEMG meeting	**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	I = 4 L = 4 High (16)	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:** Lee Martin				Adequate		I = 4 L = 4 High (16)	Director of Performance to monitor and challenge the plans for all patients over 30 weeks and agree an improvement trajectory for each specialty as appropriate **Person Responsible:** Lesley White **To be implemented by:** 31 Mar 2020		I = 4 L = 3 Moderate (12)	
				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			Care Groups are implementing weekly performance meetings with their General and Service Managers to monitor RTT performance. **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2020	**08 Jul 2019** **Rhiannon Adey** This is currently in place		
				Monthly monitoring via the Executive Performance Reviews **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						

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
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 **Risk Owner:** Lee Martin **Delegated Risk Owner:** **Last Updated:** 25 Jul 2019 **Latest Review Date:** 19 Jun 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed by COO and additional control added.	**Cause** National campaigns, celebrity or TV series storyline increasing the number of two week wait referrals a tumour site will receive **Effect** Demand exceeds capacity available Bookers struggle to have available capacity for patients Last minute additional clinics	I = 4 L = 3 Moderate (12)	Additional ad hoc capacity is provided by Consultants **Control Owner:** Christine Hudson						I = 4 L = 3 Moderate (12)	Review of current pathways to ensure that they comply with Cancer Network best practice timed pathways. **Person Responsible:** Andrew Nordin **To be implemented by:** 31 Mar 2020	**02 Jul 2019** **Rhiannon Adey** Update on behalf of Andy Nordin - We have made great progress with this - as evidenced by the improved 62 day cancer waiting times performance. There is still some way to go with some tumour sites.	I = 2 L = 2 Low (4)	
				Cancer Alliance pre-empt campaigns with an annual timeline **Control Owner:** Sarah Collins										
				Cancer Improvement Plan in place **Control Owner:** Sarah Collins										
				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:** Lesley White							Review all outpatient clinic capacity **Person Responsible:** Jackie Tapp **To be implemented by:** 31 Mar 2020	**24 Jul 2019** **Alison Fox** Work to map capacity across summer to maximise opportunities.		
				Non cancer outpatient capacity is re-allocated to cancer pathway **Control Owner:** Natalie Acheson							Review all outpatient clinic capacity **Person Responsible:** Natalie Acheson **To be implemented by:** 31 Mar 2020	**24 Jul 2019** **Alison Fox** Work to map capacity across summer to maximise opportunities.		
				Non cancer outpatient capacity is re-allocated to cancer pathway **Control Owner:** Sarah Hyett							Review all outpatient clinic capacity **Person Responsible:** Sarah Hyett **To be implemented by:** 31 Mar 2020	**24 Jul 2019** **Alison Fox** Work to map capacity across summer to maximise opportunities.		
				Non cancer outpatient capacity is re-allocated to cancer pathway **Control Owner:** Victoria Harrison							Review all outpatient clinic capacity **Person Responsible:** Victoria Harrison **To be implemented by:** 31 Mar 2020	**24 Jul 2019** **Alison Fox** Work to map capacity across summer to maximise opportunities.		
				Weekly cancer PTL meeting to monitor all cancer standards **Control Owner:** Sarah Collins										
				Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Operations Directors and General Managers **Control Owner:** Mary Tunbridge										

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
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:** 25 Jul 2019 **Latest Review Date:** 08 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed by Deputy COO, assurance provided against the controls and additional actions added to mitigate the risk. Numbers of referrals are increasing for specific tumour groups.	**Cause** Lack of capacity Consultant based decision **Effect** Patients wait longer for diagnostics and treatment plan	I = 4 L = 4 High (16)	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		I = 4 L = 4 High (16)	Additional RTT training to be delivered to Ops Managers **Person Responsible:** Mary Tunbridge **To be implemented by:** 31 Jul 2019	**24 Jul 2019** **Alison Fox** Training for Ops Directors and General Managers took place in July 2019	I = 4 L = 2 Moderate (8)	
				Track patients through their pathway to ensure there are no internal delays and the pathway is optimal **Control Owner:** Sarah Collins				Limited			Review Job Plans to increase flexibility **Person Responsible:** Sarah Collins **To be implemented by:** 31 Jul 2019	**24 Jul 2019** **Alison Fox** Review of job plans is on-going in the Care Groups with the aim of maximising capacity		
				Weekly cancer PTL meeting to monitor all cancer standards **Control Owner:** Mary Tunbridge				Adequate	Numbers of referrals are increasing for specific tumour groups which is testing the adequacy of the controls		COO to COO escalation to progress patients pathways as and when appropriate. **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2020	**08 Jul 2019** **Rhiannon Adey** Update on behalf of Mary Tunbridge - Daily escalation as and when required. Now have a named contact in London Cancer Network.		
				Weekly KPI meeting led by COO, Deputy COO for Elective Services and Director of Performance with Operations Directors and General Managers **Control Owner:** Mary Tunbridge				Adequate			Review of current pathways to ensure that they comply with Cancer Network best practice timed pathways. **Person Responsible:** Andrew Nordin **To be implemented by:** 31 Mar 2020	**02 Jul 2019** **Rhiannon Adey** Update on behalf of Andy Nordin - We have made great progress with this - as evidenced by the improved 62 day cancer waiting times performance. There is still some way to go with some tumour sites.		
				Weekly tertiary centre PTL to escalate any patients of concern **Control Owner:** Sarah Collins				Adequate						

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	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:** 25 Jul 2019 **Latest Review Date:** 08 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed by Deputy COO and delegated to Matthew Pomeroy	**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	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)	Accommodation options are being explored **Person Responsible:** Matthew Pomeroy **To be implemented by:** 31 Dec 2019	**24 Jul 2019** **Alison Fox** Architect plans are progressing for QEQM	I = 4 L = 3 Moderate (12)	
				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			Pathways are being developed to maximise integration of primary and secondary care staff **Person Responsible:** Matthew Pomeroy **To be implemented by:** 31 Mar 2020	**24 Jul 2019** **Alison Fox** Work continues with primary Care to develop pathways and models of care and to establish rotas.		
				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						

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	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:** 25 Jul 2019 **Latest Review Date:** 08 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Plans have progressed. Appointed integrated frailty lead. Moving ahead with frailty service and additional appointments are being made.	**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	I = 5 L = 3 High (15)	A joint clinical lead has been appointed to lead the service **Control Owner:** Lee Martin				Limited		I = 5 L = 3 High (15)	Implementation plan is being developed **Person Responsible:** Lee Martin **To be implemented by:** 31 Jul 2019	**08 Jul 2019** **Rhiannon Adey** This is progressing. Integrated frailty lead has been appointed and additional appointments are underway.	I = 5 L = 2 Moderate (10)	
				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				Limited			A joint programme manager will be appointed to implement the service **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2020	**24 Jul 2019** **Alison Fox** Interviews recently took place but joint appointment was unsuccessful. Interim plan in place to avoid delays.		
				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				Limited			Pathways are being developed to maximise integration of primary and secondary care staff **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2020	**24 Jul 2019** **Alison Fox** 1. ART confirmed for QEQM (GP in reach). 2. Assessment form ready for use. Rockwood scores adopted 3. Communications plan in place and commenced in June 2019 4. Links to community hubs established in Canterbury, Ashford, Dover and Deal. 5. Internal work to progress Minster QEQM on 1/8/19 6. Joint QEQM / WHH AMU meeting being organised to assess the model in AMU.		
				Senior management support has been identified to support the project **Control Owner:** Lee Martin				Limited						
				The project is being monitored monthly through the Local Care implementation group meetings **Control Owner:** Elizabeth Shutler				Limited						

Board Assurance Framework

Board of Directors

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	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:** 05 Jul 2019 **Latest Review Date:** 05 Jul 2019 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Controls / actions amended and updated.	**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	I = 4 L = 4 High (16)	Freedom to speak up guardians available **Control Owner:** Andrea Ashman						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		I = 2 L = 2 Low (4)	
				Guidance and toolkits **Control Owner:** Andrea Ashman										
				Leadership Development Plans and targeted development plans for individuals in place **Control Owner:** Andrea Ashman							Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2020			
				Leadership diagnostics **Control Owner:** Andrea Ashman							Develop operational leadership and tactical competencies at Clinical Director, Head of Nursing and Director of Operations level, General Manager and Matron level provided by external facilitator and NHS Elect. **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2020	**05 Jul 2019** **Rhiannon Adey** Programme is in progress, commencing with Clinical Directors, Heads of Nursing and extended out to Operations Directors. Currently at midpoint of the programme.		
				Staff Survey local action plans **Control Owner:** Andrea Ashman							To ensure appraisals are quality assured by HR Business Partners **Person Responsible:** Karl Woods **To be implemented by:** 31 Jul 2020			
				Team Talk sessions **Control Owner:** Andrea Ashman										

