Council of Governors Meeting in Public

Wed 15 September 2021, 12:00 - 13:45

Teams

Agenda

12:00 - 12:05
5 min

18. Chair's introductions

To note *Jane Ollis*

Agenda 210915 Public.pdf (2 pages)

12:05 - 12:05
0 min

19. Apologies for Absence and Declarations of interest

To note *Jane Ollis*

12:05 - 12:05
0 min

20. Minutes from last Council of Governors' closed meeting held on 20 May 2021 matters arising

To Agree *Jane Ollis*

20 Unconfirmed Minutes public 21052021.pdf (13 pages)

12:05 - 12:05
0 min

21. Outstanding actions

To Agree *Jane Ollis*

21 Outstanding actions.pdf (1 pages)

12:05 - 12:05
0 min

22. Ratification of Virtual Votes since the last meeting

To note *Jane Ollis*

22 Virtual voting.pdf (2 pages)

12:05 - 12:10
5 min

23. Chairs report

To discuss *Jane Ollis*

23 Chair's report.pdf (1 pages)

12:10 - 12:25
15 min

24. Chief Executive Officer's report

To discuss *Susan Acott*

12:25 - 12:40
15 min

25. Review of Trust's Complaints process

To discuss *Sarah Shingler/ Tina Inanov*

For information

12:40 - 12:50
10 min

26. Report from Chair of Membership Engagement and Communications Committee (MECC)

To discuss *Alex Lister*

26 MECC Chair report.pdf (2 pages)

12:50 - 13:00
10 min

27. Process for responding to emailed enquires

To discuss *Dorothy Otite*

27 Responding to email enquiries.pdf (5 pages)

13:00 - 13:05
5 min

28. Annual Members Meeting - update

To note *Dorothy Otite*

13:05 - 13:15
10 min

29. NED overview report

To discuss *Jane Ollis*

29a NED oversight.pdf (2 pages)
29b Annex 1 IPR.pdf (25 pages)
29c Annex 2 BAF.pdf (19 pages)

13:15 - 13:25
10 min

30. Report from Co-Chair of Staff and Patient Experience Committee (SPEC)

To discuss *Bernie Mayall*

30 SPEC Chair report.pdf (5 pages)

13:25 - 13:30
5 min

31. Constitution and Policy review group recommendations

To agree *Constitution and Policy Review Group*

13:30 - 13:35
5 min

32. Governor feedback on events attended

To note *Jane Ollis*

13:35 - 13:40
5 min

33. Questions from the public

Jane Ollis

13:40 - 13:45
5 min

34. Any other business

Jane Ollis

13:45 - 13:45
0 min

35. Date of next meeting

To note *Jane Ollis*

East Kent Hospitals University NHS Foundation Trust

COUNCIL OF GOVERNORS MEETING IN PUBLIC
15 SEPTEMBER 2021, midday
Virtual meeting – joining details in calendar invite

This meeting will be preceded by an informal meeting of the Council, starting at 11.30 am

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

AGENDA

Reference Conf. 21/ **Paper 21/**

OPENING MATTERS				
18.	Chair's introductions	To note	12.00 (05)	*Jane Ollis, Vice Trust Chair*
19.	Apologies for Absence and Declarations of Interest	To note		*Jane Ollis, Vice Trust Chair*
20.	Minutes from the last Council of Governors' Closed meeting held on 20 May 2021 and matters arising	To agree /20		*Jane Ollis, Vice Trust Chair*
21.	Outstanding actions	To agree /21		*Jane Ollis, Vice Trust Chair*
22.	Ratification of Virtual Votes since the last meeting	To note /22		*Jane Ollis, Vice Trust Chair*
23.	Chair's report	To discuss /23	12.05 (05)	*Jane Ollis, Vice Trust Chair*

Our patients Our people Our quality and safety

We care

24.	Chief Executive Officer's report	To discuss	12.10 (15)	*Susan Acott Chief Executive Officer*
25.	Review of Trust's Complaints process	To discuss	12.25 (15)	*Sarah Shingler, Chief Nursing Officer Tina Ivanov, Director of Quality Governance*
26.	Report from Chair of Membership Engagement and Communication Committee (MECC)	To discuss /26	12.40 (10)	*Alex Lister Chairman, MECC Public Governor Canterbury*
27.	Process for responding to emailed enquires	To agree /27	12.50 (10)	*Dorothy Otite Interim Group Company Secretary*
28.	Annual Members Meeting - update	To note	13.00 (05)	*Dorothy Otite Interim Group Company Secretary*
	Our future Our sustainability			
29.	NEDs overview report Papers: IPR Risk register Finance summary	To discuss /29a – 29d	13.05 (10)	*Jane Ollis Vice Chairman*
30.	Report from Co-Chair of Staff and Patient Experience Committee (SPEC)	To discuss /30	13.15 (10)	*Bernie Mayall Co-Chair, SPEC Public Governor, Dover*
31.	Constitution and Policy review group recommendations	To agree /31	13.25 (05)	*Constitution & Policy Review Group*
32.	Governor feedback on events attended	To note /32	13.30 (05)	*Jane Ollis, Vice Trust Chair*
CLOSING MATTERS				
33.	Questions from the public		13.35 (05)	*Jane Ollis, Vice Trust Chair*
34.	Any other business		13.40 (05)	*Jane Ollis, Vice Trust Chair*
35.	DATE OF NEXT MEETING 9 December 2021, 9.30 Pre-meeting from 9.00 and session scheduled to finish at 12.30 after closed meeting.		Meeting Ends 13.45	*Jane Ollis, Vice Trust Chair*

RESOLUTION TO MOVE INTO PRIVATE SESSION
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.

UNCONFIRMED MINUTES OF THE COUNCIL OF GOVERNORS MEETING TUESDAY 20 MAY 2021 AT 09.30

PRESENT:

Niall Dickson	Chairman	ND
Bob Bayford	Partnership Governor – Local Authorities	BBa
Ross Britton	Elected Governor – Swale	RBr
James Casha	Elected Governor – Staff	JCa
Nick Hulme	Elected Governor – Ashford	NHu
Alex Lister	Elected Governor – Canterbury	ALi
Bernie Mayall	Elected Governor – Dover	BMa
Sophie Pettifer	Elected Governor – Staff	SPe
Chris Pink	Elected Governor – Rest of England	CPi
Carl Plummer	Elected Governor - Folkestone & Hythe	CPl
Alex Ricketts	Elected Governor – Canterbury	ARi
Ken Rogers	Elected Governor – Swale	KRo
Paul Schofield	Elected Governor – Thanet	PSc
Debra Towse	Partnership Governor – Universities	DTo
Marcela Warburton	Elected Governor – Thanet	MWa
Sally Wilson	Elected Governor – Staff	SWi

IN ATTENDANCE:

Susan Acott	Chief Executive Officer	CEO
Phil Cave	Director of Finance For item 10	DoF
Sarah Dunnett	Non-executive Director	SD
Louise Fulchi	Non-executive Director	LF
Martin Jolly	Non-executive Director	MJ
Jane Ollis	Non-executive Director, Vice Chair	JO
Olu Olusade	Non-executive Director	OO
Chris Holland	Associate Non-executive Director	CH
Alison Fox	Group Company Secretary	GCS
Amanda Bedford	Governor and Membership Lead (minutes)	G&ML

MINUTE NO. CoG/21/		ACTION
01.	**CHAIRMAN'S INTRODUCTIONS** The Chairman opened the meeting and welcomed the newly appointed Non-Executive Directors. All present introduced themselves.	
02.	**APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST** Apologies were received from Liz Baxter, John Fletcher, Linda Judd and Paul Verrill. There were no declarations of interest.	
03.	**MINUTES FROM THE LAST COUNCIL OF GOVERNORS' MEETING HELD ON 9 MARCH 2021 AND MATTERS ARISING** The minutes of the previous meeting held on 9 March 2021 were accepted as a true and accurate representation of the meeting. There were no matters arising from the minutes not already covered in the agenda.	

04.	**OUTSTANDING ACTIONS** The Council **NOTED** the updates to the outstanding actions and **AGREED** to the proposal that they all be closed.	
05.	**RATIFICATION OF VIRTUAL DECISIONS VOTES SINCE THE LAST MEETING** The Council **NOTED** and **RATIFIED** the report on the virtual votes undertaken since the last Council meeting.	
06.	**ANNUAL PRESENTATION OF THE REGISTER OF INTERESTS AND FIT AND PROPER PERSON DECLARATION** The G&ML noted that there was one addition to register of interests: Alex Ricketts declared a Directorship in his company, Alex Ricketts Ltd. The Council **NOTED** the register of interests.	
07.	**UPDATE ON TIMETABLE FOR ANNUAL DOCUMENTS:** • **ANNUAL REPORT** • **ANNUAL ACCOUNTS** • **QUALITY REPORT** • **SELF CERTIFICATION AGAINST PROVIDER LICENCE** The GCS asked Council to NOTE that the Trust had taken the opportunity provided within the national reporting guidance to extend the deadline for publication of the Annual Report and Annual Accounts to the end of June. The report provided summarised the changes to the required content. The GCS noted that the Annual Declarations against the provider licence were going through the Board Committees the following week and the draft would be circulated to governors once the Board had had the opportunity to discuss it in private session. The GCS commented that one of the declarations related to Governor Training; the return will note that Governor training was stood down in year following instruction from NHSE. There had been one training session in 2021/22 and a programme of training would be developed over the next few months in liaison with Council. The GCS advised that at the start of the year Trusts were told that there would be a statutory instrument issued that removed the requirement to submit the Quality Account by the end of June. However, this plan has been changed and the Quality Account had to be submitted by the end of June with the other annual documents. NHSEI had now confirmed that there would be no penalties if the deadline was missed. The timetable to produce the report would be very tight and needed to allow for the production of the Governor Commentary by Council. The GCS said that she would circulate the timetable once it was confirmed. The advice from the centre was for the Quality Account to adhere to the guidance; in the past the Trust had gone beyond the reporting requirements. It was recognised that the pandemic had meant that focus would have had to be moved away from existing plans and targets. The GCS said that arrangements were being made for a training session on the Governor role in the Quality Account, from NHS Providers, given the range of experience on Council. The process for creating the Commentary	

	was for the Council to decide; the previous year it had been drafted by the Audit and Governance Committee. The purpose was for the Governors to comment on whether the content of the Quality Report was a true and fair reflection of quality performance in year. It was **AGREED** that the Commentary drafting be taken through the Audit and Governance Committee. The final document would need full approval from the Council.	
08.	**CHAIR'S REPORT** The Chair started his report by thanking the Council for appointing him. The Trust had been through a challenging period over the last few years with infrastructure and cultural issues to address and a taxing process of clinical re-configuration. The pandemic had highlighted how many excellent staff were working within the Trust and had made immense demands on them. There were many new members on both Board and Council. The Chairman hoped that, as social restrictions lifted, it would be possible to return to on site engagement with staff and patients and for there to be more interaction between Governors and Non-executive Directors. There were signs of green shoots in the organisation. A positive CQC report on emergency departments and infection control, and a good rating on use of resources from NHSEI. There were early indications that the We Care approach was beginning to turn around clinical performance. The Chairman said that the Council was another set of eyes and ears which could provide vital feedback and learning. The organisation was now operating in a new world with greater emphasis on collaboration within an intergrated care system; the potential for joint working with other trusts, local authorities, primary care, social services and the voluntary sector was positive. To make a difference, though, it had to make a difference to patients. There was also a backlog of procedures to be addressed. The Chairman added that all within the organisation would need to support one another on the journey. Attracting capital funding to the area and empowering clinical staff to have ownership of the changes and drive up standards were both essential to success. The G&ML introduced the proposal report for a framework for the Council to work within. The key change proposed was to increase the number of Council Committees from three to four by splitting the terms of reference for the current Audit and Governance Committee into two: governance roles to be covered by a new Audit and Governance Committee (AGC) and the quality and performance elements, and the development of the Governor Commentary, to a Staff and Patient Experience Committed (SPEC). Meetings of Council and Committees would be quarterly and a further, shorter meeting of Council added in the months between full meetings. The following points were raised in the discussion. • ALi said that from discussions with other lead governors he was aware that some Trusts invited governors to attend Board Committee and closed Board meetings as observers, with no rights to comment. He believed this practice had been followed in the past in EKHUFT. The purpose was purely as a mechanism to validate the authenticity of	

	information provided to Council from the Board. Governor observers would not feedback what had been said, this would remain strictly confidential, but they would be in a position to confirm that information provided to Council from those meetings was authentic. The aim was to promote transparency. The Chairman said that this was something he would need to discuss with Board members. In principle having a governor observer on committees seemed a sensible proposal. He would take it to the Board and report back. • KRo suggested that having a NED sitting on the Council's SPEC would be sensible. The Chairman agreed and said that he would also discuss this with Board colleagues. **ACTION:** the Board to be asked to consider agreeing to a Governor observer attending closed Board sessions and Board Committee meetings and a NED to be a member of the Staff and Patient Experience Committee. The Council of Governors **AGREED** the recommendations laid out in the paper: 1. discuss and agree the proposal for the framework for Council to work within; 2. agree the proposed meeting dates and schedule for the remainder of 2021/22; and 3. agree to review the framework after a full year.	Chairman
09.	**CHIEF EXECUTIVE OFFICER'S REPORT** The CEO congratulated the new Non-executive directors on their appointments; she was looking forward to developing the Board together. The CEO said that, for the first time since March last year, the Trust was reporting zero covid patients that day – a significant point in the recovery. A key factor in the post pandemic recovery was dealing with delayed procedures. Pre-covid the Trust had been reporting excellent performance against cancer waiting times and much of the service had been maintained through the pandemic. She expected performance to return to those levels relatively quickly. The Trust had also managed to maintain imaging and diagnostic services and, with the assistance of the independent sector and community services, kept delays for urgent cases to a minimum. The recovery process was therefore focussed on routine cases. The Trust had benefited from formal review sessions within the Trust and with partners to reflect on lessons learned during the second wave which could be applied should there be a third wave. General consensus was that there would be a third wave and the Trust was preparing for this. The Integrated Care Systems and Partnership work was progressing and relationships were developing. Statutory legislation was expected to formalise Integrated Care Systems (ICS) from which would be built the Integrated Care Partnerships (ICP) for the East Kent system of health and social care providers, which included the CCG as a provider and had representation from the local authorities. The Trust's Chairman was also the Chairman of the East Kent ICP. The CEO commented that collaboration was developing strongly and both the ICP and ICS were both formalising	

	priorities. For the ICP these included: mental health; children and learning disabilities; diabetes; and workforce challenges. The CEO advised that the CQC had now provided the formal reports following the unannounced visits to the emergency departments and looking at infection control procedures. These were positive and had now been published. A Director of Quality Governance had been appointed, Tina Inanov, and the new Chief Nurse, Sarah Shingler, would start in June. A webinar had been held to introduce the Chairman to the wider organisation and was attended by over 200 people. Some of the ward staff presented their work on the We Care programme to the meeting, which was beginning to demonstrate good results. Giving the We Care work a high profile in the organisation created momentum and engagement. The elective orthopaedic department at Kent and Canterbury was on track to be opened in early summer; this was key to reducing the orthopaedic backlog. The model of separating the elective and emergency care was being heralded nationally as best practice and would be key to managing winter pressures and any future pandemics. An official opening was being planned and Council members would be invited. The previous week had been palliative care week. One outcome of the pandemic had been a greater focus on end of life care and the Trust's palliative care team had been expanded. Another pandemic effect was that people were making different life style choices and the Trust was benefitting from this as experienced and skilled consultants were choosing to move out of urban areas into the more rural locations offered by EKHUFT. As a consequence the Trust had been able to appoint two experienced palliative care consultants to the team. KRo commented that he had joined the staff webinar and had been impressed by both the Chairman and the staff who were presenting. He asked whether the Trust would have the opportunity to comment on the white paper detailing the proposed legislation changes. The CEO confirmed that there was a national consultation that the Trust could contribute too and views were also being fed in via the ICS and ICP. These views could be shared with Council. **ACTION:** share with Council the comments made by the Trust to the government white paper. The CEO commented that, from a personal point of view she had been surprised that there had not been a stronger emphasis in the White Paper on the local ICP, the greater focus was on the ICS. In her view the ICP would be where the Trust and its clinical leaders would have the greatest influence. The Chairman said that he shared these views; he believed the broad direction of change towards supporting the wider health community to be correct. He welcomed the idea of working with partners to collectively address the wider issues, for example homelessness. The system being built had more complexity than expected. The Chairman said that there was no clarity yet about the role of governors in the new system, nor had the disparity between Foundation Trusts, with governors, and NHS Trusts, without governors, been addressed. The	CEO