Board Assurance Framework

Board of Directors

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
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:** 05 Jul 2019 **Latest Review Date:** 05 Jul 2019 **Latest Review By:** Andrea Ashman **Latest Review Comments:** reviewed and recommend for closure. Issues picked up in SR24 already	**Cause** **Effect**	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						I = 3 L = 4 Moderate (12)	Conduct a quality audit of 10% of 2018/19 appraisals **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2020		I = 3 L = 2 Low (6)	
				Appraisal policies in place for all staff **Control Owner:** Andrea Ashman										
				Appraisal section including FAQ and Toolkit on Staff Zone available for all staff **Control Owner:** Andrea Ashman										
				Appraisal training in place for all staff **Control Owner:** Andrea Ashman										

Strategic Workforce Committee

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

Board Assurance Framework

Strategic Workforce Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	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:** 05 Jul 2019 **Latest Review Date:** 05 Jul 2019 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Actions updated	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff * Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) * Uncertainty due to the STP plans * Increase in service demand * Potential negative impact that may arise from the publication of the Staff Survey Results. * Reputation of some medical specialties * Split site organisation increases the intensity of on call rotas **Effect** * Potential negative impact on patient outcomes and experience * High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups * Patient safety * Service delivery * Turnover * Unsafe staffing * Overtime * Withdrawal of GMC support	I = 5 L = 5 Extreme (25)	The Trust has a plan in place that supports the retention of newly qualified nursing staff locally. **Control Owner:** Amanda Hallums	*Dedicated Practice Development Nurse lead for supporting students on placement. *Progress monitoring and clinical support of all students. *Mentor support and training	*Regular meetings with Canterbury ChristChurch University - Contract monitoring meetings, faculty learning placement committee, curriculum group attended regularly. *100% students who apply to work with us are offered a post. *Monitoring of numbers of newly qualified nurses recruited and reported within N+M workforce plan. This demonstrates an improvement from 50% to 70% since 2014.		Adequate		I = 5 L = 3 High (15)	Revise and implement Care Group Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 29 Mar 2019	**12 Jun 2019** **Jane Waters** HRBPs working with Care Group triumvirates to focus on Trust values and behaviours following feedback of staff survey results.	I = 4 L = 2 Moderate (8)
				Care Group Great Place to Work Action Plans in place **Control Owner:** Jane Waters	- Plans available for all to access on Staff zone - Reviewed at the Care Group Business Boards	Progress of Plan reviewed quarterly at Clinical Executive Management Group and annually at the Strategic Workforce Committee		Adequate	Action Plan requires updating following receipt of the Annual NHS Staff Survey Results		Develop and implement a plan to recruit nurses and Drs from the UK, Europe and other countries **Person Responsible:** Louise Goldup **To be implemented by:** 30 Apr 2019	**05 Feb 2019** **Sarah James-Whatman** Draft recruitment and retention strategy has been developed and will be implemented by 1st April. Procurement process for a dedicated international recruitment agency is underway and is expected to be awarded by 31st March 2019 with campaigns scheduled in Sri Lanka for Specialty Drs in March and nurse, Medical and Sonographer recruitment in June 2019. Established pipeline of Radiographer resources from Italy and this will be offered as a model to STP partners to provide and retina resources for the Region.	
				Hard to recruit plan in place and being implemented **Control Owner:** Louise Goldup	*Updated fortnightly by the Resourcing team *Sent to the HRBPs on a monthly basis	*Signed off at the end of July 2017 *Reported monthly as part of the high level CQC improvement plan		Adequate	Plan may not be progressing				
				Implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Discussed at the Workforce CIP meeting	Regularly reviewed at SWC (deep dives on Turnover and Exit information)		Adequate					
				Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Highlight Occupational Health reports Director and Deputy Director of HR Exit Interviews and Picker Survey reports highlight areas of concerns	Occupational Health Reports to SWC quarterly		Adequate					
				Revised recruitment process has been implemented **Control Owner:** Andrea Ashman	Length of time to recruit is monitored monthly and provided as part of the IPR	Workforce KPI reviewed by the SWC at every meeting		Adequate	Programme of work being looked at to reduce time to hire (target to reduce this to 8 weeks). Updated Recruitment Improvement Plan produced which will support delivery of this timescale.		Workforce remodelling plans to introduce new roles, develop and retain staff and meet the clinical needs of the approved Clinical Strategy and 10 year plan. **Person Responsible:** Sarah James-Whatman **To be implemented by:** 30 Aug 2019		

Strategic Workforce Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
				Staff Performance Appraisals in place **Control Owner:** Jane Waters	*HR BPs carry out audit on the quality of the process and monitor the numbers of appraisals that take place	- Regular monitoring through a number of routes - Care Group Governance Boards, EPR meetings and Strategic Workforce Committee and Board	Annual staff survey results and the Picker Exit survey	Substantial	Achieved target set by the Board and now moving towards monitoring of the quality of appraisals		Work as an STP region to agree common values and approach to recruitment and retention for the stability and safety of patient care within the region **Person Responsible:** Louise Goldup **To be implemented by:** 31 Dec 2019			
				Training plans in place in each Care Group / corporate area that supports staff development. **Control Owner:** Andrea Ashman	- Each Division agrees their training plan - HR BPs review the plans on an annual basis	- Annual review by the Divisions - Annual reports to the Integrated Education Board		Adequate	*Funding gap - more bids than can be supported *Understanding of process and outcomes		Increase in staff use of benefit platform **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2020	**05 Jul 2019** **Rhiannon Adey** Rob Fordham is developing a wider suite of benefits to encourage increased take up. Recently launched lease cars to go live in the next six weeks.		
											Corporate retention Group works in partnership with NHSI to monitor and continue to improve Trust retention rates. A particular emphasis needs to be placed on retention plans for Stroke, ED and General Medicine. **Person Responsible:** Sarah James-Whatman **To be implemented by:** 31 Mar 2020			
											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			
											Pursue streamlining and passporting opportunities for new appointments across the STP **Person Responsible:** Sarah James-Whatman **To be implemented by:** 31 Mar 2021			

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
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:** **Last Updated:** 25 Jul 2019 **Latest Review Date:** 02 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Awaiting outcome of the business case from NHSI	**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	I = 4 L = 5 Extreme (20)	An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Elizabeth Shutler	Deputy Director of Estates and Director of Capital receive information from all areas of the Trust regarding maintenance and undertake a first pass at prioritisation. Capital PLanning Group - review the prioritisation exercise	FPC receive reports about Backlog maintenance showing the risks.		Adequate		I = 4 L = 4 High (16)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee **Person Responsible:** Elizabeth Shutler **To be implemented by:** 29 Nov 2019	**02 Jul 2019** **Rhiannon Adey** Business case to be submitted by November 2019 in line with NHS England timetable.	I = 4 L = 2 Moderate (8)
				Interim Estates Strategy in place **Control Owner:** Elizabeth Shutler	*Approved by Clinical Executive Management Group	- Strategy approved by the Trust Board - New NED in place to provide challenge		Adequate			The Trust has engaged with NHSI to agree priorities to spend in 18/19 and 19/20. This is with a view to reduce the Trust Backlog position further. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020	**02 Jul 2019** **Rhiannon Adey** Awaiting outcome of the business case from NHSI	
				Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Clinical Executive Management Group receives reports from Director of Strategy and Capital Planning. Business cases are received on an ad-hoc basis - some of which require improvement to infrastructure	FPC and Trust Board receives quarterly reports on capital spend.		Adequate					
				Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2017/18 **Control Owner:** Elizabeth Shutler	PEIC Action Plan available to view - The Patient Environment Investment Committee (PEIC) manages the annual investment, replacement and repair programme	*Plan approved by SIG in May 2017 *Strategic Investment Group (SIG) monthly reviews progress of action plan		Adequate					