	Chairman suggested that governors may have an opportunity to feedback their own views through the Lead Governor network.	
10.	**INTRODUCTION TO NEW NEDS AND OVERVIEW REPORT** The Chairman invited the new Non-Executive Directors to introduce themselves and share their initial impressions of the Trust. Luisa Fulchi (LF) said that the induction visits she had undertaken to the trust sites had shown her first hand the impact on services and patient care from the infrastructure issues. Space was a particular issue with modern equipment needing more storage space than available on old wards. LF said that she had been impressed by the teamwork shown by the staff. Development of digital systems was her own area of expertise and adopting digital innovation, opportunities and good practice in the Trust was essential for the future. LF commented that her experience in working in Local Authorities would be useful as the ICP work developed. Sarah Dunnett (SD) explained that she was currently Vice Chair at Maidstone and Tunbridge Wells Trust and the Chair of their Quality Committee. She had previously been Chair at Darenth Valley and was therefore well versed in the challenges across the whole health arena in Kent. Her first impressions were that there was a great deal of very good practice and extraordinarily talented staff within the Trust in both clinical and leadership areas. There were also challenges, noticeably in the estate – which was made very clear during the months of covid and brought a focus to what needed to be done. Providing a comprehensive clinical service at sub-specialty level across a wide geographic area was also a challenge. SD said that the Trust's Quality Committee was undergoing a series of change to make sure that the organisation learned from incidents and shared best practice across all sites. Due to the level of scrutiny on the organisation over a period of time the number of active action plans was high; these needed to be reviewed and used to make the vital changes necessary for the Trust to move forward on its journey to provide the highest quality service to its population. Achieving outstanding organisation status may take time but she felt it was possible. Olu Olasode (OO) explained that his background was with audit and regulatory bodies, including the CQC. The Trust was in transition and the Board's Integrated Audit and Governance Committee (IAGC), which he chaired, was critical to making sure that proper governance process was followed during the change and risk avoided or mitigated. It was important to understand what matters to people when making changes. OO noted that there were issues still to be resolved with the evolving ICP. Martin Jolly (MJ) explained that he was an engineer by profession working primarily in estates management, including in the NHS, so the estates transformation was of particular interest to him. It was intended that he would become the NED-in-Common with 2SS. Location was paramount; poor estate undermined the capability of even the best staff. He noted that as well as the longer-term estate programme, for which funding was needed, there was a shorter-term requirement to make the best of the existing facilities with the resources that were available. MJ said that he had experience of working in organisations with a large maintenance backlog; he was currently working with a commercial organisation with a similar	

maintenance backlog to the Trust so he hoped to learn, and share, from both his commercial and NED work.

The Chairman thanked Council for managing the recruitment process and appointing excellent candidates with a range of valuable knowledge and experience. He noted that there were also a number of changes in the Executive Directors on the Board and an new role in the appointment of Neil Wiggleswade as Director of Infection Prevention and Control.

As Chair of the Council Nominations and Remuneration Committee, DTo thanked the committee members for the work they had done during the appointment processes. She was very pleased to see that many NEDs were attending this Council meeting, the most in attendance for some time. DTo also thanked Council for responding quickly to the virtual voting requests for the appointments; this meant that there was now a full complement of NEDs on the Board with shadowing arrangements in place to facilitate a smooth transition when Sunny Adeusi came to the end of his term of office in October.

For clarity this meant that NEDs on the Board were: Jane Ollis and Nigel Mansley, who were on their second terms; Sunny Adeusi who would leave at the end of his second term in October; Luisa Fulchi, Olu Olasode and Martin Jolly; Sarah Dunnett would move from a temporary appointment to the substantive post on 1 June, pending agreement to the proposed change in the constitution to increase the number of NEDs on the Board by one; ; Raymond Anakwe would join on 1 June 2021 bringing clinical expertise to the Board; and Stewart Baird would join as a non-voting NED on 1 June taking up the full NED post on 1 November when Sunny completes his second term of office.

DTo advised that she would be retiring from her position at the University at the end of September so a new appointment would be needed to the Partner Governor role. DTo commented that in the last few years the voice of the governor was really coming through and Council should be proud of the part played in building a strong Board to take the Trust forward.

The Chairman thanked DTo for the support she had given to Council.

The Chairman explained that it was intended that this item would be a regular item on the agenda with the risk register, Integrated Performance Report (IPR) and a finance update provided to each meeting. In future a written report would be provided summarising the NEDs' work since the last meeting and there would be at least one NED representative of each of the Board Committees present.

The DoF went through the finance presentation, issued with the agenda and papers. This summarised the previous year's financial performance and the plans for the current financial year; including the following points.

- The Trust had achieved the four key financial targets for 2020/21.
- The year had obviously been very unusual in financial terms as a result of the pandemic. Central funding had been provided to cover costs for the first six months. Funding for the second half of the year had been provided within defined spending envelopes.

- The report provided a breakdown of income and expenditure in year.
- Staffing was the highest area of expenditure followed by PPE costs.
- Drug expenditure was effectively unchanged from the previous year.
- Staffing costs went up: high sickness rates, staff shielding and increases in the staffing establishments to manage the increased numbers of high dependency patients.
- Capital spend in year had been £70M – the highest level for some time. The report detailed the spend.
- Plans for the 2021/22 spend had been taken for discussion to the last two closed sessions of the Board.
- The planning cycle had been pushed back due to the pandemic.
- National guidance was being issued in two parts, with priorities set for the first six months. The DoF commented that the health system was working together much more closely. Break even at trust and system level was required for the first six months.
- Supporting staff recovery was a key priority. The report provided the full details, including ways the system was working collaboratively.
- The capital programme was in excess of £40M.
- Income was set on block payments.
- Risk was being shared across the health system.
- In time, guidance would be provided from the centre for the second half of the year.

KRo thanked the DoF for the presentation; he noted the absence of Cost Improvement Plans and was pleased to see more evidence of financial recovery. The DoF said that CIP was likely further down the line, at present the focus needed to be on recovery and reducing pressures are far as possible for the care groups.

NHu asked to what degree the financial planning was informed as to what would be needed for the service to get to excellent, rather than acceptable. In his own organisation there had been a recent exercise to quantify the cost of achieving excellent, moderate improvement or the status quo. In effect, this is what you can achieve with 'X' investment.

The DoF said that the care groups were asked to prioritise and present to the Executive their top priorities. Last year the list of priorities given by care groups to improve the organisation numbered around 250. These had then been considered in the light of national priorities and resources. The Executive had challenged back to determine the extent to which the priority could be achieved by means other than increasing funding.

The DoF commented that given the complexity of planning service delivery in such a large organisation, it was unlikely that the point could be reached where it could be said with confidence that extra funding of 'X' million would deliver a service of excellence. It was always a question of balancing need with the money. Investment was made into priority areas, such as maternity, and then it was important to see that the investment delivered the expected improvements.

JO commented that one element of moving towards excellence was the approach to research and innovation. The Trust had strong foundations in terms of the research capability and capacity. In the last year there had been amazing digital innovation driven by covid which could now be embedded

	and improved upon. Investment in this area, which could be via grants, would be positive. The Chairman asked whether the financial situation would improve if all staff vacancies were filled. The DoF said that there was a higher cost for using agency staff and paying for overtime, though there were some savings if a vacant post was not filled until substantive recruitment. Recruitment was a key factor in achieving financial balance. The Chairman noted that the capital spend was absolutely critical. As LF had mentioned earlier, poor estate affected the quality of care and the patient experience. The ultimate solution had to be to do something different and it would involve moving services around. RBr asked what the geographical split of the £70M capital expenditure. The DoF said that major items of capital expenditure had been spread across the area. The Chairman noted that the spend had to be based on need. SPe commented that staff retention was critical and more important that recruitment; staff would stay if they felt that they were listened to and valued. The Chairman agreed. The DoF said that the Executive were looking closely at first year retention, recognising that there were high numbers of staff leaving during this time. ALi asked SPe what in her view would be the top three reasons that staff left within the first year. SPe said that Healthcare Assistants were, in her experience, the biggest staff group where recruits left in the first year and she believed that this was due to how they were made to feel. In pressurised work areas the focus was more on what has not been done, rather than what was done. Career progression was another factor. SPe said that she would be happy to share further thoughts. SPe observed that the advantage of Trust size was not being fully capitalised. There was a lack of consistency in purchasing high cost items, such as hoists, so different companies were used and costs were higher than necessary.	
11.	**CONSTITUTION REVIEW GROUP REPORT** The Council considered each of the items listed at Appendix 1 to the report, noting the points and recommendations made by the Constitution and Policy Review Group. Council agreed the recommendations to be taken to the Board meeting on 27 May 2021. 1. <u>Voting</u> The GCS advised that enquiries were being made to confirm that the Admin Control system could be used to run a confidential ballot. Recommendation 1: *Revise the Constitution to state that confidential votes are used in extremis by agreement in Council and in a way which ensures that the individual's votes remain private. The timeframe for confidential votes to be five days, but can be shorter if required, by agreement with Council.* 2. <u>Virtual Voting</u>	

	The GCS explained that the move to virtual meetings as a result of the pandemic had prompted a re-examination of the criteria around virtual voting. Currently the bar was set higher for virtual votes – 65% majority as opposed to a simple majority. The view now developing in corporate governance circles was that the if a secure electronic system was used which guaranteed one vote per person and that papers were readily accessible by all, the higher bar was not needed. The GCS noted that there were some instances in the Constitution which outlined circumstances where a higher bar was needed and these should remain. For example the disciplinary process required 75% approval. The requirement for Public governors to be the majority of those voting was included to protect the principle that public elected governors should be in the majority. Recommendation 2 *Revise the Constitution so that virtual voting is undertaken via a secure electronic system and passed by a simple majority of the number of governors on Council, unless already stated otherwise in the Constitution. Public Governors must be the majority of those voting.* 3. <u>Governor Term of Office</u> The GCS commented that a maximum term of nine years was considered good governance practice and NHSEI had indicated that they would not support removing or increasing the maximum. Replies to an enquiry made to the Company Secretary network confirmed all had the maximum term rule bar one. In that case the change had been an accidental outcome of drafting which was being rectified. The following points were made in the ensuing discussion. • ALi said that the change would prevent recurrence of recent election history where a governor had to leave having reached the end of the maximum term and no candidates came forward for the subsequent election. Refreshing Council had to be balanced with the need for experience on the Council and avoiding long term vacancies. • Having a vacancy which could not be filled when there was a person of experience being blocked from standing by a maximum term rule was unproductive. • The view was expressed that the role of the governor different to the role of the NED and not comparable with respect to the rationale for having maximum terms. • Engaging with communities in a different way to invigorate interest in the role of Council and Governors was another way to address the problem of having positions elected unopposed or elections having to be repeated. There was a danger in being perceived as acting in a paternalistic manner. • It was acknowledged in the discussion that there was potential for conflict of interest for governors present who were in their final term under the current rules. • The benefit of experience needed to be balanced against the risk of stifling new ideas or thinking. Council had to be accessible to new people and there was potential for this to be blocked if governors were	

	able to serve for very long periods. • Current history suggested that unfilled vacancies was more likely than refreshing of Council being blocked; this suggested that the maximum term served no purpose but could be reviewed at a later date if the situation changed. • A proposal was made that the three terms of three years maximum be retained but the flexibility added that in exceptional circumstances, which should be defined, this could be extended on a one year basis. • Governors leaving the Council at the end of the maximum term would be able to attend public meetings. • The Chairman commented that it was unlikely given the Trust's high profile with regulators that the Board would be amenable to making a change which was known not to be supported by them. Future regulatory inspections of the Trust will be looking at adherence to expected practice and modern governance does tend to restrict terms of office. Accepting the point that public and staff governors were elected, the electoral process for governors is not so robust to create a counterweight of accountability. A set maximum term does encourage governors to serve with time period in mind to make their mark. The Chairman acknowledged that differing views had been expressed by governors during the discussion; some supported the proposal, others did not. He proposed that he have further discussion with the Lead Governor and with the Board and seek to arrive at a compromise solution. This was agreed. Chairman to carry forward. **ACTION:** Discuss the issue of changing removing the maximum term of office rule for Governors with the Board and with the Lead Governor and seek to reach a compromise solution. 4. <u>Taking over a Governor term of office</u> Council agreed that there was no further points to raise on this item. No immediate action required, pending outcome of 3 above. 5. <u>Composition of Council</u> No action required. 6. <u>Partner Governors having Deputies</u> It was agreed that there were no further points to raise on this item. Recommendation 3 *The change to allow partner governors to have deputies should not be accepted. Check to be made to ensure the definition for partner governors is consistent and clear.* 7. <u>Governors standing down when they move out of area</u> It was agreed that there was no further points to raise on this item. Recommendation 4 *No constitutional change needed in relation to governors standing down if they move out of area mid-term.* 8. <u>Involving younger members in Council meetings</u> Council agreed no action required.	Chairman

	9. NED appointments It was agreed that there was no further points to raise on this item and no recommendation to be taken to the Board. 10. & 11. NED term of office and appraisal review It was agreed that there was no further points to raise on this item and no recommendation to be taken to the Board. 12. Composition of the Board It was agreed that there was no further points to raise on this item. Recommendation 5 Revise the Constitution to: • Increase the maximum number of NEDs on the Board to eight excluding the Chairman. • Define Non-voting NEDs and Executive Directors. • Define Associate Directors • Remove the reference to SECamb. **ACTION:** Recommendations agreed relating to the Constitution Review to be taken to the next Board meeting for discussion and feedback to the Council.	AB
12.	**LEAD AND DEPUTY LEAD GOVERNOR ELECTIONS** The report was noted and no comments made.	
13.	**COMMITTEE MEMBERSHIP** The G&ML said that the paper was based on the assumption that the number of Committees had been increased to four. It was proposed that the Nominations and Remuneration Committee be constituted from volunteers as need, and a proposal for membership on the other three committees was contained in the paper and based on the criteria listed. There were no comments on the membership suggested. The proposal provided seven members for each committee, although previous practice had been to have eight members. Quoracy for the meetings was four governors attending. To have eight members per committee, three governors would have to volunteer to join the two governors who were already working on two committees. The G&ML reminded Council that all governors were able to attend any routine meeting of a Committee. The Council AGREED the proposed membership. MWa suggested that reaching quoracy would be more difficult if there were only seven designated members in each committee. The G&ML commented that problems with reaching quoracy had been rare in the past. The Chairman noted that being able to meet virtually did increase attendance and it was likely that this would continue in some form moving forward; something for Council to discuss in the future. The Chairman said that the workload for Governors would increase when site visits and engagement events were re-instated; he was concerned about the workload if five governors had to serve on two committees.	

	JCa said that he would be willing to work on more than one Committee. His preference would be to continue with a membership of eight people. ARi suggested that he had had experience of a system where membership of one committee was assigned with a pool of members ready to step in if there were issues of quoracy. He said that he would be happy to talk with the G&ML about this. It was AGREED that the Committee work would be taken forward on the basis of the membership proposed in the paper and a proposal made at a later date with respect to final numbers, taking into account the impact on quoracy. KRo noted that the terms of reference for the meetings needed to be reviewed as some referred to NEDs who were no longer on the Board. The G&ML said that the review of the terms of reference would be included in all first meetings of the Committees and the documents brought back to Council for ratification. **ACTION:** terms of reference to be reviewed at each Committee and brought to the next Council meeting for ratification.	AB
14.	**GOVERNOR FEEDBACK ON EVENTS ATTENDED** There was no feedback from events attended. The Chairman welcomed this as an agenda item, requesting that where possible Governors give notice of items that they wish to raise to assist him in the timing of the meeting.	
15.	**QUESTIONS FROM THE PUBLIC** There were no members of the public present.	
16.	**ANY OTHER BUSINESS** There was no further business.	
17.	**DATE OF NEXT PUBLIC MEETING: TO BE CONFIRMED** Date to be set in accordance with agreement under item 8 above.	