Board Assurance Framework

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

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
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:** 03 Jul 2019 **Latest Review By:** Simon Hayward **Latest Review Comments:** Trust Executive agreed Strategic Priorities for next three years and transformation teams effort if now focused on supporting these e.g. theatres, maternity transformation and Paediatric transformation. The Getting to Good steering Groups has been reviewed and linked to strategic objectives and to the CQC improvement requirements	**Cause** * Lack of experience / capability in the particular area of change * Lack of capacity of those who need to lead and embed the change * Lack of resources to deliver / implement and sustain change * Trust's lack of appetite for change in some areas to be implemented *Unavailability of the space and physical resources to implement and embed improvements * Mechanism / governance structures for Transformation is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to deliver the transformation required to meet Trust objectives * Licence restrictions *Regulatory concerns * Reputational damage	I = 4 L = 5 Extreme (20)	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	*Implementation Team in place to deliver 8 point agenda *Skills audit complete *Head of Transformation in post and Chairing Group *Focus on training and development and Trust wide methodology	*Purpose agreed by EMT in June 2017 *Reports to EMT and the Transformation Improvement Group *Programme, project and improvement methodology for the Transformation journey was submitted the Transformation Improvement Group in October 2017 - to be agreed with programme refresh in 2018 *Improvement proposal going to Trust board March 2018		Adequate					
				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	Reports to the Chief Executive	Independent assessment of all financial information including discussions with Exec team and senior leadership teams		Substantial					
				Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Andrea Ashman	Implementation plan in place and completed for Phase . Alignment review completed and shared with NHSI	EMT workshops held between February and April 2017 to agree transformation work-streams linked to financial recovery CIPs and annual priorities.		Adequate					
				Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS hospitals **Control Owner:** Elizabeth Shutler	*Programme Manager does monthly horizon scanning *Periodic trips to other European Health Services *Periodic visits to other NHS Trust with similar issues to identify good practice.	*Reports on Horizon Scanning are presented for information to EMT and Management Board. * Presentations to committees and Board on an ad hoc basis.	Clinical Senate reviews held periodically - reviews models of care and adherence to best practice	Adequate	Links to transformation / service improvement from learnings not explicit.				

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
				Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	*Principles for the transformation governance agreed through alignment review, workshops and follow-up work with EY / Plum *Financial recovery governance included input from Financial Improvement Director and linked to Transformation governance.	* EMT review of governance structures via email * Board reviewed the draft proposal (10/4/17)	Discussed at a Financial Oversight meeting with NHSI	Adequate						
				Transformation Improvement Group is in place to ensure programme is delivered **Control Owner:** Susan Acott				Adequate					
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:** **Last Updated:** 25 Jul 2019 **Latest Review Date:** 02 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Business case to be submitted by November 2019 in line with NHS England timetable.	**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	I = 5 L = 4 Extreme (20)	STP Governance Process **Control Owner:** Elizabeth Shutler						I = 5 L = 4 Extreme (20)	Influence CCG through STP Governance Process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020	**02 Jul 2019** **Rhiannon Adey** Business case to be submitted by November 2019 in line with NHS England timetable.	I = 5 L = 3 High (15)	
				STP system leaders group **Control Owner:** Elizabeth Shutler							Chief Executive and Chairman engage external bodies to gain support **Person Responsible:** Susan Acott **To be implemented by:** 31 Mar 2020	**10 Jun 2019** **Susan Acott** Meetings with Anne Eden, Glen Douglas to progress and share context; ensuring the evaluation is completed on time and schedule to the correct quality - several conversations internally and externally to facilitate inc Nuffield Trust		

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	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 project **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** **Last Updated:** 25 Jul 2019 **Latest Review Date:** **Latest Review By:** **Latest Review Comments:**	**Cause** **Effect**	I = 4 L = 4 High (16)	Chief Executive lead appointed for East Kent Integrated Care Partnership (ICP) **Control Owner:** Elizabeth Shutler						I = 4 L = 4 High (16)	Review governance information for the Integrated Care Partnership **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020		I = 4 L = 2 Moderate (8)	
				Clinical Executive Management Group review large scale change programmes **Control Owner:** Elizabeth Shutler							East Kent ICP development board terms of reference **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020			
				Programme governance structure in place reporting to CEMG **Control Owner:** Elizabeth Shutler										
SRR 28	If capital is not allocated to the permanent orthopaedic theatres this may impact on delivery of care across the Trust **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 25 Jul 2019 **Latest Review Date:** 02 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Awaiting confirmation from NHSI whether capital is available. Alternative options are being sought.	**Cause** **Effect**	I = 4 L = 3 Moderate (12)	Care Group Steering Group **Control Owner:** Elizabeth Shutler						I = 4 L = 3 Moderate (12)	Continued engagement with consultants throughout the process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020		I = 4 L = 2 Moderate (8)	
				Engagement and updates with Clinical Leads **Control Owner:** Elizabeth Shutler							Evaluation criteria completed and signed off **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020			
				Mobile laminar flow operating theatres currently in place **Control Owner:** Elizabeth Shutler										
				Orthopaedic pilot currently on-going **Control Owner:** Elizabeth Shutler							Chief Executive and Chairman in negotiation with the centre for capital **Person Responsible:** Susan Acott **To be implemented by:** 31 Mar 2020	**10 Jun 2019** **Susan Acott** FD and I have met with finance team at NHSI albeit without definitive conclusion; currently considering financial flexibilities with the theatre provider and our own subsidiaries		

Board Assurance Framework

Board of Directors

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
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:** 05 Jul 2019 **Latest Review Date:** 05 Jul 2019 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Controls updated and actions assigned	**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	I = 4 L = 4 High (16)	Ambassadors for Freedom to Speak Up **Control Owner:** Michelle Webb						I = 4 L = 4 High (16)	Increased take up of resilience and respect workshops **Person Responsible:** Claire Berry **To be implemented by:** 31 Dec 2019		I = 4 L = 2 Moderate (8)	
				Annual Staff Survey **Control Owner:** Andrea Ashman							Raising the profile of workforce equality, diversity and inclusion **Person Responsible:** Bruce Campion-Smith **To be implemented by:** 31 Mar 2020			
				Leadership development programme in place **Control Owner:** Andrea Ashman							Source and implement a cultural change programme **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2020			
				Occupational Health service provide one to one support **Control Owner:** Andrea Ashman							Delivery of cultural change programme at Care Group level **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2021			
				Staff Networks in place **Control Owner:** Andrea Ashman							Resource mindfulness programmes to invest in health and wellbeing of staff **Person Responsible:** Emma Palmer **To be implemented by:** 31 Mar 2021	**16 Jul 2019** **Emma Palmer** Risk removed as this has now been incorporated into the Mental Health Action Plan		

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	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:** 02 Jul 2019 **Latest Review Date:** 02 Jul 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** At end of month 2 the Trust is £134,000 better than plan. The forecast remains at £36.6 million deficit and the actions in this risk record will be closely managed to ensure optimum position	**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	I = 5 L = 5 Extreme (25)	Clinically led business planning process embedded. **Control Owner:** Philip Cave	Business planning meetings	*Review by CEMG; and feeds into the FPC and Board		Limited	External assurance not yet completed. This will be undertaken as part of the well-led review, results will be presented to the Board in July 2019.	I = 5 L = 4 Extreme (20)	Executives to be given objective relating to financial performance **Person Responsible:** Susan Acott **To be implemented by:** 31 May 2019	**14 May 2019** **Rhiannon Adey** Appraisals for Executives is underway	I = 5 L = 3 High (15)
				Contracted ex-Chief Executive to provide challenge to the Care Groups and Executives **Control Owner:** Susan Acott	Reports to CEO	- Report to Executive Team and Board - Report to FPC	Appointed by NHSI and reports to NHSI	Substantial			Provide to Finance Committee the robust temporary staffing policy **Person Responsible:** Andrea Ashman **To be implemented by:** 26 Jul 2019	**02 Jul 2019** **Rhiannon Adey** SJW update 28/6/2019 The policy has now been approved by the Trust Policy approval Group on 26th June providing several minor changes are made and the policy is included on the Staff Committee agenda on 16th July 2019.	
				Cost Improvement Plan for 2019/20 developed **Control Owner:** Philip Cave			Sign off of plan by NHSI	Adequate					
				Cost Improvement Plan targets in place with workstream in support **Control Owner:** Philip Cave	*Monthly Executive Performance Review and Key Metric Reviews *Fortnightly confirm and challenge meetings with the Financial Improvement Director (FID)	* Executive review weekly * Turnaround report to FPC * Exception reports to BoD	- NHSI challenge at Performance Review meetings (monthly) - NHSI carrying out deep dive review around sustainability for 2017/18, 2018/19 (including Governance) - Appointment of Financial Improvement Director	Adequate					
				Financial Annual Plan for 2019/20 in place **Control Owner:** Philip Cave	- Care Groups, PMO and FID developed plans	*Board received plan on 26/03/19 *Reviewed at FPC and Board monthly	*FID developed plans *Integrated Assurance meetings monthly with NHSI to review plan	Substantial			Full implementation of rostering for medical staffing and demonstrate 100% compliance on usage **Person Responsible:** Paul Stevens **To be implemented by:** 31 Jul 2019		
				Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Philip Cave	*Chaired by the Finance Director	*Monthly reports to FIC	NHSI and FID attend FIOG meetings	Adequate			Create and implement a clear workforce document outlining vacancies, future need and recruitment plan by Care Group **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Jul 2019	**15 Apr 2019** **Andrea Ashman** Work underway with HRBPs / resourcing and Beautiful Information to produce charts with accurate / current information. Initial draft expected for June SWC	
				Fortnightly confirm and challenge meetings with the Care Groups (including Corporate) **Control Owner:** Philip Cave	*Chaired by the Head of PMO	*Monthly review by TIG	*Financial Improvement Director to oversee on a quarterly basis confirm and challenge meetings	Adequate			Proposal to be developed to FPC on training for the Trust on budget management **Person Responsible:** Guy Dentith **To be implemented by:** 30 Aug 2019	**02 Jul 2019** **Rhiannon Adey** Formal objectives have now been set with Deputy Director of Finance to lead on this project.	
				HFMA training available for staff across the Trust **Control Owner:** Andrea Ashman				Adequate					
				Improved Business Planning process in place for 2019/20 **Control Owner:** Philip Cave				Adequate					