CoG 21/21
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST - OUTSTANDING ACTIONS, 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)
21 01	20.05.21	8	Chairman's report	The Board to be asked to consider agreeing to a Governor observer attending closed Board sessions and Board Committee meetings and a NED to be a member of the Staff and Patient Experience Committee.		Chairman	15.09.21: for update on Chairman's return
21 02	20.05.21	9	CEO report	Share with Council the comments made by the Trust to the government white paper.		CEO	15.09.21: to be confirmed.
21 03	20.05.21	11	Constitution Review Group Report	Discuss the issue of changing removing the maximum term of office rule for Governors with the Board and with the Lead Governor and seek to reach a compromise solution.		Chairman	15.09.21: for update on Chairman's return
21 04	20.05.21	11	Constitution Review Group Report	Recommendations agreed relating to the Constitution Review to be taken to the next Board meeting for discussion and feedback to the Council.		AB	15.09.21: for verbal update at the meeting
21 05	20.05.21	13	Committee membership	Terms of reference to be reviewed at each Committee and brought to the next Council meeting for ratification.		AB	15.09.21: for verbal update at the meeting

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**15 SEPTEMBER 2021**
REPORT TITLE:	**RATIFICATION OF VIRTUAL VOTING SINCE LAST MEETING**
PAPER AUTHOR:	**GOVERNOR AND MEMBERSHIP LEAD**
PURPOSE:	**TO NOTE FOR RATIFICATION**
APPENDICES	**ANNEX 1: record of virtual votes and outcome**

BACKGROUND AND EXECUTIVE SUMMARY

This report presents the outcomes of the virtual votes carried out since the last Council meeting for ratification of the decisions taken. In all cases the criteria applied was that the vote would be passed if 65% of Governors vote for the motion and at least 70% of all governors able to vote has voted.

The details of the virtual votes and the outcomes are provided at Annex 1.

As noted in the Co-Chair's report from the meeting of the Audit and Governance Committee held on 6 September; it has been recognised that the criteria for virtual voting changed following the Board's agreement to the recommendation made by Council following their consideration of the report from the Constitutional and Policy review group.

> Recommendation 2
> Revise the Constitution so that virtual voting is undertaken via a secure electronic system and passed by a simple majority of the number of Governors on Council, unless already stated otherwise in the Constitution. Public Governors must be the majority of those voting.

Therefore, there was no need to carry out second voting processes as the first votes for the Governor Commentary and the Interim Chair remuneration did meet the minimum voting requirement under the changed criteria.

The outcome of these votes would not have altered had the correct criteria been applied. With 19 governors on Council a simple majority is 10 and in both cases at least 10 votes were cast agreeing to the proposal in the first vote.

LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to note the outcomes of the virtual voting carried out since the last meeting for ratification.

East Kent Hospitals University NHS Foundation Trust

Appendix 1

VIRTUAL VOTING RECORD SUMMARY						
DATE REQUESTED	**DESCRIPTION**	**FOR**	**AGAINST**	**ABSTAIN**	**NUMBER OF GOVERNORS IN COUNCIL**	**OUTCOME**
26.05.21	Proposal to appoint Sarah Dunnett as the Senior Independent Director	14	0	1	19	Agreed
28.07.21	Request to agree the draft Governor Commentary to the Trust's Annual Quality Report				19	13 Votes cast. Insufficient governors voted to validate process
30.07.21	Request to agree the draft Governor Commentary to the Trust's Annual Quality Report	12	0	2	19	Agreed
23.08.21	Request to agree remuneration for the interim Chair during Niall Dickson's period of planned sick leave.				19	12 Votes cast. Insufficient governors voted to validate process
01.09.21	Request to agree remuneration for the interim Chair during Niall Dickson's period of planned sick leave.	15	0	0	19	Agreed

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**15 SEPTEMBER 2021**
REPORT TITLE:	**VICE CHAIRMAN'S REPORT**
SPONSOR:	**VICE TRUST CHAIRMAN**
PAPER AUTHOR:	**GOVERNOR AND MEMBERSHIP LEAD**
PURPOSE:	**TO DISCUSS**
APPENDICES	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

This report is brief as much of the updating to Council on significant issues will be done by in the CEO report. I would however like to take this opportunity, following Susan's announcement last week that she will be leaving us next Spring, to thank her for her dedication, tireless work and improvements made during her time at East Kent.

As you are aware, I am standing in for Niall during this meeting and I am pleased to report he is making an excellent recovery. I know that it was his wish that the programme of Governor and Board member visits to the hospital site should start again as soon as possible and this has been achieved. The plan is for Marcella Warburton and Stewart Baird, Non-Executive Director 'in waiting', to visit some of the HR team and the Stroke Unit at Kent and Canterbury on 14 September. I look forward to hearing some immediate feedback from Marcie later in this agenda and am also interested in any comments you have in relation to the rolling programme of these visits that Neville Daw is organising.

I joined Bernie Mayall and Stewart Baird this week for a visit to the Harmonia Village site, which gave us the opportunity to learn more about the future plans. We were escorted by Henry Quinn, Head of Strategic Development, and Philip Brighton, Frailty Consultant.

I appreciate that we have packed a lot of items into the agendas for your meetings today and there is a lot of ground to be covered. Again, I would welcome your feedback about the content and planning; either at the end of the meeting or afterwards by email.

We have started to hold some of the Board meetings face to face in recent weeks and I am sure that this is something that Niall will want to discuss with you on his return.

Lastly, I am pleased to be welcoming Dorothy and Neville to their first formal meeting of Council. I know that they are both intending to meet with each of you individually over the next few weeks and this will give an excellent opportunity for you to share your views on how best Council can be supported.

LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to note and discuss the content of this report.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**2021**
REPORT TITLE:	**MEMBERSHIP ENGAGEMENT AND COMMUNICATION COMMITTEE (MECC) CHAIR'S REPORT**
PAPER AUTHOR:	**MECC CHAIR**
PURPOSE:	**TO AGREE**
APPENDICES	

BACKGROUND AND EXECUTIVE SUMMARY

This report updates Council on the meeting of the MECC held on 8 July 2021. Members attending the meeting were myself, Carl Plummer, Linda Judd, Alex Ricketts, Paul Schofield, Paul Verrill and Marcella Warburton – Sohie Pettifer gave apologies. Bernie Mayall and James Casha were also in attendance.

This was the first meeting of the Committee since 4 November 2020 and the first since the membership on Council Committees was renewed; I was confirmed as the Committee Chair.

There were a number of outstanding actions and the majority of the meeting was taken with reviewing these and deciding on a plan of action for the Committee now that the restrictions caused by the covid pandemic are easing.

The Committee are recommending that three specific and positive steps are taken immediately which are designed to make governors and Council more visible to the public:

1. Governor Newsletter: to continue with the electronic governor newsletter making the content short with a call for action to sign up as members. Alex Ricketts agreed to provide the suggested content for the next newsletter.

2. Council twitter account: this has previously been discussed and agreed by Council. Carl and Linda have volunteered to work with the communications team to start up the account. The plan is to have two to three weeks of material ready and to start slowly to make sure it runs smoothly before publicising the account.

3. To make enquiries about using existing Council newsletter circulations to their constituents to send information about Council and governors.

These plans fall within the content of the existing Council's Members and Membership Engagement Strategy. The view was to take this action immediately rather than review and change the existing 2019 – 2022 strategy, though some amendments may be needed.

The Committee also considered arranging for leaflets to be added to Trust outpatient letters but decided on balance that this was not a viable route to follow. The cost to do so was relatively high and it would not be possible to target a specific audience.

The Committee had previously been developing an idea for a staff survey around cleanliness with the aim of giving staff the opportunity to raise concerns direct with Council. Advice from the Trust's audit team was that there were existing trust's audits on this subject and Council would need to be clear about the outcome required from the survey and how this would be additional to the existing work. After discussion the Committee agreed to request that the Director of Nursing and the Director of Infection Prevention and Control be asked to attend a

East Kent Hospitals University NHS Foundation Trust

Council meeting to explain how the Trust worked with 2SS, the subsidiary company responsible, under contract to the Trust, for housekeeping services. The Committee also noted that governors were previously involved in self inspection PLACE surveys which were conducted nationally in ward areas prior to the pandemic.

The Committee received an update from the Director of Communications with respect to the plans for the Annual Members Meeting. I understand that a further update will form part of the Chairman's report to Council as circumstances have changed since the MECC meeting.

LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to note the proposal for three positive actions to be undertaken and agree the suggestion that that the Director of Nursing and the Director of Infection Prevention and Control be asked to attend a Council meeting to explain how the Trust worked with 2SS.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**15 SEPTEMBER 2021**
REPORT TITLE:	**PROCESS FOR RESPONDING TO EMAILED ENQUIRIES**
PAPER AUTHOR:	**GOVERNOR AND MEMBERSHIP LEAD**
PURPOSE:	**TO AGREE**
APPENDICES	**Annex 1: categories of enquiries and actions**

BACKGROUND AND EXECUTIVE SUMMARY

This report is a discussion document for the Council of Governors around protocols for responding to emails to the dedicated governor email addresses.

There are two email addresses available for use by FT members and the public:

- foundationtrust@nhs.net – for contact with the Membership office
- governorsquestions@nhs.net – for contact with Governors/Council

The basic premise is that emails addressed to governors are shared with Council immediately and the email acknowledged; which is straightforward to do. However, the wide range of enquiries that are raised through the governor emails has necessitated developing a set of protocols for the action to take to ensure transparency and consistency.

The principles applied in drafting the protocols are:

- to ensure a definitive response is provided in a timely manner;
- that the content of the response is decided and agreed by Council; and
- that the response is factually correct.

Enquiries received should usually fall under one of the following categories, though this is not an exhaustive list:

1. Requests for general information of a factual nature i.e. how to become a member.
2. Enquiries from members about their membership.
3. Complaints about:
   a. individual patient care; or
   b. from staff or ex-staff about their employment
4. Complaints about a named person, not falling into category 3:
   a. Member of staff;
   b. Non-Executive Director (NED); or
   c. Governor;
5. Concerns about specific departments, including suggested changes to those services.
6. Enquiries specifically linked to public consultations.
7. Requests to pass on:
   a. a personal message to a named governor not related to their role;
   b. an email to a member of staff or Board member and addressed to them; or
   c. a communication to a named Trust department.
8. Potential FOI (Freedom of Information) request.

East Kent Hospitals University NHS Foundation Trust

Not all responses will need agreement from Council; for example those in categories 2 and 7a. Some responses will be standard; for example those in category 6 would need to be referred to the organisation running the consultation.

Enquiries in Category 5 are likely to be more complex and will need direction from Council on the content, supported by information and advice from the Trust on the background detail and, in some instances, possible legal, political or reputational ramifications. These replies will need agreement from Council and confirmation from the Trust with respect to factual accuracy. This category will take the longest to respond to and be at the most risk of delay. To mitigate this risk, the draft protocol suggests that a decision is taken at the start on whether the response can be agreed by a smaller group of governors or if it needs formal agreement by Council. A record would be made of the reasons for the decisions taken.

Category 4 enquiries will need a flexible approach to find a balance between making governors aware of the concerns raised and the organisation's responsibilities to the named individual. Decisions will need to be taken on a case by case basis and a record made of the reasons for the actions taken.

For all categories the details will be logged and governors made aware of the enquiry. Quarterly summary reports would be presented to Council via the Membership Engagement and Communication Committee (MECC) and Staff and Patient Experience Committee (SPEC) to enable governors to identify themes and trends. MECC to focus on issues relating to member/public engagement and SPEC on quality issues.

The table at Annex 1 takes the categories listed above and proposes how each will be processed by the Governors' support team.

It is recommended that the protocol is reviewed after 6 months by the Council.

LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked to:
- discuss and agree a protocol for responding to enquiries made to the membership and governors email addresses.
- agree the review of the protocol after 6 months.

East Kent Hospitals University NHS Foundation Trust

Annex A

Note: all emails received will be acknowledged within two working days of receipt.
All contacts will be recorded on a concerns raised database and a quarterly summary report provided.

Governor Support Office - GSO

Category	**Description**	**Action**	**Informing Council**	**Time frame** Working days from date of receipt
1	Requests for general information of a factual nature.	GSO responds to the enquiry directly.	Enquiry and reply shared with Council when the response is sent. Included in quarterly summary report to governors under this category.	3
2	Enquiries from members about their membership	GSO responds to the enquiry directly.	Quarterly report provided to governors on the number and nature of enquiries made under this category.	3
3a	Complaints about individual patient care.	GSO provides standard response that the email has been forwarded to the PALs department.	Council informed about the nature of the concerns raised. Care taken not to share person identifiable information.*	Immediate
3b	Complaints from staff or ex-staff about their employment.	GSO provides standard response to enquirer that the email has been forwarded to the HR department.	Council informed about the nature of the concerns raised. Care taken not to share person identifiable information.*	Immediate
4	Complaints about a named person not falling within category 3: a. Member of staff	GSO provides standard response to enquirer that the email has been forwarded to the HR department.	Council informed that a complaint has been received and forwarded to the HR department.	2

East Kent Hospitals University NHS Foundation Trust

Category	Description	Action	Informing Council	Time frame Working days from date of receipt
	b. NED	GSO forwards to the Trust Chairman for decision.	Trust Chair to inform Council that a concern has been raised and the action plan for addressing the complaint.	As per plan
	c. Council member	Handle within the established procedure for investigating allegations of a Breach of the Code of Conduct.	As per the procedure.	As per the procedure.
5	Concerns about specific departments, including suggested changes to those services	Email shared with Lead Governor or Deputy and action plan agreed: • What information will Council require. GSO may be able to provide some background information immediately. • Who will draft the reply. • How will the draft be approved. • When will the Trust have the opportunity to agree the factual content. • Timescales	Concern raised and action plan shared with all governors once plan is agreed.	As agreed in plan
6	Enquiries specifically linked to public consultations	GSO to forward to consultation co-ordinator and advise that this has been done.	At end of consultation, Governors advised of number of responses forwarded by GSO.	2
7	Request to pass on: a. a personal message to a named governor not related to their role	GSO to action.	Quarterly report provided to governors on the number and nature of enquiries made under this category.	2
	b. an email to a member of staff or Board member and addressed to them			

East Kent Hospitals University NHS Foundation Trust

Category	Description	Action	Informing Council	Time frame Working days from date of receipt
	c. a communication to a named Trust department.			
8	Potential FOI request	GSO to action.	Quarterly report provided to governors on the number of enquiries made under this category. All FOI responses are published on the Trust's website	Immediate

* In rare cases this will mean that not all information can be included – some instances are so specific that the patient/staff involved can be identified by the nature of the events.

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**15 SEPTEMBER 2021**
REPORT TITLE:	**NON-EXECUTIVE DIRECTOR OVERSIGHT REPORT**
PAPER AUTHOR:	**VICE CHAIR**
PURPOSE:	**TO DISCUSS**
APPENDICES	**Annex 1: Integrated Performance Report** **Annex 2: Board Assurance Framework** **Annex 3: finance summary**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides a brief summary of the work being undertaken by each of the Board Committees. The aim of this item is to provide Council with an opportunity to raise with the NEDs any areas of specific concern and to gain assurance that the NEDs are assured about the performance of the Board; is aware of potential risks and taking appropriate action.

The Integrated Performance Report, the Risk Register and a finance summary are appended at Annexes 1, 2 and 3 for additional information. The timings of Board and Council meetings means that the most recent versions for Annex 1 and 2 are those published in July.

Each of the Board Committee Chairs provide a report on their meetings to the next Board meeting. Board papers can be accessed at https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/
These reports raise any issues of concern for the attention of the Board.

For this first report the intent is to provide Council with an idea of the role of each of the Committees and the current key issues. Council members may wish to discuss how useful the report is and how it might be refined.

Chris Holland and Stewart Baird will also be present at the Council meeting. We are currently at the end stage of confirming the roles and responsibilities of each NED – you will see these reflected in the 2021/22 NED objectives paper presented to the closed meeting of Council. In addition to membership on the Board Committees, some NEDs will have 'Lead NED' roles with respect to specific issues; examples of these are Maternity, Speaking up and Care of Vulnerable patients.

Once the roles and responsibilities of individual NEDs are confirmed, Council will be provided with a chart showing Committee membership and areas of specific interest.

Moving forward the intent is to ensure that there is at least one NED member of each of the Board Committees present to answer your questions. It is recognised that this item may need more time allotted to it in future meetings

The Integrated Audit and Governance Committee met on 17 August. This Committee is chaired by Olu Olasode and its purpose is to ensure that the Trust's governance systems are operating properly. As such, it has overarching responsibility for the oversight of risk and reviewing the Trust's Board Assurance Framework is a regular item on the agenda. The Committee has had some concerns about the process of populating the BAF document and changes have been made so that items included are clearly risks to the organisation, rather

than issues, and that action is taken in a timely fashion with gaps identified and controls put in place.

Examples of other items considered by the IAGC include: the annual report on gifts, hospitality and conflicts of interest; Management training compliance; and freedom to speak up guardians report. Reports were taken at the last meeting from both the external auditors, Grant Thornton, and the internal auditors, RSM.

The Quality and Safety Committee met on 24 August and is chaired by Sarah Dunnett. 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. It receives regular reports on issues such as infection prevention and control, and reports from each of the care groups. The Committee also reviews the Integrated Performance Report at each meeting. Response to CQC and other regulator reports is overseen by this Committee.

At the last meeting the Committee received a paper recommending a re-structuring of the sub-committees reporting into the Quality and Safety Committee so that the structure aligns with the We Care methodology. Other changes were recommended, such as chairing by Executive Director or their deputies, which will strengthen the system and ensure that: each committee has a clear purpose and there is no duplication; reporting lines are clear; and each committee adds value.

The Board's Finance and Performance Committee meets on the same day as the Quality Committee and is chaired by Nigel Mansley. The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. It receives reports on the month end financial position and a savings and efficiencies update. Finance and Operation risks are reviewed on a quarterly basis and currently there is a regular update on the reset, restore and recovery programme. Progress on the capital programme is reviewed and business cases presented for approval. Emergency planning and Winter planning also fall under the remit of this Committee.

The last meeting of the Strategic Workforce Committee (SWC) was held on 28 July, chaired by myself. The Committee is responsible for providing the Board with assurance on all aspects relating to the workforce, including strategy, delivery, governance, and risk management. The Committee reviews the IPR and Corporate Risks register at each meeting and receives updates on the leadership development plans, workforce planning and occupational health/well being. At the last meeting the Committee was informed about changes in the Equality, Diversity and Inclusion Team following the retirement of the Head of the Department. The HR department are obviously central to the work in the Trust on cultural change and workforce management and the SWC expects to see evidence of robust and clear progress in these areas reflected in the information provided at the meetings.

LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**

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

NHS
East Kent
Hospitals University
NHS Foundation Trust

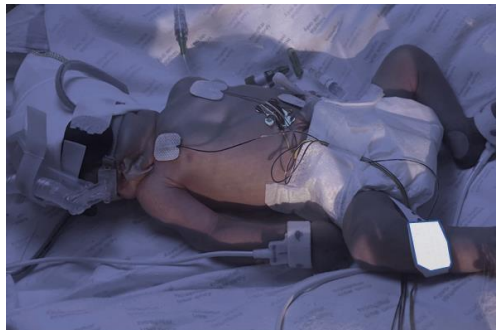
Integrated Performance Report

June 2021







We care

Our vision, mission and values

We care' is how we're working to give great care to every patient, every day. It's about being clear about what we want to focus on and why and supporting staff to make real improvements, by training and coaching everyone to use one standard method to make positive changes.

We know that frontline staff are best placed to know what needs to change. We've seen real success through initiatives like 'Listening into Action', 'We said, we did', and 'I can'.

'We care' is a bigger version of this – it's the new philosophy and new way of working for East Kent Hospitals. It's about empowering frontline staff to lead improvements day-to-day.

It's a key part of our improvement journey – it's how we're going to achieve our vision of great healthcare from great people for every patient, every time.

For 'We care' to be effective, we need to be clear about what we are going to focus on – too many projects will dilute our efforts.

For the next five years, our strategic focus centres on five themes:

- our **patients**
- our **people**
- our **future**
- our **sustainability**
- our **quality and safety**

What is the Integrated Performance Report (IPR)?

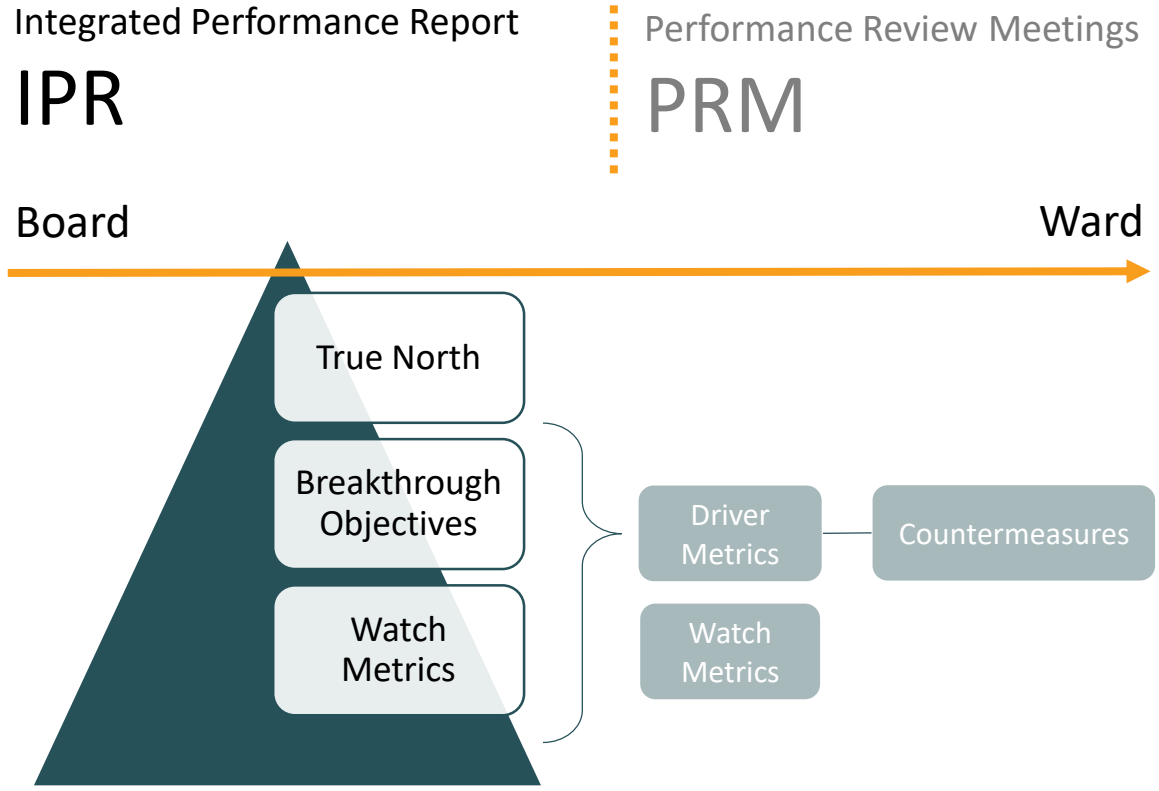
To turn these strategic themes into real improvements, we're focusing on five key objectives that contribute to these themes for the next year.

- Reducing falls
- Reducing healthcare acquired infections
- Reducing deaths from sepsis
- Improving theatre capacity
- Reducing patient time in ED once there has been a decision to admit.

We have chosen these five objectives using data to see where we can make the most significant improvements by focusing our efforts. We'll also use data to measure how much we're making a difference.

Frontline teams will lead improvements in these areas of focus. They will be supported by our Improvement Office, which will help give teams the training and tools they need, and our Executive Directors will set the priorities and coach leaders in how to support change. Our corporate teams will work with frontline teams to tackle organisation-wide improvements.

We recognise that this change in the way we work together means changing our behaviour and the way we do things. We will develop all leaders – from executive directors to ward managers - to be coaches, not 'fixers'. We will live our Trust values in the way we work together, and involve patients in our improvement journey.



The IPR forms the summary view of Organisational Performance against these five overarching themes and the five objectives we have chosen to focus on in 2020/21. It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

The 'We Care' methodology incorporates the use of SPC Charts alongside the use of Business Rules to identify common cause and special cause variations and uses **NHS Improvement** SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

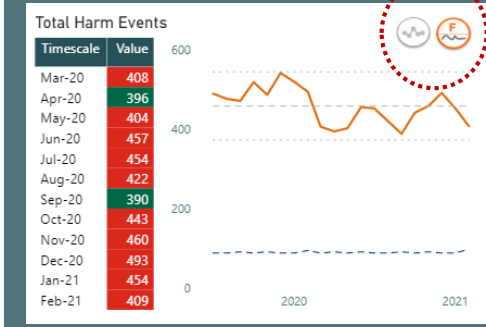
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (ie no significant change.

NHS Improvement SPC icons

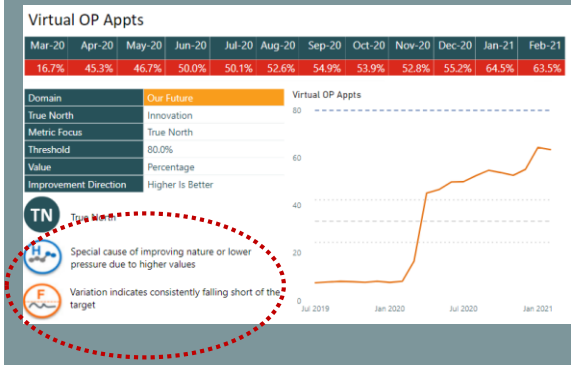
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Where to find them

True North



Breakthrough Objectives



What are the Business Rules?

East Kent Hospitals University NHS Foundation Trust

Business rules work in conjunction with SPC alerts to provide a prompt to take a specific action.

This approach allows the organisation to take a measured response to natural variation and aims to avoid investigation into every metric every month, supporting the inch wide mile deep philosophy.

The IPR will provide a summary view across all True North metrics, detailed performance, actions and risks for Breakthrough Objectives (driver) and a summary explanation for any alerting watch metrics using the business rules as shown here as a trigger.

#	Rule	Suggested rule
1	**Driver** is **green** for reporting period	Share success and move on
2	**Driver** is **green** for six reporting periods	Discussion: 1. Switch to watch metric 2. Increase target
3	**Driver** is **red** for 1 reporting periods (e.g. 1 month)	Share top contributing reason, and the amount this contributor impacts the metric
4	**Driver** is **red** for 2 reporting periods	Produce Countermeasure summary
5	**Watch** is **red** for 4 months	Discussion: 1. Switch to driver metric (replace driver metric into watch metric) 2. Reduce threshold
6	**Watch** is out of control limit for 1 month	Share top contributing reason (e.g. special / significant event)

Executive Summary

East Kent Hospitals University NHS Foundation Trust

Our Quality & Safety

Sarah Shingler

Rebecca Martin

Incidents Potentially Contributing to Harm
The True North target is to achieve zero avoidable harm within 5-10 years. Our calculation includes incidents with harm or those that have the potential to lead to harm and aggregates the following;

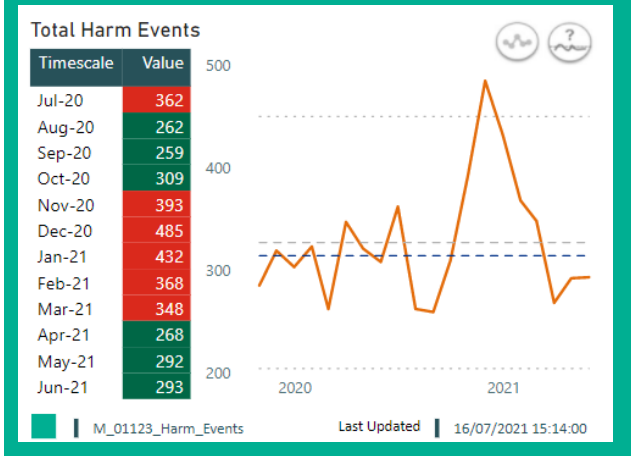
- Falls
- Pressure Ulcers
- C Difficile (in-hospital)
- E.Coli (in-hospital)
- Covid Infections (in-hospital)
- Nutrition Incidents
- Medication Errors

The effects of patient safety incidents go beyond the impact of the physical injury itself. Patients and their families can feel let down by those they trusted, and the incident may also lead to further unnecessary pain and additional therapy, or operative procedures and additional time in hospital or under community care.

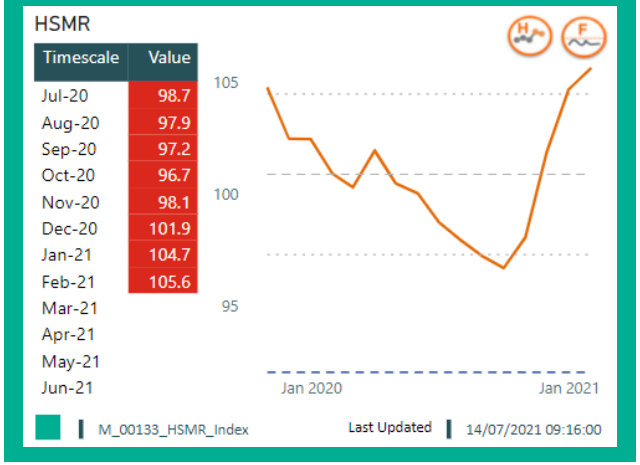
Mortality (HSMR)
Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Our aim is to reduce mortality and be in the top 10% of all Trusts for the lowest mortality rates in 5 to 10 years.

Incidents Potentially Contributing to Harm
To achieve and sustain zero avoidable harm.



Hospital Standardised Mortality Ratio (HSMR)
To reduce our Hospital Standardised Mortality Ratio and be in the top 10% of all Trusts.



Executive Summary

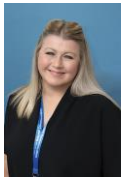
NHS
East Kent
Hospitals University
NHS Foundation Trust

Our Patients

Rebecca Carlton

Trust Access Standards (Cancer, RTT & ED)
It is poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, financial and regulatory risk for the Trust.

The Trust has struggled to achieve consistently the national access standards for ED, RTT and Cancer, for a number of years. It is therefore important that these form a key part of our True North strategy for the coming years.

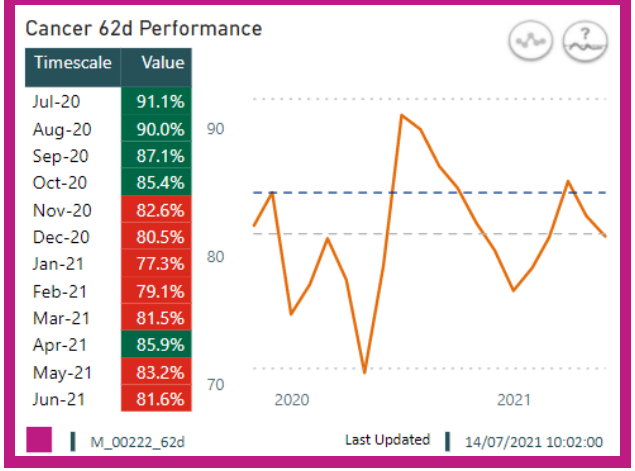


Sarah Shingler

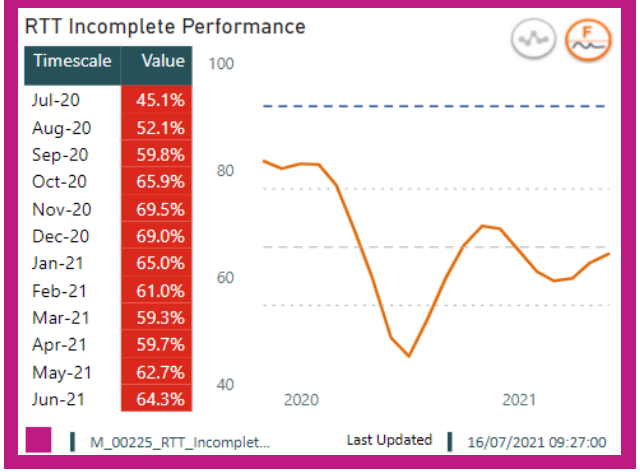
Patient Experience (FFT)
The Family and Friends Test is a national measure which confirms how likely patients are to recommend the Trust as a place for treatment. This data collection incorporates a scale for quantitative analysis and an area for free text comments and is gathered on a monthly basis.

The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall recommended score together, we have therefore added completion rates as watch metrics to our overall scorecard.

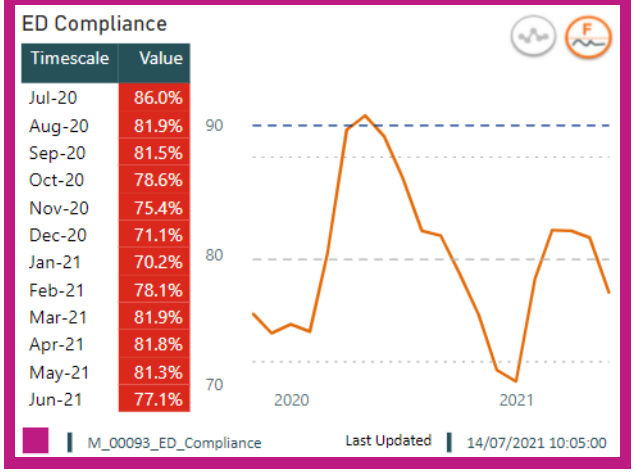
Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.