Board Assurance Framework

Finance and Performance Committee

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	
				Local Vacancy Control Panel in place **Control Owner:** Philip Cave	Chaired by the Deputy Chief Executive	*Escalation to weekly EMT meetings *Review at Confirm and Challenge sessions with the FID		Adequate			Strategy to be developed to use benchmarking tools including Patient Level Costing, Service Line Reporting, Model Hospital, Getting It Right First Time and RightCare **Person Responsible:** Guy Dentith **To be implemented by:** 30 Sep 2019	**02 Jul 2019** **Rhiannon Adey** Objectives have been set for the Deputy Director and on track for delivery		
				Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Philip Cave	*Escalated through the FD to the CEO	*Escalate concerns to NHSI *Finance & Technical Group meetings with NHSI	*New MoU signed with the Commissioners	Adequate	Trust is seeking assurance from NHSE/I about next steps - Commissioners challenge					
				Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Philip Cave	*Information and Income Teams monitor and report on plan *Information Team produce monthly update of Productivity plans (with forward looking indicators)	Review by the FIOG; and FIC if escalation is required		Adequate			Design and implement finance function training for clinicians **Person Responsible:** Guy Dentith **To be implemented by:** 30 Sep 2019	**02 Jul 2019** **Rhiannon Adey** Clinical Development Programme - Financial Awareness and Business Planning Day on 17 September		
				Programme Management Office (PMO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Philip Cave	*Weekly CIP tracking *Direct line management by Director of Finance	*Monthly reports to CEMG, EPR and FPC	Regular contact with NHSI	Adequate			Full implementation of HealthRoster for nursing and demonstrate 100% sign off within 6 weeks **Person Responsible:** Amanda Hallums **To be implemented by:** 30 Sep 2019			
				Regular reporting on the Trust's Financial position to the Trust Board and senior management team (including ensuring the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood). **Control Owner:** Philip Cave	*Review by Executive Management Team *Care Groups attend FPC on a four monthly rolling basis	*Regular updates to FPC, Board, Clinical Executive Management Group and Transformation Improvement Group *Review at the A&E Governance Board (currently meeting three times a week)	Monthly FSM meetings with NHSI and FID.	Adequate			Care Groups to work with the PMO to identify 90% green CIPs for 2019/20 **Person Responsible:** Philip Cave **To be implemented by:** 30 Sep 2019	**02 Jul 2019** **Rhiannon Adey** End of June 70% of CIPs are green. We meet with Care Groups every 2 weeks to develop the CIP programme		
				Weekly Care group Meeting looking at improving run rate or discretionary spend and increasing Elective, Out Patient and Day Case activity trends. **Control Owner:** Lesley White	Presentations of action items			Limited	change in KPIs proving improvement in run rates		Ensure budget holders have read and accepted the Standing Financial Instructions **Person Responsible:** Guy Dentith **To be implemented by:** 31 Dec 2019	**02 Jul 2019** **Rhiannon Adey** Standing Financial Instructions have been delayed in their sign off.		
				Workforce and Agency Control Group in place **Control Owner:** Andrea Ashman	Chaired by Director of HR	Monthly review by FIC		Limited			Implement plan for financial budget management training **Person Responsible:** Guy Dentith **To be implemented by:** 31 Mar 2020	**14 May 2019** **Rhiannon Adey** Written to all Care Groups with their budgets and asked them to sign off by the end of the month.		

Getting to good

Getting to good 2019-20

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
Deliver the Falls Stop programme and reduction in falls Falls limit at year end is <5 per 1000 beds days April 2019 5.76 achieved.	**On track (5.6 reported for Q1).** **Milestone Target of 5.65 achieved.** **Implementation of falls CQUINN is on track. Trust wide work to improve against 7 indicators is in place, this builds on pilot areas** **Improvement plan in place.**	Target 5 50 falls per 1000 bed days Monitor plan against agreed timeframes	Target 5 25 falls per 1000 bed days Monitor plan against agreed timeframes	Target 5 00 falls per 1000 bed days Monitor plan against agreed timeframes	Falls <5 per 1000 beds days Programme delivered
Pressure Ulcers Pressure ulcers: 10% reduction against 2018/19 baseline of 0.884 per 1000 bed days.	**Milestone target of 0.86 not achieved.** **0.989 per 1000 reported Q1. This performance includes sub optimal achievement in April and May and a recovering position in June. The improvement in June was insufficient to meet trajectory, actions remain in place to secure required improvement for Q2..**	Milestone target of 0.84	Milestone target of 0.82	Milestone target of 0.795	Target 0.795 per 1000 bed days by year end

Getting to good 2019-20

East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
Improved medicines safety	Reduction in omitted doses of medicines to 19% Achieved (18.8%)	Reduction in omitted doses of medicines to 15%	Reduction in omitted doses of medicines to 9%	Sustain 9% trajectory of omitted doses of medicines	Omitted doses of medicines is comparable to the National Average (between 9 – 11%)
	Percentage of missed doses due to 'not documented' is reduced towards a trajectory of <55% **Achieved (51.3%)**	The percentage of missed doses due to 'not documented' is < 25% of all missed doses	The percentage of missed doses due to 'not documented' is < 15% of all missed doses	The percentage of missed doses due to 'not documented' is < 1% of all missed doses	Missed doses due to 'not documented' is< 1% of all missed doses
	Reduction in missed critical medicines to 8% (including patient refusal) **(Achieved 7.8%)**	The percentage of patients of a missed dose of critical medicine is < 6.5% (including patient refusal)	The percentage of patients of a missed dose of critical medicine is < 5% (including patient refusal)	The percentage of patients of a missed dose of critical medicine is sustained at < 5% (including patient refusal)	Missed doses of critical medicine is below National Average of 5.9%
	The percentage of missed critical medicines is 70% (excluding patient refusal) **(Not achieved 74.1%)**	The percentage of missed critical medicines is 25% (excluding patient refusal)	The percentage of missed critical medicines is 15% (excluding patient refusal)	The percentage of missed critical medicines is 1% (excluding patient refusal)	Missed doses of critical medicine is < 1%
	All wards should have a ward storage audit compliance in each of the six metrics > 90% **(Achieved 95%)**	All wards should have a ward storage audit compliance in each of the six metrics > 95%	All wards should have a ward storage audit compliance in each of the six metrics > 98%	All wards should have a ward storage audit compliance in each of the six metrics at 100%	Ward storage audit compliance consistently 100%