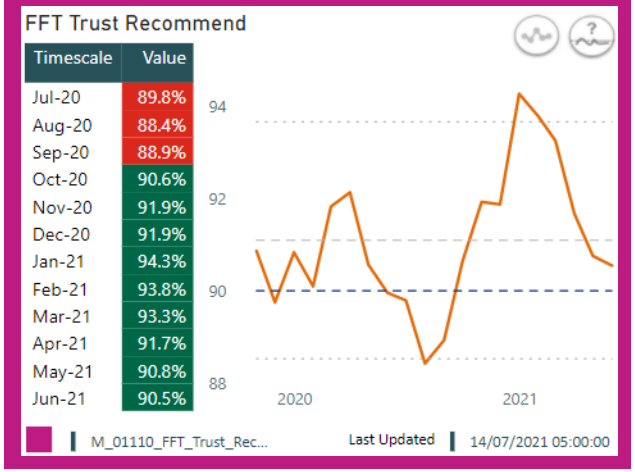
RTT: 18 Week Compliance
To achieve and sustain 92% of all patients waiting less than 18 weeks for first definitive treatment.



ED 4 Hour Compliance
To achieve and sustain 95% of all patients attending ED receiving treatment or admission with 4 hours.



Patient Experience (Friends & Family Test)
To achieve consistent recommendation rates in excess of 90% from patient friends and family.



NHS
East Kent
Hospitals University
NHS Foundation Trust

Our People

Andrea Ashman

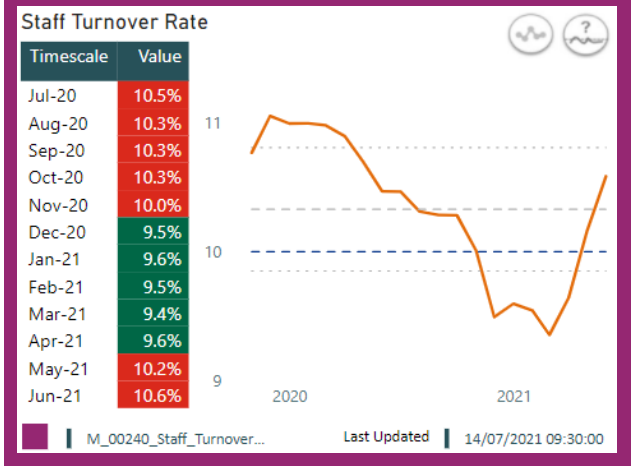
Staff Turnover (rate)
The annual turnover rate provides us with a high-level overview of Trust health.

Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

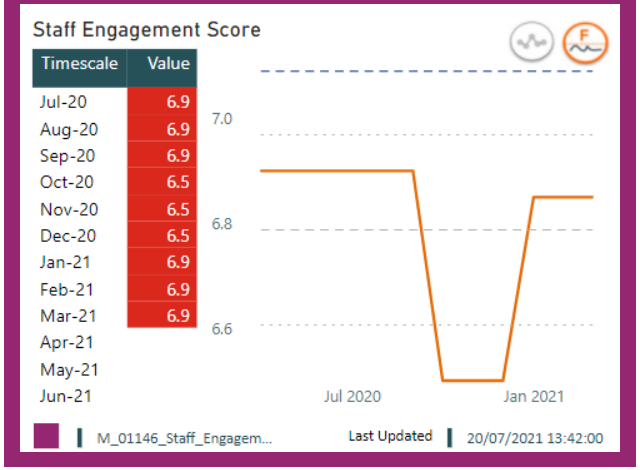
Staff Engagement (score)
Staff satisfaction levels are amongst the bottom 20% across the country, which can lead to difficulty in recruitment and retention.

The annual national staff survey is used to give an indication of staff engagement. We will be monitoring this at quarterly intervals throughout the year via the staff friends and family test.

Staff Turnover
To achieve and maintain a 10% staff turnover rate.



Staff Engagement
To improve our staff engagement score as demonstrated in the annual staff survey.



East Kent Hospitals University NHS Foundation Trust

Our Sustainability

Phil Cave

Financial Position (I&E Margin)
Whilst there has been a significant financial deficit over the last 3 years at the Trust, in the current year a breakeven position was delivered. This metric will measure us against our long terms aim to maintain a breakeven position.

The impact of Covid-19 has paused the NHS business planning process nationally and has limited the ability of the Trust to hit its cost efficiency targets.

Liz Shutler

Carbon Footprint (CO2e)
Being environmentally sustainable is a key element of our Trust; True North.

Implementing environmentally sustainable principles and reducing our greenhouse gas emissions, adds value to our patients and reflects the ethics of our staff.

The Trust's carbon emissions are made up of:

- Direct emissions: natural gas
- Indirect and direct emissions: from for example electricity consumption, waste and water
- Waste

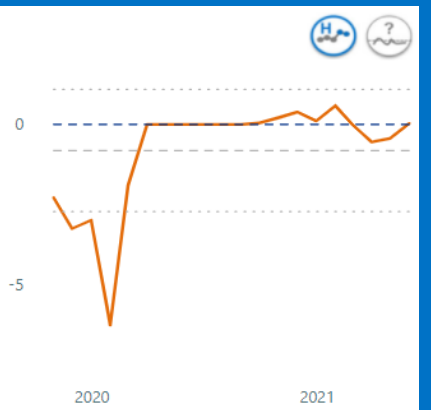
It is these areas we will be focussing on improving over the coming five to ten years.

Financial Position

To achieve and sustain a break even financial position.

I&E Margin (£M)

Timescale	Value
Jul-20	0.000
Aug-20	0.000
Sep-20	0.000
Oct-20	0.046
Nov-20	0.213
Dec-20	0.392
Jan-21	0.109
Feb-21	0.588
Mar-21	-0.007
Apr-21	-0.548
May-21	-0.438
Jun-21	0.030



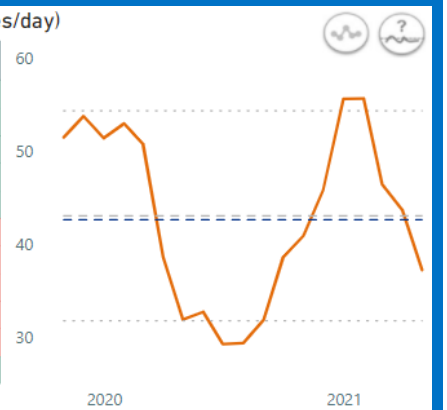
M_00148_I&E_Margin | Last Updated | 16/07/2021 09:18:00

Carbon Footprint

To achieve an organisational carbon neutral footprint.

CO2e Total (tonnes/day)

Timescale	Value
Jul-20	29.23
Aug-20	29.33
Sep-20	31.84
Oct-20	38.59
Nov-20	40.90
Dec-20	45.83
Jan-21	55.64
Feb-21	55.69
Mar-21	46.43
Apr-21	43.64
May-21	37.20
Jun-21	



M_01145_2gether_Trust_... | Last Updated | 12/07/2021 10:17:00

East Kent Hospitals University NHS Foundation Trust

Our Future

Liz Shutler

Medically Fit for Discharge
Across the Trust, patients are deemed as 'ready' and 'medically fit for discharge' but continue to remain under our acute care.

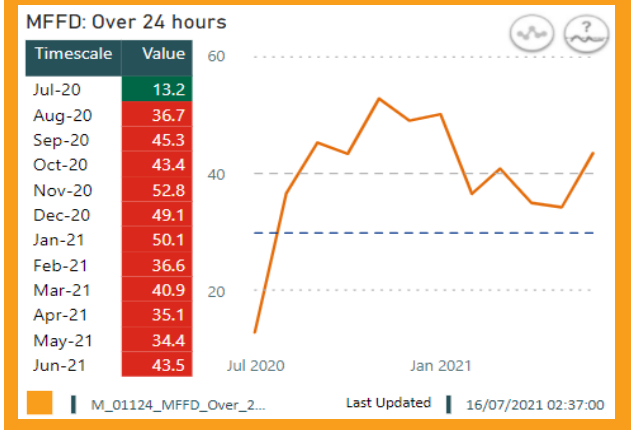
Unnecessary bed stays can negatively affect patient experience. In addition prolonged stays in hospital (especially for those who are frail or elderly) can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes mental and physical deconditioning.

By working with our partners in the wider heath & social care community to ensure patients return to their usual place of residence, or other care setting, as soon as it is safe to do so patient flow will improve thought the system. This metric was chosen as it represents the system working in an integrated way. As the system matures this metric my change to 'criteria to reside'.

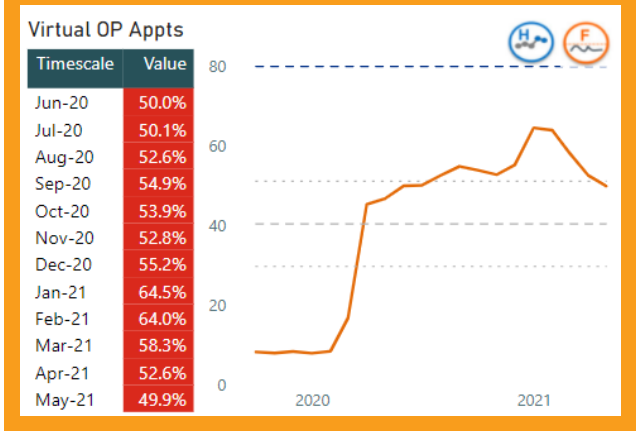
Innovation (Virtual OP Apps)
The current process for achieving innovation at the Trust is cumbersome and untimely. A cultural shift needs to take place using IT as a key enabler to drive the process.

Outpatients are working towards the targets set by our commissioners of at least 25% of all patient appointments and 60% of all follow ups to be conducted via telemedicine, where clinically appropriate, and to that end we have developed an enhanced engagement plan to meet this target and also to encourage the shift to Web from phone were possible. We have also set a stretch target of 80% to drive innovation in this area.

Medically Fit for Discharge
To ensure patients are cared for in the appropriate setting in a timely manner.



Innovation
To increase the use of technology and innovation in the delivery of high quality care for the East Kent population.



2020/21 Breakthrough Objectives

NHS East Kent Hospitals University NHS Foundation Trust

Falls

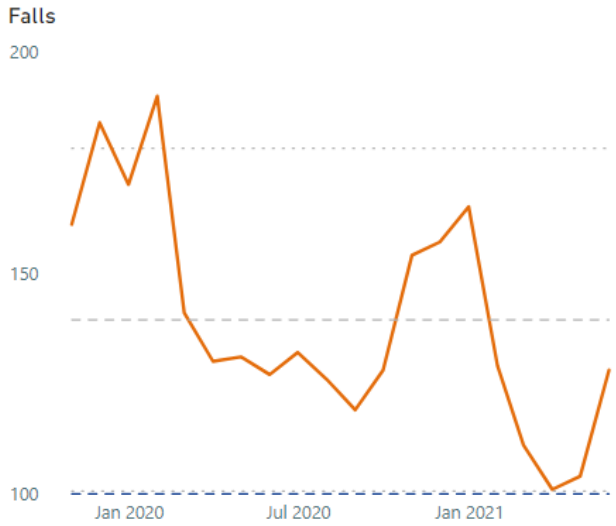
Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
132	126	119	128	154	157	165	129	111	101	104	128

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	100
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

Special cause of improving nature or lower pressure due to lower values

Variation indicates consistently falling short of the target



Understand the data

Total number of recorded falls. Assisted falls and rolls are excluded.
Data source - Datix

We are driving this measure because...

The Quality & Safety True North target is to achieve zero avoidable harm within 5-10 years. Our analysis shows that currently falls are the greatest contributor (40%) to harm events. Currently 45% of falls are reported as not resulting in harm and 54% of falls are reported as resulting in low harm. The assessment of falls is not currently standardised across the Trust.

Any fall can leave patients and their families feeling let down by those they trusted, with the potential need for further therapy, pain, operative procedures or additional time under community care or in hospital. All can impact long term outcome.

Performance

Current Performance: 128 falls recorded in June 2021. The current wards involved in We Care Falls group, show a sustained improvement. An additional 6 areas have been identified from data as the current highest contributors to falls. These have been invited to join the driver group and are undertaking training. Non clinical areas are identified as a top contributor and reflects falls occurring in outpatient areas (e.g. toilets, reception, car park)

Key areas of focus for this breakthrough objective are:

- Improving ward level visibility/focus on falls reduction/ level of harm.
- Standardising the trusts approach to reporting of falls on Datix.

Key achievements include:

- development of A3s at ward level with targeted understanding of route causes and focused actions.
- Sharing of learning/improvements through A3 presentations at driver meetings.
- development of a falls dashboard with accessible ward level data, co-designed and challenged at driver meetings.
- development of an MDT approach to reviewing falls through utilisation of a falls decision tool and a multi-professional falls/pressure ulcers panel to support the SI process.
- progression towards a self directed driver meeting with SRO co-chairing with surgical/medical matrons.
- Several PDSA projects underway e.g. Yellow blanket trial; Falls ward boxes; Standardised High risk of falls Medication lists.

Risks

Risk of capacity for some wards to undertake We Care Falls work due to on-going commitment to other We Care projects.

Mitigation is through escalation at We Care EMT discussions.

... | M_00320_Falls

Last Updated | 14/07/2021 08:03:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Composite HSMR: Sepsis/Resp

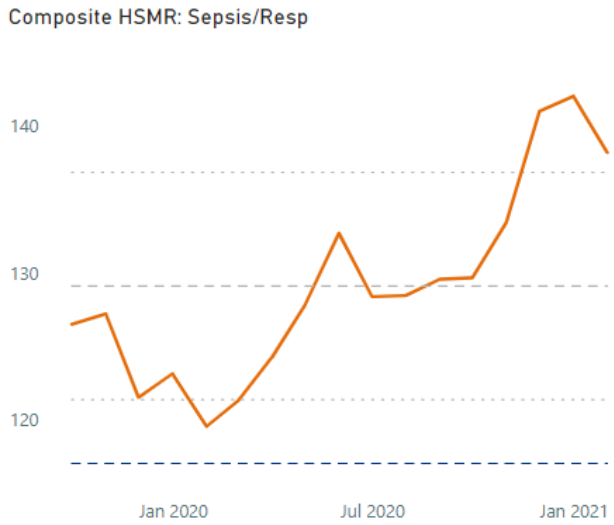
Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
132.7	128.4	128.4	129.6	129.7	133.5	141.0	142.0	138.2			

Domain	Our Quality & Safety
True North	Mortality
Metric Focus	Driver
Threshold	117.0
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

Special cause of concerning nature or higher pressure due to higher values

Variation indicates consistently falling short of the target



Understand the data

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality comparing a Trust's actual number of deaths to its expected/predicted number of deaths. This Composite HSMR metric is a subset of HSMR and only accounts for two of the 56 diagnosis groups: "Septicemia (except in labour)" and "Respiratory failure, insufficiency, arrest (adult)".

If a Trust has an HSMR of 100, this means that the number of patients who died is exactly as would be expected. Values above 100, suggest a higher than expected mortality and those below as within an acceptable range. HSMR is an important indicator that acts as a smoke signal for potential problems with the quality of care. The figures represent a 12-month rolling position.

We are driving this measure because....

Sepsis and respiratory failure have consistently triggered as primary diagnostic categories making the greatest contribution to the Trust's HSMR over the last few years.

We believe that understanding and acting on the drivers behind this performance will help us provide a safer service for our patients.

Performance

Last month's performance shows a rolling 12-month composite Hospital Standardised Mortality Ratio (HSMR) for respiratory failure and sepsis of 138.2.

Key areas for focus to achieve the overall goal
- Recognition, escalation and response to patients deteriorating from sepsis and respiratory failure by clinical teams
- Sepsis
- Embedding learning from harm incidents

Achievements over the last 30 days
- We Care fundamental training has been delivered to 7 additional frontline teams including Maternity

Ambition for the next 30 days
- Firm up timeline and implementation plan for TEP re-launch
- Agree Sepsis audit tool on digital platform

Risks

There are no identified risks to delivery of this breakthrough objective at this point.

Risks are identified and managed through weekly driver meetings and where needed escalated at We Care Executive Management meetings.

... | M_00133_Deteriorating_Patient

Last Updated | 14/06/2021 09:18:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

IPC: Total Infections

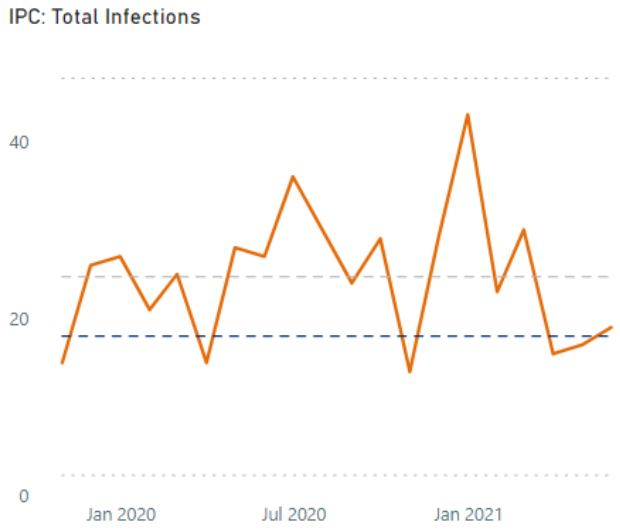
Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
36	30	24	29	14	29	43	23	30	16	17	19

Domain	Our Quality & Safety
True North	Harm Events
Metric Focus	Driver
Threshold	18
Value	Number
Improvement Direction	Lower is Better

D1 Driver is red for 1

Common cause (no significant change)

Variation indicates inconsistently passing and falling short of the target



Understand the data

"Healthcare associated infection" (HCAI) also known "nosocomial" or "hospital" infection is an infection occurring in a patient during the process of care in a hospital or other health care facility which was not present of incubating at the time of admission. This aggregate measure will be updated to include a count of the number of MSSA*, MRSA, C diff, MRSA, E coli*, Klebsiella species* (spp.) and Pseudomonas aeruginosa* cases.

*bloodstream infections only

We are driving this measure because....

Infection prevention control has been a focus of the organisation throughout 2020 and great strides have been made to improve performance across all sites.

It is important to continue the good work set in place during the global pandemic and apply learning to reduce all in hospital infections.

Performance

Current Performance for total in-hospital infections is 19 in June, Performance has shown common cause variation over the last three months. Cdiff performance continues to be good but there is significant variation in the remainder of the metric.

In the last month:

- Existing front line teams have continued to work on their A3 activities
- Engagement in driver meetings had been challenging with clinical pressures
- Further site wide invasive device work has been initiated at QEQM site
- AMS work has been delayed due to sickness in the AMS team and limited resources
- The Cdiff policy and supporting tools have been updated. Front line teams are using PDSA to test the revised diarrhoea assessment tool (DAT).

Next month

- Further development of the driver meetings and engagement
- Gemba walks by the AMS Team and DIPC in ED
- Gemba walks by the DIPC in front line areas engaged in the work

Risks

The Pareto analysis suggests that the infections that contribute to the metric are distributed, rather than concentrated. This creates a risk that the (worthwhile and important) activities of the front line teams may have a limited impact on the metric unless there are considerably more front line teams engaged.

... | M_01142_IPC_Infections_Combined

Last Updated | 21/07/2021 11:57:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

ED - Aggregated Patient Delay

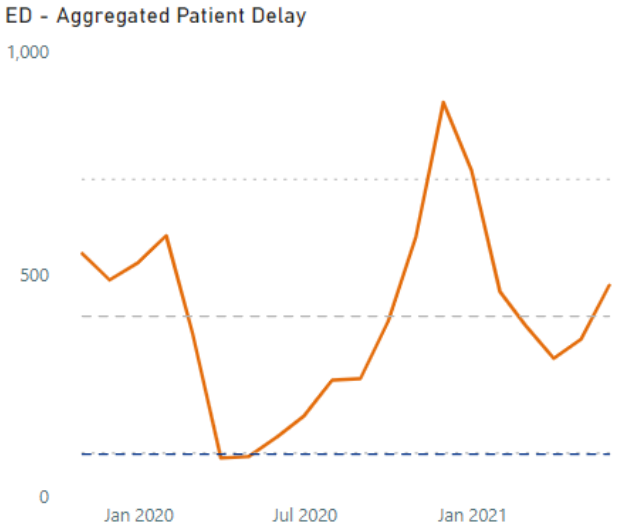
Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
181	261	265	392	584	886	732	460	385	311	353	475

Domain	Our Patients
True North	ED Compliance
Metric Focus	Driver
Threshold	95
Value	Number
Improvement Direction	Lower is Better

D2 Driver is red for 2

Common cause (no significant change)

F Variation indicates consistently falling short of the target



Understand the data

A&E performance is directly dependent on the number and flexibility of available admitted beds, the aggregated patient delay measure counts the amount of time patients who breached the 4 hour standard spent in A&E awaiting admission to an Acute Medical Unit, Medical or Surgical Bed.

We are driving this measure because....

Long waits across our Emergency Departments have been a challenge to the organisation for several years, thought to be driven by a lack of access to inpatient beds. Recent improvements in bed availability have shown improvements in compliance. Consolidating and building on these improvements and improving timely care within ED will continue to improve patient care and the compliance against this metric.

We are making this an area of clinical and operational focus to drive down the wait times, improve flow and the standard of care for our patients.

Performance

Performance for June is an aggregated delay of 475 hours. Performance improvement of this metric has fallen.

- The identified risk of an increase in ED demand above planned levels materialised with a rise in demand of 24% since April.
- Admissions on both acute sites increased (6.5% at QEQM)
- Post acute flow has also reduced with RTS ward discharges reducing by 4.6% and Super Stranded patients increasing by 26%.
- Simple discharges rose on both acute sites (7.8% at QEQM) and the conversion rates reduced to below 19% at both acute sites partly mitigating the increase in demand.
- SDEC and FEA continued to stream patients from ED and supported flow.

Key areas of focus for this breakthrough objective are;

- Emergency Portals
- Time in Hospital
- Discharge Process
- ED process and streaming patients to Urgent Treatment Centres with available capacity
- Improvement in access to specialist bed will be refreshed and will build upon front line efforts to ensure patients are seen by a specialist and where possible able to return home
- Working with system partners to reduce delay for patients ready to leave hospital.

Risks

- Staffing challenges
- Ability for specialty teams to process ward discharges in a timely way and improve ED patient access a bed.
- Continued increase demand for ED and admissions beyond planned levels
- Increase in acuity of emergency admission patients impacting on LOS and demand for post-acute capacity.
- Continued issues with access to post-acute care capacity fails to meet demand.

... | M_00888_Agg_Delay

Last Updated | 14/07/2021 11:24:00

2020/21 Breakthrough Objectives

East Kent Hospitals University NHS Foundation Trust

Theatre Session Opp.

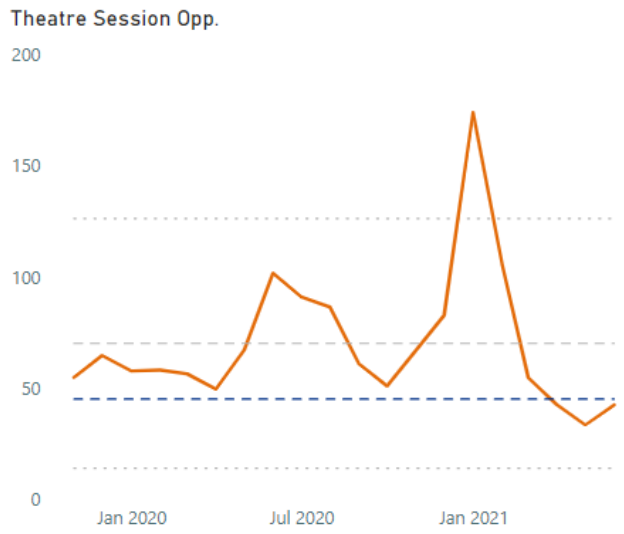
Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
91	86	61	51	67	83	174	106	55	42	33	42

Domain	Our Patients
True North	RTT - 18 Weeks
Metric Focus	Driver
Threshold	45
Value	Number
Improvement Direction	Lower is Better

D1 Driver is green for

Common cause (no significant change)

Variation indicates inconsistently passing and falling short of the target



Understand the data

Total excess minutes (represented as 4 hr theatre lists) associated with specified non operative events during scheduled theatre time.

Non Operative Events (Cancelled Sessions, Turn Around Times Exceeding 10 Minutes, On The Day Cancellations, Early Finishes Exceeding 45 Minutes, Late Starts Exceeding 15 Minutes)

Exclusions (Emergency Lists, Non Bookable Lists (e.g. Trauma), Sessions Cancelled Due to Audit / Bank Holiday, Sessions Cancelled in Specialised Theatres (e.g. Ophthalmic Suite / Buckland), Sessions where Total available Opportunity <60 Minutes

We are driving this measure because....

Efficient use of our theatre complex is key to maximising the throughput of routine elective care.

Emerging from the second wave of COVID-19 it is imperative that deferred elective surgery is prioritised alongside Cancer and urgent operative needs to minimise any harm to our patients and reduce our overall waiting times for elective surgery.

Ensuring that the theatre capacity we have available is utilised in the most efficient manner will allow for subsequent decisions regarding any residual capacity deficits and new ways of working.

... | M_00146_Theatres_Utilisation

Last Updated | 16/07/2021 09:18:00

Performance

The current metric performance indicates an opportunity of 42 sessions for the month of June.. Whilst this remains below the threshold it is a deterioration on the previous month, In terms of the theatres element this has been exacerbated by the breakdown of key ophthalmic equipment. Outside of endoscopy the greatest opportunity is within late starts and early finishes. This is disappointing as significant work has been undertaken to improve start times and ensure maximum booking to ensure all theatres are filled to capacity. In terms of endoscopy a separate action plan has been developed to focus on a number of areas and actions related to improving utilisation include:

- Daily Huddles
- Timetable released 8 weeks in advance to ensure all sessions are covered
- Review of current job plans.

Key areas of work of focus for the coming month are late starts and early finishes, support in the endoscopy action plan and support for the care group in opening theatre sessions with appropriate staff..

Actions for next period continue to include review of booking processes to deliver six week advance booking of theatres as we move into our elective recovery programme (4R), Care Group root cause analysis on in session 'lost' time with specific focus on turnaround times .
All patients cancelled on the day are reviewed to understand the reason for the cancellation, lessons learnt and how this may align with improving pre operative assessment processes

Risks

3rd Wave of COVID could significantly impact on theatre utilisation if there is a need to cease routine work.

Theatre staff recruitment has been challenging previously. This includes anaesthetic cover along with theatre personnel.

Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Mar-21	Apr-21	May-21	Jun-21
Harm Events			Nutrition Incidents	60	45	56	63	68
	W4		Optimal Cord Clamping <32w	85.0%	75.0%	0.0%	72.7%	50.0%
	W4		IP Spells with 3+ Ward Moves	500	541	530	521	539
			Maternity Serious Incidents	2	2	3	3	6

Performance

Harm Events

Since the recruitment of the Nutrition and Hydration Clinical Team, we are beginning to see an increase in Nutrition incidents as awareness and education standards are raised and there is overall greater scrutiny around the standards of the nutritional care that we provide.

This has led to further review of our catering services, our enteral nutrition standards, mealtime standards and parenteral nutrition. This is being reported in detail through the Nutrition and Oral Hydration Steering Group. Given that we have reviewed and are comfortable with the numbers an increase to the threshold has been proposed and will be agreed through the mini catchball process.

The Women's Health Care Group has selected optimal cord clamping as one of their focused improvement projects recognising there has been inconsistent performance in this area. Continued work on countermeasures within the care group continues to focus actions to consistently deliver this standard.

Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Mar-21	Apr-21	May-21	Jun-21
RTT - 18 Weeks	W4		RTT 52w Breaches	2,586	5,232	4,942	4,521	4,270
	W4		DM01 Compliance	99.0%	73.6%	73.9%	75.2%	75.2%
			RTT 35w Undated	8,500	8,122	8,440	8,881	9,412
			RTT 1st OPA Booking Breaches	14,000	12,888	13,288	13,608	13,904
ED Compliance	W4		Clinical Assessment within 1hr	50.0%	41.6%	38.9%	36.6%	35.4%
	W4		DTAs within 4hrs	600	1,326	1,420	1,467	1,258
	W4		Super Stranded >21D	75	125	93	80	98
FFT	W4		FFT IP Response Rate	25.0%	16.6%	15.9%	16.1%	15.7%
	W4		FFT DC Response Rate	30.0%	28.9%	26.6%	27.8%	26.5%
			FFT ED Response Rate	12.0%	14.5%	14.2%	13.8%	13.3%
	W4		FFT OP Response Rate	20.0%	19.1%	17.2%	17.7%	17.1%
	W4		FFT Maternity Response Rate	18.0%	6.2%	5.4%	5.8%	4.8%
	W4		Complaint Response	90.0%	65.5%	75.5%	74.2%	75.6%

Performance

RTT 18 Weeks

The Trust is focussed on rapidly increasing access to elective services in order and in line with the national elective recovery programme. It is encouraging to note that we have reduce the number of patients waiting over 52 weeks by 1,000 since March 2021. The trust is exploring all options to assist with reducing long waiting patients including Insourcing , use of the Independent sector and work with the system to reduce inequalities in waiting times.

ED Compliance

Work is underway with local system and regional partners to understand the 24% increase in ED patients attending since April.

The unplanned reattendance rate is inflated due to planned returns not recorded accurately. Work has commenced to produce a data set to reflect this.

EKHUFT 'simple' discharges continue to rise and we are working with community colleagues to implement plans to address process delays impacting on 'complex' discharges to home based services or community inpatient beds and reduce the high number of Super Stranded patients.

Friends & Family Test (FFT)

While the FFT percentage of response rate remains below the internally set EKHUFT targets there has been a considerable increase in the volume of responses received. Since moving over to the new text message collection system in October 2020 EKHUFT has now been able to send out considerably more surveys to patients, over 20,000 per week.

June 2021 EKHUFT received 14,805 responses. As June 2020 was during the first wave of the pandemic comparison of data is difficult between these years. However the response rate figures for June 2021 are amongst the highest response rate EKHUFT has ever received. As the data is recorded as a percentage of responses to survey sent this increase is not recognised.

The EKHUFT teams are continuing to work to increase the response rate further with initiates underway in Maternity, ED and paediatrics.

Alerting Watch Metrics: Our People

True North Domain	Type	BO	KPI	Thres.	Mar-21	Apr-21	May-21	Jun-21
Staff Turnover Rate			Vacancy Rate	9.0%	6.3%	6.5%	8.5%	8.8%
	W4		Staff Turnover: Nursing	10.0%	11.0%	11.7%	12.0%	12.1%
Staff Engagement	W4		Appraisals Compliance	85.0%	69.7%	73.6%	74.8%	74.0%
	W4		Statutory Training	93.0%	91.1%	91.7%	92.1%	92.8%

Performance

Staff Turnover

Overall turnover has slightly increased again for a second month above the True North target of 10% to 10.6%. This was anticipated in the aftermath of Covid-19 as previously reported. Nursing turnover is increasing significantly and there are a number of programmes to address this with links to both the national and regional approaches and focuses on key areas – generational (those coming in and those leaving), international recruitment, flexible working and key elements of the NHS People Plan (Wellbeing, EDI).

Staff Engagement

Appraisal compliance is gradually improving as the year progresses. Although this is an alerting metric rather than a driver, it continues to be a good indicator of staff engagement and personal development planning and more recently has also included wellbeing conversations and personal risk assessment reviews. Although mandatory training compliance is improving it remains below the threshold and continues to be an important 'watch' at monthly Performance Review Meetings.

Alerting Watch Metrics: Our Future & Our Sustainability

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Mar-21	Apr-21	May-21	Jun-21
Med. Fit for Disch.	W4		MFFD: Spot Purchase	5.0	11.3	9.3	10.4	9.3
	W4		MFFD: Community Hospital	5.0	10.1	8.6	5.6	9.6
	W4		MFFD: Home With Support	5.0	10.3	9.4	10.1	15.5

Performance

Medically Fit for Discharge

The number of patients MFFD is alerting due to more that seven consecutive monthly data points above the threshold. This is being addressed and closely monitored through the 'Criteria to Reside' implementation to improve compliance throughout the Trust.