Getting to good

Getting to good 2019-20

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
	All wards should have CD audit compliance > 90% **(Not achieved)** **Medicines reconciliation rate within 24 hours to be at 22%** **(Achieved 22%)** **40% of EDN's to be screened by pharmacist** **(Achieved 40%)**	All wards should have CD audit compliance > 95% Medicines reconciliation rate within 24 hours to be at 20% 50% of EDN's to be screened by pharmacist Annual review with stakeholders and publication of the Trust Medication Self Assessment Report	All wards should have CD audit compliance > 98% Medicines reconciliation rate within 24 hours to be at 30% Sustained 50% of EDN's to be screened by pharmacist	All wards should have CD audit compliance at 100% Medicines reconciliation rate within 24 hours to be at 30% Sustained 50% of EDN's to be screened by pharmacist	CD audit compliance to be consistently at 100% Over three years, medicines reconciliation within 24 hours to be at 90% Over three years, screening of EDN's required by pharmacists to be at >95%
Improved identification, treatment and support of patients at high risk of deterioration	**Milestone for Quarter 1 achieved.** **Scoping exercise and agreement for areas of focus completed.** **Areas of focus have been confirmed as News 5 and 7 escalation; training and education (continuing on the work of sepsis) ;and work up of ReSPECT**	Data tool for collection of baseline data of the deteriorating patient agreed Use of RESPeCT tool across the East Kent System agreed Clinical leads identified to include an intensivist	Trustwide baseline data collection audit of escalation baseline review of vitalpac observation data completed Agreed and mandated education programme for next 3 years for medical, registered and non registered staff Education propgramme in place for RESPeCT All care groups to report on response to escalation and cardiac arrest data monthly	25% of all Trust clinical Nursing assistants to have completed Beach Course 10 % of Band 5 registered nurses to have completed the skills framework for deteriorating patient 10% of band 5 AHP' s to have completed the skills framework for the deteriorating patient	Achieve 98%% of patients having their vital signs recorded in accordance with Vital Pac protocol to ensure early detection of deterioration. 30% Reduction in cardiac arrests over 3 years %Compliance with NEWS2 escalation protocol (will need base line data before committing ourselves to an improvement target)

Getting to good

Getting to good 2019-20

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
				>90% of Foundation Doctors to have completed agreed education on deteriorating patient	>90 % of patients receiving antibiotics within golden hour >90% patients with a NEWS of 7 having a TEP by April 2022
Nutrition	**Milestone Target. audit programme for quality measures reviewed and agreed has been Achieved.**	Baseline audit/ review of MUST compliance in all clinical areas against National standard to be completed 95%of all ward/Departmental managers and link nurses to have received a MUST training update Monthly reporting from all relevant care groups on MUST compliance Multi professional plan on dietary management agreed	90% of Audits to be collected electronically by all clinical areas 50% improvement from baseline on mealtime standards (RAG Green) Must improvement to 80% on initial and ongoing assessments in all areas Education programme for Nutrition with agreed milestones in place	90% of Audits to be collected electronically by all clinical areas 90% improvement on from baseline on mealtime standards (RAG green) Must improvement to 95% *on initial and ongoing assessments* in all areas. 100% of all ward/departmental managers to have completed NG Insertion training Relevant ward managers to have received PN Training 95%of all ward/Departmental managers and link nurses to have received a *MUST training* update	90% of Audits to be collected electronically by all clinical areas 90% improvement on from baseline on mealtime standards (RAG green) MUST assessment within 24 hours – 95% and ongoing weekly in all areas.
All ward-based audits complete	**Milestone Target - standardised and agreed electronic ward audit programme for wards/Departments with RAG rated performance for compliance in place work ongoing nearing completion end of July 2019**	Education for clinical staff complete with expectations of undertaking udit s to agreed standard in own areas Electronic Audit dashboard in place and 30% of Audits completed from ward areas	100% of all clinical areas completing agreed audits in own areas	Peer reviews for auditing in place across all areas	All wards peer reviewed and consistently exceeding minimum % rating for good / compliance Monthly audits – "green " , zero tolerance of nil returns Mock CQC surveys in all care groups – rating Good

Higher standards for patients

Higher standards for patients 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
Patients pathways improved to reduce the number of attendances at A&E for respiratory conditions	**To achieve 85.6% overall ED compliance by end of June 2019.**	To achieve 85.3% overall ED compliance by end of September 2019.	To achieve 91% overall ED compliance by end of December 2019.	To achieve 86.2% overall ED compliance by end of March 2019.	Improvement trajectory of **86.2%** by 31 March 2020
	ACTUAL: 81.4% (JUNE)				
The number of patients waiting longer than 52 weeks for planned care is eliminated	**To sustain zero 52 week waits across all specialties.**	To sustain zero 52 week waits across all specialties.	To sustain zero 52 week waits across all specialties.	To sustain zero 52 week waits across all specialties.	Zero 52 week waiters.
	ACTUAL 52wk: 3 (June) **ACTUAL RTT comp: 82.1% (80% Traj)**				
National Cancer standards for access to cancer care, achieved	**To achieve 85.3% overall 62 day compliance by end of June 2019.** **To sustain zero 104 day patients.**	To achieve 86% overall 62 day compliance by end of September 2019. To sustain zero 104 day patients.	To achieve 86.1% overall 62 day compliance by end of December 2019. To sustain zero 104 day patients.	To achieve 85.6% overall 62 day compliance by end of March 2019. To sustain zero 104 day patients.	Compliant 62 day pathway from January 19. Zero 104 day breaches
	ACTUAL 104 = 2 (June) **ACTUAL 62 = 73.2% (June)**				
Working with CCGs, co-located Urgent Treatment Centres are established	**EKHUFT and CCG to progress implementation in line with project plan.**	EKHUFT and CCG to progress implementation in line with project plan.	Go live December 2019.		UTCs (one on each site) to be established by December 2019
Frailty and older peoples pathways are integrated	**East Kent COOs to monitor progress in line with project plan.**	East Kent COOs to monitor progress in line with project plan.	Go live December 2019.		Frailty & older peoples pathways integrated.

A great place to work

A great place to work 2019-20

NHS
East Kent Hospitals University
NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
Respect for each other and our contributions to delivering service excellence in place	Respect programme redesigned and shared with EMT	Respect programme rolled out across the trust via Care Group leadership	Unconscious bias training and Managing diverse teams delivered to leaders.	Reduction in perception of bullying and harassment - reduction of 2% on staff survey	Staff survey reduction in number of grievances
Behaviours that are inconsistent with our values, are challenged	Develop Vandebilt programme	Implement Vandebilt programme and train peer messengers	Implement joint review meetings netween FTSGs and HR / ER team to manage point response and support	Reductio in percetion of bullying and harrassment – 2% Increased appropriate use of available services	Increase in use of freedom to speak up guardians, workplace buddies and use of Vandebilt programme
Organisational Development (OD) framework for consistent leadership standards in place	Design and facilitate the Care Group Development programme for key triumvirates, cascading from CDs, Ops Dirs and HoN	Complete the online Leadership Framework which defines 'what good likes like' for leaders at EKHUFT and provides resources to develop the defined competencies	Review national NHS TM guidelines and toolkit and incorporate into EKHUFT guidelines and toolkit where relevant	L&D and HRBPs to have TM and succession planning conversations with Care Group(CG) Leadership teams so that all teams have a current succession plan I place	The OD framework used as the basis for assessment and measurement of performance underpinning personal development plans

We care

A great place to work

A great place to work 2019-20

NHS
East Kent Hospitals University
NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
Meaningful appraisals support staff, their careers and skills acquisition	Updated appraisal paperwork to reflect 3-year Strategic Priorities and 'golden thread' required	Initial scoping of online appraisal completed Appraisal rates at least 80%	HRBPs and L&D staff to engage in Succession planning discussions with Care Groups leadership teams	Inline Appraisal toolkit rolled out with full training support. Appraisal rates at or above 85%	Personal development plans aligned to skills development opportunities at all levels
Staff supported in first year of employment is embedded	Explore existing means through which staff retention can be improved across the entire Trust e.g. targeted interviews to assess intention to stay/leave and reasons Join NHSI Retention support programmes with particular focus on ED	Develop greater data intelligence with regards to the demographic profile of our workforce to improve understanding of retention challenges and harness opportunities	Complete the development of the Local Induction online toolkit and implement across the Trust Collaborate with resourcing to produce recruiting managers online toolkit	Provide analysis and reporting of key staff survey data (Staff Survey, FFT, Turnover) Turnover reduced to 12%	Staff retention within first year improved
Staff recognition/ reward programme	Implement Neyber financial wellbeing platform	Add further benefits to platform for salary sacrifice schemes and wellbeing intitaitves	10% increase in use of platform	Review 'Reward & Recognition' offering including Long Service Awards, Trust Awards and monthly recognition programme	New elements added to the reward and recognition programme. Increase in staff use of benefits platform

Delivering our future

Delivering our future 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
Work with partners to establish an Integrated Care System / Integrated Care Provider and new contract arrangement	**Establish membership and terms of reference for the ICP**	**Agree the vision and mission for the ICP and reach agreement on the governance structures**	**Establish quick wins and finalise a communications and engagement plan with key stakeholders**	**Identify one, clear and agreed tangible outcome for delivery by the ICP**	Successfully working with partners to establish clear contractual arrangements and have a number of services which become integrated within the ICS / P by March 2020
Establish other routine elective surgical procedures that could be undertaken on a planned site/s	**Produce a paper with recommendations for EMT and the CCGs by June 2019**	**Approval from CCGs obtained by July 2019**			Agree through the STP, which surgical specialties will be delivered from the planned site/s. by August 2019
Undertake a pilot elective orthopaedic centre for in-patient surgery established	**Establish funding routes for pilot by June 2019**	**Obtain agreement from the Board for Business Case by July 2019**	**Institute project group and timelines for delivery by October 2019**	**Start on site February 2020**	Agree the BC for the pilot EOP including identification of the funding scheme

We care

Delivering our future

Delivering our future 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
To produce the first full draft of PCBC completed for review	**Complete the evaluation templates and ensure EMT and CCG governance sign of by June 2019**	**Support the CCG assessment process to score Do minimum, Option 1 and Option 2 as part of the JCCCG by September 2019**	**Work with the CCG to complete the PCBC for sign off by the Trust Board and for circulation to NHSI / E by November 2019**	**Finalise the PCBC following comments from NHSI / E and take through the Trust Board by March 2020**	Finalise evaluation criteria by June. To sign off the PCBC (current CCG timeline) November 2019 for submission to NHSI / E December 2019
Undertake a public consultation on short listed options.				**Establish with NHSI / E and the CCGs a likely timeline for consultation by March 2020**	DoH approval to commence consultation (currently there is no CCG timeline for this)
Go live with phase one of T3 (EHR).	**Complete the build of clinical documents and commence User Acceptance Testing (UAT) by June 2019**	**Provide all required information to undertake go / no go decision for Phase 1 - Order Coms by September 2019**	**Commence Phase 1 user training for Order Coms go live by October 2019** **Go live with Order Coms November 2019**	**Provide all required information to undertake go / no go decision for Phase 2 Clinical Documents by February 2020**	Successful deployment of Sunrise CM

We care

Right skills right time right place

Right skills, right time, right place 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
A robust recruitment pipeline is in place	Involvement in workforce planning to build trajectory of growth, business cases required for recruitment. Turnover trajectory produced to give combined target	Appointment of overseas recruitment partner for nursing and medical recruitment	Production of overseas candidate packs, ensuring onboarding and understanding of the Trust and local area is fulfilled prior to colleagues commencing employment	Vacancy rate stabilised at 8% Turnover at 12% Time to hire 8 weeks	Reduction in vacancy numbers, reduction in time to hire
We attract staff who haven't traditionally considered a role in the NHS	Recruitment programme to schools and to achieve greater reach earlier in the education cycle	Increase advanced and degree level apprenticeship offer. Register EKHUFT as subcontractor to provide apprentice placements eg nursing associates.	Implement new work experience policy and programme	Introduce a new Apprenticeship policy to reflect recent apprenticeship levy reforms and ensure more competitive T&Cs	Increased apprenticeships, wide range of sources of recruitment
Local Terms and Conditions enable individuals to have flexible working, with financial efficiencies and reduced reliance on temporary staff	Flexible working group to advise Employee Relations team on desired approach to new working practices	Identify and establish flexible working practices that would both attract new staff to the organisation and support existing staff to extend their working lives.	Lead a shift in organisational thinking around flexible working. Challenge the view that it represents an operational problem that increases short term cost to one	Review of all relevant and related employment policies/procedures and provide associated training to staff completed and accessible to all staff Increased use of flexible working arrangements to	Increase in variety of flexible working contracts / informal arrangements reduction in temporary workforce

Right skills right time right place

Right skills, right time, right place 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
A positive approach to mental health, including mindfulness, promotes personal resilience for staff	Mindfulness Start and Finish Group established Mental health first aid training implemented – 200 staff per year to be trained	Quarterly OH access and update reports to be sent to each care group to increase awareness and engagement	Promotion of Spencer Choose and Book service for staff		Increased take up of resilience workshops / mindfulness training or similar, reduction in absence due to mental ill health, staff survey , Friends and family
Kent & Medway Medical School research strategy	Implementation of KMMS Steering Group	Local Consultants approached to participate in programmes with KMMS by the trust R&I Director	New appointments to academic / research posts / joint appointments with medical school confirmed	Candidates ready to take up post and work in conjunction with the trust and KMMS on clinical programmes	Trust R&I Director consulted on drafting KMMS research strategy
Staff have ready access to support to create a healthy, supportive and caring environment	Monthly health promotions developed and promoted	Support and develop the healthy workplace champions network	Increase in staff accessing workplace health promotions and reduction in stress related sickness absence	Overall sickness absence reduced to 4% per care group	Reduced absence due to mental ill health, staff survey, friends and Family Test.

We care

Healthy finances

Healthy finances 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
1-3 year strategic financial programme developed	**Meet I&E plan for Q1 2019/20**	Meet I&E plan for Q2 2019/20 Develop system strategic 5 year plan and associated financial recovery plan	Meet I&E plan for Q3 2019/20 System strategic 5 year plan and associated financial recovery plan formally approved & submitted to NHSI/E	Meet I&E plan for Q4 2019/20 Detailed operational plan for 2021 developed building on financial recovery plan.	Meet planned control total for 2019/20 (measured against the financial plan) Developed plan for 2020/21 & 2021/22
A clear workforce document outlining vacancies, future needs and a recruitment plan by care group	**Workforce document developed with recruitment plan for each care group**	Workforce document completed & formally adopted	Recruitment plan enacted leading to reduced agency usages	Recruitment plan enacted leading to reduced agency usages	Reduction in the use of agency measured against the agency reduction trajectory
Patient Level Costing, Service Level Reporting, Model Hospital, GIRFT and RightCare in annual business planning and monthly monitoring	**Identify key areas of opportunity from SLR/GIRFT/PLICS/Model hospital**	Further develop opportunities & develop trajectories for 2019/20 and 2020/21	Ensure delivery against agreed trajectory in EPR and build opportunities for 2020/21.	Ensure delivery against agreed trajectory in EPR and build / refine opportunities for 2020/21.	Undertake work through Q1/Q2 to identify areas of focus and present to FPC the end of year plan to improve in specific areas at that point a metric will be agreed

Healthy finances

Healthy finances 2019-20

NHS East Kent Hospitals University NHS Foundation Trust

Objective	Quarter 1 milestone	Quarter 2 milestone	Quarter 3 milestone	Quarter 4 milestone	Measure
100% agency/bank and overtime shifts signed off against a robust temp staffing policy	**Policy drafted & accepted by staff committee.**	Policy formally adopted & distributed throughout organisation	70% compliance with policy measured through EPR Delivery of planned agency reduction CIP	100% compliance with policy measured through EPR Delivery of planned agency reduction CIP	Agency and bank reduction trajectory.
Nursing and medical rostering effective, 100% sign off and even leave distribution	**E-rostering tool rollout**	Erostering tool adopted & used usage reported at EPR	Erostering tool usage increasing aiming for 50% usage for all care groups	100% usage of erostering tool for all care groups	Trajectories to come from Care Groups by end of Q1 and measuring against them thereafter.
Finance training rolled out to all care groups	**SFI s updated** **Summary of SFI s for managers generated**	SFIs approved Training package for all budget holders developed using face-to-face material and online courses	50% of budget holders to have reviewed and tested on the SFIs Rollout & advertise budget holder training packages	All budget holders to have reviewed and been tested on the SFIs All budget holders to be offered training opportunities	All budget holders to have reviewed and been tested on the SFIs Q3/4 Specific / group training delivered to all budget holders by end of March 2020.

Extract from the confirmed minutes for the meeting on 12 September 2019

19/81 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR REPORT**

BW highlighted the risks as detailed in the report that were currently outside the Board's risk appetite, which were reviewed and monitored at the appropriate Board Committees. The Board needed to be aware of these risks, the actions being taken to address these and reduce the level of risk to bring them in line with the agreed risk appetite.

The Committee discussed the risk management system in place highlighting that timely updates on the actions and progress were still not reflected in the risk register. It had been agreed that at future meetings the register would be reviewed live on the system. The new Deputy Director of Risk, Governance and Patient Safety would be undertaking a review of the processes in place, how risks were managed, the provision of timely updates, reducing the number of risks on the register by reviewing the risks and removing those that were not real risks. The Committee was assured of the processes and framework in place, an internal audit report had been received providing substantial assurance.