Appendix 1
Non-Alerting Watch Metrics: Our Quality & Safety

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Mar-21	Apr-21	May-21	Jun-21
Harm Events	W		52w Severe Harm Review	0	0	0	0	0
	W		Covid-19 HCAI	1	53	1	0	0
	W		Medication Errors	90	61	55	78	52
	W		Pressure Ulcers: Cat 2	32	42	28	24	27
	W		Pressure Ulcers: Cat 3 & 4	3	4	1	1	0
	W		Pressure Ulcers: DTI	10	9	13	5	5
	W		Pressure Ulcers: Unstageable	10	7	3	6	5
	W		IPC: Audits Composite	80.0%	87.5%	86.7%	87.2%	88.0%
	W		VTE Assessment Compliance	90.0%	93.8%	93.1%	92.8%	91.3%
	W		Safeguarding Incidents	20	12	14	13	28
	W		Clinical Incidents	2,500	2,166	1,635	1,684	1,664
	W		Serious Incidents	18	25	15	19	28
	W		Never Events	0	0	1	1	0
Mortality	W		Extended Perinatal Mortality	6.35	6.78	2.62	5.09	5.87

Appendix 1
Non-Alerting Watch Metrics: Our Patients

East Kent Hospitals University NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Mar-21	Apr-21	May-21	Jun-21
Cancer 62d	W		Cancer 2ww Performance	93.0%	98.8%	98.0%	98.1%	97.8%
	W		Cancer 31d Performance	96.0%	94.1%	98.4%	97.4%	98.6%
	W		Cancer 28d Performance	75.0%	79.6%	72.6%	73.6%	72.3%
	W		Radiology Diags vs Plan	Traj.	15,477	15,809	16,637	15,939
	W		Endoscopy vs Plan	Traj.	1,119	1,029	1,313	1,150
RTT - 18 Weeks	W		OPA vs Plan	Traj.	82,124	74,161	76,381	83,377
	W		Elective Admissions vs Plan	Traj.	4,607	4,487	5,172	5,513
ED Compliance	W		ED Non-Admitted Compliance	90.0%	91.2%	90.0%	89.1%	85.4%
	W		Ref to Spec 2.5h	40.0%	45.0%	43.2%	43.4%	40.5%
	W		A&E Atts vs Plan	Traj.	18,870	20,691	22,958	23,137
	W		Unplanned Re-attendance ED	10.0%	10.6%	6.0%	10.1%	10.8%
	W		Discharges by Midday	15.0%	17.7%	18.4%	17.4%	17.1%
	W		NEL Admissions vs Plan	Traj.	6,601	6,817	7,378	7,095
	W		NEL Readmissions	15.0%	12.3%	12.2%	12.1%	11.5%
	W		Stroke Ward within 4 Hours	50.0%		57.7%	39.2%	60.0%
FFT	W		Complaints	100	65	65	75	92
	W		PALS Enquiries	550	599	508	469	530

Appendix 1
Non-Alerting Watch Metrics: Our People, Future & Sustainability

NHS
East Kent Hospitals University
NHS Foundation Trust

True North Domain	Type	BO	KPI	Thres.	Mar-21	Apr-21	May-21	Jun-21
Staff Turnover Rate	W		Staff Turnover: HCA	13.5%	11.1%	10.6%	11.7%	11.8%
	W		Premature Turnover Rate	25.0%	20.1%	20.3%	20.2%	20.2%
Staff Engagement	W		Sickness	5.0%	3.5%	3.4%	3.7%	
	W		Safeguarding Children Training	85.0%	86.0%	90.7%	91.2%	92.3%
Financial Position	W		Total Pay	0.0%	0.2%	-1.7%	-1.0%	0.5%
	W		Premium Pay	Traj.	9,105	7,829	7,396	5,768
	W		Non Pay	0.0%	-11.3%	2.1%	3.8%	1.9%
Carbon Footprint	W		CO2e Waste (tonnes/day)	0.28	0.22	0.21	0.20	
	W		CO2e Gas (tonnes/day)	38.19	29.12	28.37	22.60	
	W		CO2e Electricity (tonnes/day)	18.00	16.61	14.89	14.41	
	W		CO2e Water (tonnes/day)	0.55	0.48	0.17	0.20	
Med. Fit for Disch.	W		MFFD: Assessment	5.0	0.7	1.1	1.7	1.8
Innovation	W		Virtual OP Appts - First	25.0%	48.9%	44.7%	42.4%	43.2%
	W		Virtual OP Appts - Follow Up	60.0%	62.2%	55.9%	53.1%	49.8%

Appendix 2: Glossary of Terms

NHS
East Kent
Hospitals University
NHS Foundation Trust

Term	Description
A3 Thinking Tool	Is an approach to thinking through a problem to inform the development of a solution. A3 also refers to the paper size used to set out a full problem-solving cycle. The A3 is a visual and communication tool which consists of (8) steps, each having a list of guiding questions which the user(s) work through (not all questions may be relevant). Staff should feel sure each step is fully explored before moving on to the next. The A3 Thinking Tool tells a story so should be displayed where all staff can see it.
Breakthrough Objectives	3-5 specific goals identified from True North. Breakthrough Objectives are operational in nature and recognised as a clear business problem. Breakthrough Objectives are shared across the organisation. Significant improvement is expected over a 12 month period.
Business Rules	A set of rules used to determine how performance of metrics and projects on a scorecard are discussed in the Care Groups Monthly Performance Review Meetings.
Catchball	A formal open conversation between two or more people (usually managers) held annually to agree the next financial year's objectives and targets. However, a 6 monthly informal conversation to ensure alignment of priorities is encouraged to take place. The aims of a Catchball conversation are to: (1) reach agreement on each item on a Scorecard e.g. driver metrics, watch metrics tolerance levels, corporate/ improvement projects. (2) Agree which projects can be deselected. (3) Set out Business Rules which will govern the process moving forward.
Corporate Projects	Are specific to the organisation and identified by senior leaders as 'no choice priority projects'. They may require the involvement of more than one business unit, are complex and/or require significant capital investment. Corporate Projects are often too big for continuous daily improvement but some aspect(s) of them may be achieved through a local project workstream.
Countermeasure	An action taken to prevent a problem from continuing/occurring in a process.
Countermeasure Summary	A document that summarises an A3 Thinking Tool. It is presented at monthly Performance Review Meetings when the relevant business rules apply.

Appendix 2: Glossary of Terms

East Kent Hospitals University NHS Foundation Trust

Term	Description
Driver Lane	A visual tool containing specific driver metric information taken from the A3 (e.g. problem statement, data, contributing factors, 3 C's or Action Plan). The driver lane information is discussed every day at the improvement huddle and in more detail at weekly Care Group driver meetings and Monthly Performance Review Meetings. The structure of a driver lane is the same as the structure of a countermeasure summary.
Driver Meetings	Driver Meetings are weekly meetings that inform the Care Group of progress against driver metrics on their scorecard. Having a strong awareness of how driver metrics are progressing is vital for continuous improvement. Driver meetings also enable efficient information flow. They are a way of checking progress to plan.
Driver Metrics	Driver Metrics are closely aligned with True North. They are specific metrics that Care Group's choose to actively work on to "drive" improvement in order to achieve a target (e.g 'reduce 30 day readmissions by 50%' or 'eliminate all avoidable surgical site infections'). Each Care Group should aim to have no more than 5 Driver Metrics.
Gemba Walk	'Gemba' means 'the actual place'. The purpose of a Gemba Walk is to enable leaders and managers to observe the actual work process, engage with employees, gain knowledge about the work process and explore opportunities for continuous improvement. It is important those carrying out the Gemba Walk respect the workers by asking open ended questions and lead with curiosity.
Huddles (Improvement Huddle) Boards	Huddle or Improvement Boards are a visual display and communication tool. Essentially they are a large white board which has 9 specific sections. The Huddle or Improvement Boards are the daily focal point for improvement meetings where staff have the opportunity to identify, prioritise and action daily improvement ideas linked to organisational priorities (True North). The Huddle or Improvement Board requires its own Standard Work document to ensure it is used effectively. The aims of the Huddle/Improvement board includes: 1. help staff focus on small issues 2. prioritise the action(s) 3. gives staff ownership of the action (improvement)
PDSA Cycle (Plan Do Study Act)	PDSA Cycle is a scientific method of defining problems, developing theories, planning and trying them, observing the results and acting on what is learnt. It typically requires some investigation and can take a few weeks to implement the ongoing cycle of improvement.
Performance Board	Performance boards are a form of visual management that provide focus on the process made. It makes it easy to compare 'expected versus actual performance'. Performance Boards focus on larger issues than a Huddle Board, e.g. patient discharges by 10:00am. They help drive improvement forward and generate conversation e.g.: 1. when action is required because performance has dropped 2. what the top 3 contributing problems might be 3. what is being done to improve performance

Appendix 2: Glossary of Terms

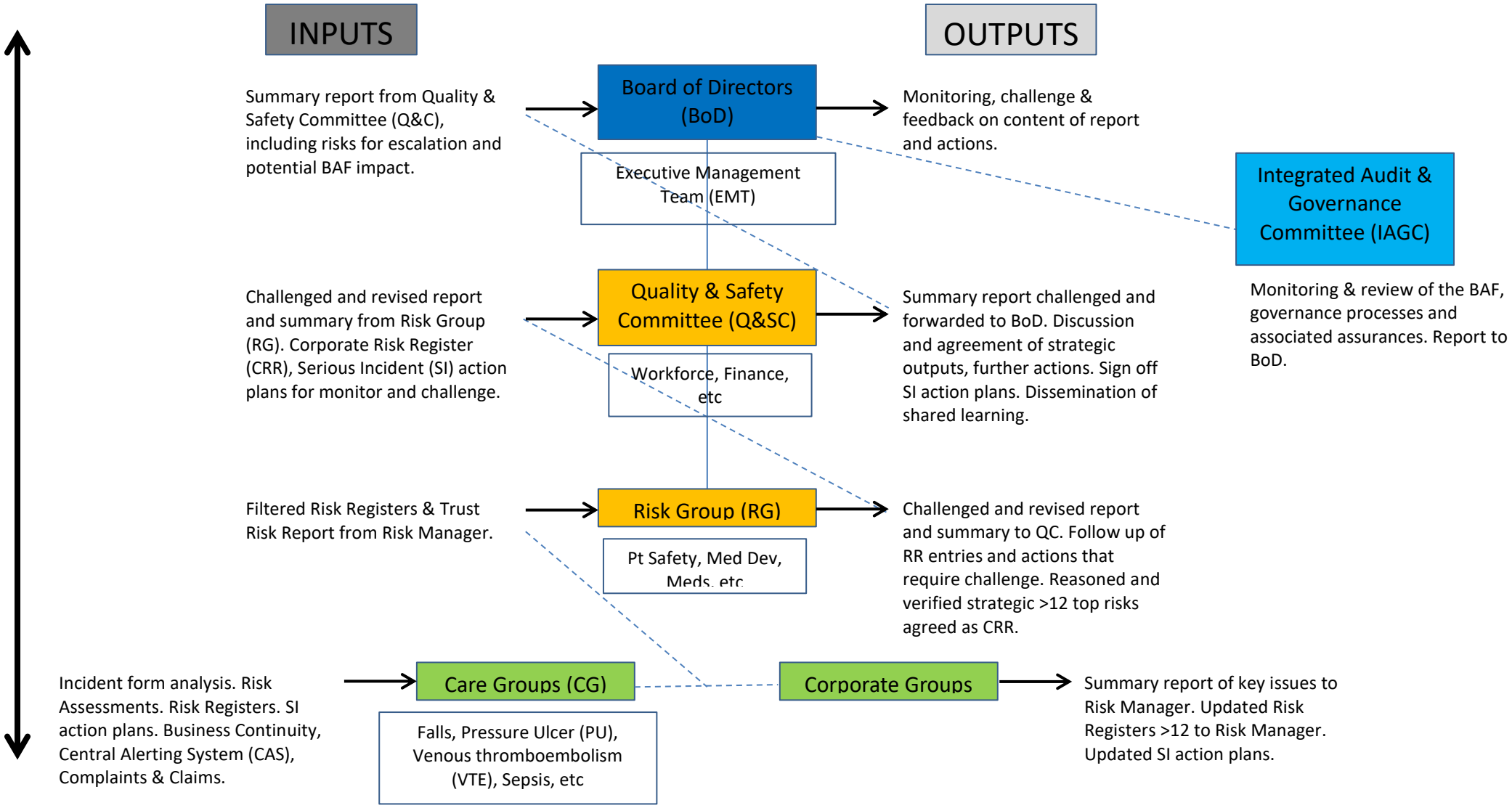
NHS
East Kent Hospitals University
NHS Foundation Trust

Term	Description
Scorecard	The Scorecard is a visual management tool that lists the measures and projects a ward or department is required to achieve. These measures/projects are aligned to True North. The purposes of a Scorecard include: 1. Makes strategy a continual and viable process that everybody engages with 2. focuses on key measurements 3. reflect the organization's mission and strategies 4. provide a quick but comprehensive picture of the organization's health
Standard Work	Standard work is a written document outlining step by step instructions for completing a task or meeting using 'best practice' methods. Standard Work should be shared to ensure staff are trained in performing the task/meeting. The document should also be regularly reviewed and updated.
Strategy Deployment	Strategy Deployment is a planning process which gives long term direction to a complex organisation. It identifies a small number of strategic priorities by using an inch wide mile deep mindset and cascades these priorities through the organisation.
Strategy Deployment Matrix	A resource planning tool. It allows you to see horizontal and vertical resource commitments of your teams which ensures no team is overloaded.
Strategic Initiatives	'Must Do' 'Can't Fail' initiatives for the organisation to drive forward and support delivery of True North. These programmes of work are normally over a 3-5 year delivery time frame. Ideally these should be limited to 2-3. Initiatives are necessary to implement strategy and the way leaders expect to improve True North metrics over time (3-5 years).
Structured Verbal Update	Verbal update that follows Standard Work. It is given at Performance Review Meetings when the relevant business rules apply.
Tolerance Level	These levels are used if a 'Watch Metric' is **red** against the target but the gap between current performance and the target is small or within the metrics process control limits (check SPC chart). A Tolerance Level can be applied against the metric meaning as long as the metrics' performance does not fall below the Tolerance Level the Care Group will continue watching the metric.
True North	True North captures the few selected organisation wide priorities and goals that guide all its improvement work. True North can be developed by the Trust's Executive team in consultation with many stakeholders. The performance of the True North metrics against targets is an indicator of the health of the organisation.
Watch metrics	Watch metrics are measures that are being watched or monitored for adverse trends. There are no specific improvement activities or A3s in progress to improve performance.

BOARD ASSURANCE FRAMEWORK (BAF)

Quarter 1 - 2021/22

Inputs and Outputs from the Risk Pathways, Ward to Board



21/41.3 – APPENDIX 1
STRATEGIC GOALS AND OBJECTIVES

The Trust Board have identified, agreed and published the following Strategic Goals and Objectives for 2021/22. They form the basis of the Trust's Annual Business Plan for 2021/22.

2021/22 Top 5 objective headings	Objectives linked to 'We Care Deliverables'
1) Our Quality & Safety: (Linked to prioritised Trust Risk No. 5. IPC and Harm) Improve **patient safety** reduce harm. Chief Medical Officer (CMO)/Chief Nursing Officer (CNO), Director of Infection Prevention and Control (DIPC)	1a) Achieve compliance with Trust Scorecard for pressure ulcers, falls with harm, VTE risk assessments. 1b) Show year on year reduction in the Hospital Standardised Mortality Ratio (HSMR) 1c) Reduce Covid-19, MRSA, Clostridium difficile and other key infections.
2) Our Patients: (Linked to prioritised Trust Risk No. 4. Patient Experience) Improve **Patient Experience** deliver excellent clinical outcomes. Gov Dir, CMO/Chief Operating Officer (COO)	2a) Develop and implement a Quality Strategy, including annual Quality Account reporting and clinical audit arrangements. 2b) Develop, implement and monitor the Trust Board Scorecard trajectories for improvements in patient experience as measured by the national patient survey 2c) Deliver patient waiting times agreed with commissioners including standards for timeliness of care in Accident & Emergency (A&E) and Cancer waiting time targets.
3) Our People: (Linked to prioritised Trust Risk No. 1. Workforce) Reduce Whole Time Equivalent (WTE) vacancies and **enable staff** to maximise their potential. Director of HR & Organisational Development (OD)	3a) Achieve set trajectories for improvements in staff experience as measured by the national staff survey. 3b) Ensure that staff trajectories for appraisal and mandatory training compliance is met by the end of the year. 3c) Recruit to WTE staff vacancies and skill mix.
4) Our Future: (Linked to prioritised Trust Risk No. 3. 'Statutory Compliance') Develop and implement governance strategies that continually improve both the delivery and quality of Trust services**.**	4a) Embed an integrated and forward-looking governance and performance management system across the Trust. 4b) Ensure that the Trust is compliant with its terms of authorisation at all times. 4c) Commence construction of the new Emergency Department (ED) Centres.