WC commented that the QC had similar discussions regarding risks and how these could be presented, reviewed and discussed at future QC meetings. She highlighted that performance against a number of the priorities for the Getting to Good strategic objective remained red. AF confirmed that focussed discussions had taken place at the QC regarding the areas where performance had not been met and any areas that were at risk of not being achieved. Quarterly Board Assurance Framework (BAF) and Annual Objectives 2019/20 reports were presented to the individual Committee meetings providing members the opportunity to raise and question the lead Executive Director any areas of concern and underachievement.

DECISION: The Board discussed the IAGC report and **APPROVED** the Board Assurance Framework (BAF) and Annual Objectives 2019/20 Quarter 1 report.

NHS
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Be involved

You're part of our Trust and its future

Autumn 2019

Welcome to the latest edition of the Governors' Newsletter, keeping you informed about what your Governors are doing and plans for the future.

A massive thank you to:

- those of you who participated in the short survey included in the July newsletter. The results were considered by the Council's Membership Engagement and Communication Committee. It was really helpful to understand your views and we will be including more interactive content in these newsletters in the future so we can adjust it to meet your needs;

- everyone who came along to the League of Friends' Summer Fair at the Kent and Canterbury Hospital and to those who bought Grand Draw raffle tickets. This was the most successful fair in ten years, raising an impressive **£12,957.31**. Congratulations to everyone involved in running the event – a spectacular achievement. All the monies raised will be used to provide equipment for the Hospital;

- everyone who attended our Annual Members Meeting; and

- every member who voted in the recent Governor elections to choose your representatives on Council.

October Open Evenings – Innovations in Surgery at EKHUFT
We will be showcasing some examples of innovative working by our surgical teams at a series of open evenings in October, and are inviting stakeholders and members of the public to come and hear about the work we do. You will meet members of the Trust board, and hear from our clinicians about how we are helping patients in hospital – and how we are working to keep people out of hospital, thanks to specialist staff and services.

The events will take place at each of our three main sites, light refreshments will be provided and you will also be able to meet some of our Governors and ask questions.

Dates are below, and each session is from 5.30pm to 7pm. To book, contact Jazmine Davis at jazmine.davis@nhs.net or call 01233 651954.

- 22 October at WHH
- 28 October at QEQM
- 29 October at K&C

If you have ideas for a topic we can cover in a future Open Evening or ideas about how we can improve this newsletter please email jazmine.davis@nhs.net.

Council of Governor Election Results
The elections closed on 19 September. Jane Martin was elected unopposed to represent the Ashford Constituency and Carl Plummer was elected to represent the Folkestone & Hythe Constituency.
Their terms of office will end on 28 February 2021.
These governors will take up their posts on 1 March 2020, their three-year term, ending on 28 February 2023.

- Canterbury Graeme Sergeant
- Dover John East (second term)
- Folkestone & Hythe Rebekah Marks-Hubbard
- Thanet Paul Schofield and Marcella Warburton (second term)
- Staff Julie Pain and Sally Wilson

There will be an election at the end of this year for the vacancy in the Ashford constituency on 1 March 2020. If anyone is interested in standing as a candidate in the elections please contact Amanda Bedford, Governor and Membership Lead, on 01233 651891 or at Amanda.bedford1@nhs.net.

Annual Members meeting
Around 100 people attended the Trust's Annual Members Meeting, which took place on 3 September at the Spitfire Cricket Ground in Canterbury. Attendees were able to speak to staff representing a range of services including diabetes, therapies, oncology and dementia. There were presentations about avoiding falls and the Trust's exciting 'I can' project to encourage patients to stay active and avoid muscle loss, based on an idea from physiotherapist, Alex Armstrong (pictured) who introduced a card above each patient's bed stating what they 'can' do.

The Chair and Chief Executive of the Trust described the performance for 2018/19 and plans for the future. Lead Governor, Sarah Andrews spoke about the work done by the Council of Governors. Questions at the end of the meeting covered topics such as dementia, sharing of medical records and staffing.
Read the Trust's Annual Report for 2018/19 by clicking here.

Council of Governors meeting in public 5 August 2019
One of the main items of business was the approval of the Membership and Members' Engagement Strategy 2019 2022 which sets out how the Council plans to engage with its members and the public and how it will monitor its success. You can read it here.

There was a presentation from the Co-Chair of the Trust's Youth Forum, Jonah Barrett. We would like to see more of our members coming from younger age groups, following the presentation we are exploring how we do this. If you or a member of your family is aged between 16 and 25 and would be interested in joining the forum to be more involved in our local hospitals contact mandy.carliell@nhs.net as she would love to hear from you.

Meetings are held every three to four months and tours of our sites give you greater understanding of how a hospital works and the relationship between each department.

Finally, the Chairs of the two Board of Directors Committees (non-executive directors) gave the Council the opportunity to question them on finance and staffing.

Date of the next Council meeting
The next Council meeting in public is on 12 November 2019 at the Queen Elizabeth the Queen Mother Hospital in Margate. The public are very welcome to attend and can ask questions at the end about the issues covered during the meeting.

Click here for details of the venue and timings for the meeting closer to the date, and view past papers and minutes which provide more detail about the work of the Council.

Have a question that you would like to raise with your governor? Email us at ekh-tr.GovernorsQuestions@nhs.net.

Site visits
One of the regular events that governors take part in is monthly Joint Site Visits, Two Governors, one Executive Director and one Non-executive Director visit each of our five sites on a rota, spending around two hours talking to clinical and support staff in a wide range of departments and services.

This gives the staff an opportunity to meet members of the Board and Council. They can raise concerns which are acted on. A recent example, was incorrect signage at Buckland Hospital which has now been addressed.

The Trust's website www.ekhuft.nhs.uk provides a range of information for patients and the public, including contact numbers for wards and departments. Click here for volunteer roles, which currently includes news about the exciting Gardener Project.

Sent on behalf of East Kent Hospitals' governors

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**12 NOVEMBER 2019**
REPORT TITLE:	**MEMBERSHIP ENGAGEMENT AND COMMUNICATION COMMITTEE (MECC) CHAIR'S REPORT**
PAPER AUTHOR:	**MECC CHAIR NICK WELLS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**ANNEX A: AUTUMN GOVERNOR NEWSLETTER**

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

This report provides a summary of the key items discussed at the MECC meeting held on 7 October 2019. Members in attendance were myself, Julie Barker, Junetta Whorwell, Marcella Warburton; apologies from Roy Dexter, David Bogard and Alex Lister. Sarah Andrews also attended the meeting.

Background

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

Annual Members Meeting (AMM)

The Committee felt that the AMM had gone well, though there was one presentation which could have been tighter. More detailed feedback was provided, such as taking care with the visuals in the presentations to avoid stereotyping patients; Natalie Yost was present and took note for next year. It was suggested that the Trust could explore setting up a system for attendees to submit feedback on the meeting via electronic means next year.

MECC had suggested undertaking a straw poll of members during the evening, which did not happen. We agreed that it would be helpful for MECC to spend time at the July meeting next year to talk in more detail about the plans for the AMM and contribute to the planning, including making suggestions for the subjects of the presentations and the content of the Lead Governor's presentation. The topics for the presentations should attract public attention; possibly exciting areas of clinical practice or linking to public health messages, such as obesity and mental health, while still linking this to the work of the Acute Trust.

The Committee agreed that using the Spitfire Cricket Ground as the venue for the next meeting was sensible; parking was plentiful, the location was central to the whole patch and the spaces available worked for the meeting and market place. It was also close to the Kent and Canterbury Hospital which was useful on a practical basis. The Committee suggested that there needed to be more work done next year on promoting the event.

Membership Feedback Report

The Committee received the regular report on feedback from members and the public since the last meeting; no trends or themes were recognised. It was noted that data showing performance against the targets set in the Members and Membership Engagement Strategy would be included in the report moving forward.

Open Evenings

The Committee noted that there were three events planned for the end of October and these would focus on the work of the Surgical and Anaesthetics Care Group. It was agreed that the programme should include a slot for one of the Governors to speak and that the content would be agreed before the meeting so that the same message was given at each event. Sarah Andrews spoke at the William Harvey and QEQM events and John East at the Kent

and Canterbury event.

It is worth recording that the WHH and Kent and Canterbury events were well attended by the public. Feedback from all three events was very positive and the content of the presentations was well received. Unfortunately, I was away for all three events: Sarah, Jane and Junetta attended the WHH event; Marcella and Sarah were at the QEQM event; and John East, Jenny, Junetta, Philip and Ken at the Kent and Canterbury. The Committee will look at the events in more detail at our next meeting and make suggestions on how to improve these moving forward.

Governor Newsletter (GNL)

At the meeting we considered a draft for the newsletter to be issued after the meeting, which was issued on 14 October: attached at Annex A for information. The main change that we made as a Committee to the draft was to increase the amount of interactive content.

As per the agreed process, at the meeting in January we will be considering the draft for the Winter GNL; we have asked Debra Towse if she would provide a short article covering the Kent and Medway Medical School and Julie Barker volunteered to provide a write-up of the 12 November Council meeting. The draft for this edition of the GNL will go to the January MECC meeting and all governors are invited to comment when the meeting papers are issued. Ideas for items which could be included in the GNL in the future would be most welcome.

The Committee also agreed that an item be added to the next agenda to look at what other Trusts do by way of newsletters and websites. Jaz is pulling together a report for the Committee, including links to sites, which will be circulated in December so that members will have a chance to look for themselves before the January Committee discussion. This can be shared with the whole Council, if that is of interest.

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.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to note this report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**12 NOVEMBER 2019**
REPORT TITLE:	**CoG AUDIT AND GOVERNANCE COMMITTEE (AGC) CHAIR'S REPORT**
PAPER AUTHOR:	**JOHN EAST AGC CHAIR**
PURPOSE:	**DISCUSSION**
APPENDICES:	

BACKGROUND AND EXECUTIVE SUMMARY

Executive Summary

This report updates Council on the recent changes to the dates of AGC meetings and provides a summary of the key items discussed at the AGC meeting held on 29 August 2019. Members in attendance were myself, Ken Rogers, Junetta Whorwell, Sarah Anderws, Philip Wells and John Sewell. Apologies were received from Mandy Carliell and Bob Bayford.

Background

Meeting schedule

In setting dates for the AGC meetings through 2019/20 the aim was to time the meetings so that members could receive the quarterly performance and risk data in a timely fashion. The Committee receives the same papers that are considered by the Board's Quality Committee, Finance and Performance Committee, and Strategic Workforce Committee. Ideally, the AGC should also take place in close proximity to the formal Council meetings so that it reports through in a timely fashion.

Quarterly data used to be provided to the Committees in the middle of the month following the end of the quarter. The quality of the data using this timescale was not as robust as it might have been as there was little time to test the information before issuing it. The Board therefore agreed to move their Committee meeting dates, including the quarterly Integrated Audit and Governance Committee (IAGC), a month further on – the second month after the end of the quarter – and to hold them at the end of the month.

It would not be appropriate for Council to receive data before the Board has had a chance to discuss and review it, which means that the meeting dates of the AGC need to be moved. You will be aware that the AGC planned for the 7 November has been moved to the 9 December. Elsewhere on the meeting agenda, Alison will present a paper on the implications that this has on the dates of Council meetings. I have asked Amanda to provide a paper to the next AGC meeting confirming the timetable for the remaining AGC meetings and how this will be used to prepare and share with Council the draft for our commentary on the Trust's Annual Quality Report.

AGC meeting 29 August 2019

The Committee wishes to bring the following information to the attention of Council in relation to the items covered at the meeting on 29 August 2019.

Grant Thornton, External Auditors

Darren Wells, Director, and Tom Beake, Audit Manager, attended the meeting representing the Trust's new Auditors – Grant Thornton. They were appointed by the Council for a three year period, commencing from the 2019/20 audit. Tom gave the Committee a short introduction to their approach to audit work, following which we spent some time in discussion around the setting of the Council nominated Quality Indicator.

The main conclusions reached were:

- the choice of indicator should not be confirmed prior to the national guidance on Quality Reports being issued, however, it is helpful if the auditors have a reasonable amount of noticed so that they can decide the process for the audit and schedule it into the timetable;
- it was essential that the indicator chosen was measurable so that an audit could be conducted, Grant Thornton said that they would be happy to comment on suggested indicators from an auditor's point of view;
- there was no appetite in the Committee for repeating the SBAR audit for a third time; and
- 2018/19 quality targets where the data suggests improvements were still needed would be one source of information to inform the final decision;

Quality Performance

The Chief Nurse and Director of Quality, Amanda Hallums, attending the meeting; this was in lieu of her planned attendance at the August Council meeting when she had had to pull out due to sickness.

Amanda acknowledged the decline in the SBAR (situation, background, assessment, recommendation) communication tool audit results from the 2017/18 to the 2018/19 audits and commented that this was unacceptable. It was an everyday tool used by staff and contributes to basic nursing care.

Amanda explained that she and Paul Stevens, Medical Director, had agreed quality targets for 2019/20 aimed at getting back to basics – getting to good on the Trust's objectives:

- Nutrition
- Pressure ulcers
- Falls prevention
- Medication safety
- Recognising the deteriorating patient

and SBAR crossed all of these. Amanda explained that she and the Deputy Medical Director, Jonathan Purday, were now reviewing the Trust's transfer policies and working to amalgamate these into one policy which would be taken to the Patient Safety Committee in two months' time.

In the discussions on this part of the agenda the Committee asked questions relating to: preventing patient falls, physiotherapists' involvement in patient care, preventing pressure ulcers, the role of in-patient carers on the ward and sepsis.

Quarter 1 performance data

Alison Fox attended the meeting to present the data, as considered at the Board's IAGC meeting that week. She reported that the IAGC had spent some time talking about the gaps remaining in the control process – the risks are well described, there is less information on the action being taken. Alison noted that one area which needed to be refined was to link cause and effect.

Specific areas that the Committee discussed included the following.

- Staff appraisal – what that meant in reality, its importance to staff morale and the need to link appraisal outcome across to performance.
- That some columns in the Board Assurance Framework (BAF) were not completed.
- The emerging risk around the lack of engagement between the CCGs, GPs and EKHUFT Clinical staff in arrangements for the urgent treatment centres. Alison noted that papers would be coming to Board and Council meetings once the situation was

better understood.

Constitutional Review
The Committee agreed to add this as a substantial agenda item to the next AGC agenda. Some of the items to be included were the involvement of younger members in Council meetings and representation on Board/Council from the Medical School.

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.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to note this report.

CoG 19/46 Annex A

	Board IAGC	Board	AGC - original	AGC - revised	Council - original	Council - revised	MECC No change
2019/20							
November	26 Q2		7		12	Stet	
December				Moved: 9th - Q2 data Could report in to January strategy meeting			
January					21 - strategy	Stet	7
February	25 Q3		11	Move - see below	27 Full and NED Joint	Move - see below	
March				Moved: 3rd - use to agree basis of commentary		Moved: wk of 9th - Full and Joint NEDs	
2020/21							
April	30 year end		15	Cancel - manage drafting commentary virtually so it can be submitted to Board meeting on 19			6
May		19 to sign off Annual documents	6	Stet - look at year end data following on from the IAGC and confirm the commentary	21	Stet Annual documents - closed session	
June							
July					14 Training	Stet	6
August	25 Q1		15	Move - see below	3		
September				Moved - wk of 7th Q1 data		Moved wk 14th	
October							5
November	24 Q2		14	Move - see below	26	Move - see below	
December				Moved - week 1 December Q2 data		Moved 2 week	
January							11
February	25 Q3		20	Move - see below	23	Move - see below	
March				Moved: wk 2 March Q3 data and agree basis of commentary		Moved - wk 9th	

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**12 NOVEMBER 2019**
REPORT TITLE:	**COUNCIL MEETING SCHEDULE**
PAPER AUTHOR:	**ALISON FOX** **GROUP COMPANY SECRETARY**
PURPOSE:	**DECISION**
APPENDICES:	**Annex A: dates schedule**

BACKGROUND AND EXECUTIVE SUMMARY

The Council will be aware that the date for the next CoG Audit and Governance Committee (AGC) has been changed from 7 November to 9 December 2019. As explained in the email from the Chair of the Committee, John East, this action was taken to ensure that the AGC can receive the quarterly performance data in a timely fashion and after the Board have had a chance to review the information.

Dates for Board and Board Committees were changed in August this year so that the data presented is confirmed, and therefore robust. The impact of this on the Council and Council Committee meetings had not been fully appreciated.

The Council schedule has been reviewed and at Annex A the current dates are mapped against some proposals to make changes.

Council is asked to discuss and agree the proposed changes for AGC and Council the columns highlighted in pink.

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.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council is asked to discuss and agree the proposed changes to the meeting schedule for the Council of Governors.