Director of Quality Governance (DQG), Deputy Chief Executive Officer (DCEO), Company Secretary (CoSec)	
5) Our Sustainability: (Linked to prioritised Trust Risk No. 2. Infrastructure) Achieve sustainable **financial health.** Director of Finance (DoF)	5a) Achieve income, expenditure, efficiency and cash targets as agreed by the Board. 5b) Develop and implement a plan for long term productivity and efficiency savings. 5c) Accurate activity recording and clinical coding to enable recovery of income in line with contractual and other obligations

21/41.3 – APPENDIX 1

STRATEGIC GOAL: 1) Our Quality & Safety: (Linked to prioritised Trust Risk No. 5. IPC and Harm) **Objective:** Improve **patient safety** reduce harm.							
	Objective Owner: Chief Medical Officer (CMO)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: There is a risk of potential or actual harm to patients if high standards of care and improvement workstreams are not delivered, leading to poor patient outcomes with extended length of stay, loss of confidence with patients, families and carers resulting in reputational harm to the Trust and additional costs to care. **Origin Date:** 17/05/2021 **CRR Ref:** 71, 77, 110, 36, **Source**: Risk registers, Care Quality Commission (CQC) reports, Clinical Commissioning Group (CCG) led Quality Review group, external reports of quality, triangulation of incidents, complaints and claims, NHS England/NHS Improvement (NHSE/I) Improvement Directors review of Governance **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) The Quality Strategy (2019-2022), approved at Quality & Safety Committee (Q&SC), Sep 19 2) NHSE/I led Governance review supported restructure and revised terms of reference for the Q&SC 3) Reduction in harm and reduction in mortality are True North objectives agreed by the Executive team and progress monitored monthly at Executive management Team meetings and reported in the Board Integrated Performance Report (IPR) 4) Breakthrough Objectives aligned to True North are monitored at monthly Executive management Team meetings and reported in the Board IPR	**Int**: 1) Approval and monitoring of the Trust Quality Strategy, We Care objectives and Trust priority improvement projects through EMT, Q&SC and BoD. **Ext**: 1) CQC reports monitored by the BoD and action plans developed and monitored by CQC and NHSE/I	1) The Quality Strategy needs realigning with the We Care improvement programme to support quality and safety priorities and the Medium-Term Improvement Plan 2)Q&SC oversight to be strengthened by the introduction of Care Group Governance reports from Jun 21 3) Roll out of We Care programme to frontline teams where improvements delivered were delayed by the Covid-19 Pandemic	1) Write an updated Quality Strategy for 21/22 incorporating We Care and medium-term improvement plan agreed priorities for safety and quality. **CNO Nov 21 -** A3 produced. 2a) Approval of Quality Strategy by Q&SC. **CNO Nov 21** Quality Strategy on agenda for Nov 21 for final approval at BoD on Dec 21 2b) Standardised Governance Agenda to be agreed for all Care Groups to feed reporting template. **Director of Quality Governance,** 3a) Building on training and experience of centre of excellence team by KPMG. **Director of Strategy** 3b) Revised trajectory for roll out to frontline teams agreed by 'Centre of Excellence' team to complete **Director of Transformation**	L4 x S5 = 20	L3 x S5 = 15	L1 x S5 = 5

	5) Monthly performance Review Meetings established to ensure Care Group accountability against the delivery of quality and safety priorities, and to escalate new concerns to driver metric status through Catchball when identified 6) CQC Improvement meeting established under the Chair of CNO to monitor regulatory requirements to deliver safe care		4) Revised Quality and Safety reporting structures and reporting to be established. Initial meeting of CNO, CMO and DoQG to describe quality and safety meetings needed to deliver agenda now being implemented into structures with agreed Terms of Reference (ToR) and chairs 5) Additional IPR metrics need to be identified to give greater oversight that supports delivery of quality and safety 6) Improve oversight of health and safety governance that impacts on patient safety 7) Establish responsibility and accountability for Hospital Director teams for delivery of safe care on their respective sites 8) Improve clinical outcomes through internal review, effective use of data and implementation of recommendations from national clinical audits and outcomes, NICE recommendations and	4) Implement outputs of quality and safety reporting meetings and structure review with emphasis on learning within ToR. **DoQG** Action completed to be presented at Q&SC July 21 for sign off. 5) Update IPR metrics with agreed thresholds taken through Catchball session with full Board. 6) Review of subsidiary governance and reporting structures and feed into Q&S reporting structures. **Group Company Secretary** 7a) Agree model for matrix working. 7b) Implement agreed model. 8a) Review clinical effectiveness structures and meetings. **CMO** 8b) Establish effective governance of NICE guidance. **CMO**			

			Getting it Right First Time (GIFRT)	8c) Review governance and approval for clinical guidelines. **DoQG – TPIP agreed**			

STRATEGIC GOAL: 1) Our Quality & Safety: (Linked to prioritised Trust Risk No. 5. IPC and Harm) **Objective:** Improve **patient safety** reduce harm.							
	Objective Owner: Director of Infection Prevention and Control (DIPC)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to prevent avoidable healthcare associated (HCAI) cases of infection with reportable organisms, infections associated with statutory requirements and Covid-19, leading to harm, including death, breaches of externally set objectives, possible regulatory action, prosecution, litigation and reputational damage **Origin Date:** 14/05/2021 **CRR Ref:** 85, **Source**: Risk Registers, "hygiene code" gap analysis, CQC reports, surveillance data **CQC:** **Is it Safe** **Is it Effective**	1) Surveillance and reporting of HCAI via Public Health England (PHE) Data Capture System (DCS) and national Covid-19 reporting – reported monthly to Quality and Safety Committee with progress against objectives where relevant 2) Compliance with requirements of the "hygiene code" with a plan to address any gaps reported monthly to the Quality and Safety Committee 3) Collaboration and agreement with 2gether	**Int**: 1) Formally reportable data are signed off by the CEO and are reported monthly to the Quality and Safety Committee and annually, publicly via DIPC Annual Report 2) Infrastructure issues reported via Director of Strategic Development and Capital Planning (reference to strategic goal 4 and statutory compliance) "3) Hygiene Code" gap analysis report to Quality and Safety Committee, Covid third wave planning reports to Covid Gold command, twice weekly	1) "Hygiene Code" gap analysis not yet completed 2) Process to identify IPC risks associated with infrastructure not complete, outputs will be from 2SS not IPC (related to 6 facet survey described in BAF for strategic objective 4)	1) Completion of gap analysis, identification of gaps, adjustment of risk and BAF and new actions stemming from any gaps. **DIPC end Jun 21** 2a) Completion and agreement of priorities for infrastructure investment and inclusion in business planning and investment strategy **DIPC/MD of 2SS and Director of Strategic Development and Capital Planning (timescale governed by others, unclear atm)** 2b) Implementation of year	L4 x S5 = 20	L3 x S5 = 15	L1 x S5 = 5

Is it Caring **Is it Responsive** **Is it Well-led**	Support Solutions (2SS) on priorities for investment to address gaps in infrastructure compliance, based on clinical (infection prevention) risk and included in business planning 4) We Care Breakthrough Objective focussed on externally reportable HCAI organisms -reported monthly to Executive Management Team and Monthly to Board 5) Third wave of Covid-19 business continuity planning	**Ext**: 1) Data are shared with CCG and are available to NHSE/I and CQC (automatically)	3) We Care Breakthrough Objective in early stages and not guaranteed to impact on outcome at this stage 4) Covid-19 third wave planning not complete	one of agreed plan for infrastructure improvement **MD 2SS Mar 22, (BAF Objective 4)** 3) Implement We Care Breakthrough Objective and monitor impact on outcome metric on a monthly basis **DIPC monthly until end Mar 22** 4) Complete Desk top resilience exercise for Covid-19 third wave planning **Covid Medical Director/DIPC/ Emergency Planning leads May/Jun 21 (TBC)**			

STRATEGIC GOAL: 2) Our Patients: (Linked to prioritised Trust Risk No. 4. Patient Experience) **Objective:** Improve **Patient Experience** deliver excellent clinical outcomes							
	Objective Owner: Director of Quality Governance (DQG) and Company Secretary (CoSec)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to adequately resource, implement and embed effective governance processes throughout the Trust may result in inadequate identification, management and escalation of risks that require mitigation, poor delivery and quality and safety of services, and subsequently failure to meet statutory and regulatory requirements resulting in damage to reputation, regulatory action, and harm patients. **Origin Date:** 19/05/2021 **CRR Ref:** 78, **Source**: Risk Registers, CQC reports, audit data **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) Suite of governance policies / strategies in place, 4Policy system provides a reminder system for documents reaching their renewal date 2) Additional Executive post created, and portfolios split to provide more capacity and expertise. Director of Quality Governance appointed and joined the Trust May 21 3) Organisational structure in place below Executive Level to support the governance agenda 4) Governance structure in place 5) Governance Review Action plan in place and agreed with NHSEI 6) Sign off process for governance review implemented	**Int**: 1) Strategies and major policies signed off in line with the Trusts Policy on Document management by the BoD 2) Document in place showing the current governance structure signed off by the BoD 3) Executive led Regulatory Compliance Committee (RCC) in place to oversee compliance with statutory and regulatory requirements **Ext**: 1) Data are shared with CCG and are available to NHSE/I and CQC (automatically) 2) NHSE/I governance review highlighted concerns that quality governance is not embedded. 3) Well-led governance review (NHSE/I Dec 2020)	1) Feedback is that strategies / policies are not consistently followed and are not embedded 2) The new structure / job descriptions have not been tested and it will take time to assess any gaps, overlaps or challenges 3) Corporate and Care Group structure to support quality governance is not well resourced. 4) Possible gaps in understanding of the breadth of both the clinical and corporate governance agenda	1a) Undertake a review of all strategies / policies in relation to governance framework to streamline / simplify, **AF/TI Jul 21** 1b) Once revised strategies / polices are in place communicate / train and embed. **AF/ TI Dec 21** 2) Review the structure in 6 months' time, **SAc /AA Dec 21** 3) Undertake a review of the clinical & corporate governance team structure, **TI Jul 21** 4a) Undertake a review of the Care Group governance support and team structure and present a business case to ensure adequate resource is in place. **RC/TI Jul 21**	L2 x S5 = 10	L2 x S5 = 10	L1 x S5 = 5

				4b) ensure the knowledge, qualification and skills in the job descriptions are fit for purpose, **AF/TI Jun 21**			
			5) Regulatory Compliance Committee (RCC) not fully embedded into the governance structure and requires a review to avoid duplication and ensure no gaps (linked to assurance 3 but more specific in relation to the actual risk identified)	5) Undertake a review of the terms of reference and modus operandi of RCC to ensure this supports the Director of Quality Governance and the Company Secretary in discharging their roles in relation to compliance **AF/TI Aug 21**			
				6) Agree evidence sign-off process **Jun 21 PC – Action closed**			
			7) delivery of all actions	7) Action plan to be delivered **PC Aug 21** – on track for delivery			
			8) Agree how delivery and embedding of the actions will be monitored as part of business as usual.	8) Agree how the focussed work will move to business as usual **PC Aug 21** – on track for delivery			

21/41.3 – APPENDIX 1

STRATEGIC GOAL: 2) Our Patients: (Linked to prioritised Trust Risk No. 4. Patient Experience) **Objective:** Improve **Patient Experience** deliver excellent clinical outcomes							
	Objective Owner: Chief Operating Officer (COO)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to deliver the operational constitutional standards due to the national directive to stop all planned care following the Covid-19 Pandemic **Origin Date:** 10/05/2021 **CRR Ref:** 78, **Source**: Risk assessment **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) Kent and Medway System Elective Care Programme Board provides system wide strategic direction attended by the COO 2) 4R programme is overseen by the Clinical Director 3) Waiting list validation of prioritisation codes by clinicians is at 97% 4) Weekly monitoring at the PTL meeting is chaired by the COO 5) Live reporting via the Referral to Treatment (RTT) App is monitored by the Deputy COO for planned care 6) Use of the independent sector is managed by the Deputy COO for planned care	**Int**: 1) We Care Breakthrough Objective 'Improving theatre capacity' monitored monthly through the Integrated Performance Report presented to the BoD **Ext**: 1) Kent and Medway System Elective Care Programme Board reports to the ICS Partnership Board	1) Development of a Systemwide PTL 2) Delivery of 80% of outpatient appointments virtually 3) Optimisation of independent sector 4) Optimisation of additional capacity via CCG	1) Delivery of workstream supporting development of PTL and patient access to any provider, **COO, Sep 21** 2) Review of outpatient areas to increase virtual outpatient appointments, **Ops Dir, Jun 21** 3) Maximise use of independent sector, **Dep COO, Planned Care, Sep 21** 4) Contracts to be developed with community providers, **Dep COO, Planned Care, Jun 21**	L4 x S4 = 16	L4 x S4 = 16	L2 x S4 = 8

21/41.3 – APPENDIX 1

STRATEGIC GOAL: 3) Our People: (Linked to prioritised Trust Risk No. 1. Workforce) **Objective**: To deliver our People Strategy to develop a positive culture and address key risks faced in terms of **recruitment and retention** to become an **"employer of choice"** by **enabling staff** to maximise their potential.							
	Objective Owner: Director of HR and OD						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to recruit and retain high calibre staff could potentially result in negative patient outcomes and experience and impact on the Trust's reputation. **Origin Date:** 23/02/2016 **CRR Ref:** 76, **Source**: Risk Registers, Incident reports, CQC reports, NHS People Plan **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) A five-year People Strategy – People at the Heart 2020-2025 has been approved by Trust Board and is monitored via the Strategic Workforce Committee (SWC). 2) Engagement of staff scores and Turnover are True North measures which are reported and monitored monthly via We Care and Staff Committee. 3) A Recruitment & Retention Strategy with associated plans has been signed off and is monitored via the SWC. 4) A Rural & Coastal Strategy led by the Associate Medical Director has been developed and agreed at Trust Board and is monitored via the SWC. 5) The Director of HR &OD attends ICP	**Int**: 1) Approval and monitoring of the agreed HR KPIs (Inc. vacancy rate, turnover and engagement scores) are monitored via We Care and PRMs and reported at SWC. 2) Workstreams and project work is monitored via the HR Senior Leads meeting, We Care and reported through SWC to BoD. **Ext**: 1) Review of EKHUFT's People Strategy via NHSE/I. Benchmarking and links with national People Team. 2) Director of HR & OD part of Future of NHS & OD national programme.	1) Lack of supply of professional qualified staff is a national issue. 2) Hard to recruit areas such as Nursing and Consultants have been identified.	1&2) Use of bank, agency and other temporary workforce solutions in place via NHS Professionals platform. **Dir. HR&OD ongoing** 1&2) International Nurse recruitment pipeline utilisation with cohorts planned throughout 2021 to achieve 300 additional Nurses by winter 2021. **Deputy Dir HR Mar 22** 1&2) Links with ICP and newly formed Kent & Medway Medical School (KMMS) to develop rotational and joint posts to support medical staff recruitment. **Dir. HR&OD ongoing** 2) Recruitment and retention working group to review and overhaul recruitment, marketing, targeting and attraction strategy **Dep Dir. HR&OD ongoing**	L4 x S5 = 20	L3 x S5 = 15	L2 x S5 = 10

	workforce groups to align plans and develop other system side opportunities and agendas. 6) A Diversity & Inclusion action plan has been developed and published as part of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and is monitored via the Equality Diversity and Inclusion (EDI) Steering Group, Staff Committee and reported to SWC.		3) Highest turnover identified in Nursing and HCA workforce.	3) Ready to Care Programme launched to address Nursing and Healthcare Assistant (HCA) retention. **Associate Dir of OD ongoing**			

21/41.3 – APPENDIX 1

STRATEGIC GOAL: 4) Our Future: (Linked to prioritised Trust Risk No. 3. 'Statutory Compliance') **Objective:** Develop and implement governance strategies that continually improve both the delivery and quality of Trust services**.**							
	Objective Owner: DCEO						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to implement the strategic change required to address the service delivery, workforce and estate condition identified in the Pre Consultation Business Case (PCBC), could result in lapses in core clinical standards and patient safety issues, and may affect adherence to estate statutory compliance, increased estate backlog risks and impact on the Trust's reputation. **Origin Date:** 27/04/2021 **CRR Ref:** 78, 13, **Source**: Risk Registers, Medium Term Risk Assessment, CQC reports, Clinical Senate advice, Royal College recommendations **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) The Chairman and CEO confirm that the Sustainability and Transformation Partnership (STP)/ICS Partnership Board prioritises and signs off the East Kent Transformation for agreement with NHSE/I. 2) The Director of Strategic Development and Capital Planning ensures that the PCBC is signed off by the Trust's FPC and BoD. 3) The Director of Strategic Development and Capital Planning ensures that the implementation of the clinical strategy receives oversight from the Joint Development Board and FPC. 4) The Trust's position in terms of statutory compliance is published, reported and reviewed six-monthly by CEMG and the BoD.	**Int**: 1) Approval and monitoring of the Trust framework proposals and workstreams through Strategic Investment Group (SIG), CEMG, JDB, Q&C, FPC and BoD. **Ext**: 1) Sign off by ICP, STP/ICS and NHSE/I.	1) Final sign off and approval of capital investment is outstanding from NHSE/I. 2) Gaps and risks relating to backlog and statutory compliance have been identified.	1a) The outstanding actions from NHSE/I's Stage Two Assurance process have now been completed and a final meeting with NHSE/I is being set for completion of the Stage Two process in May. **DSD&CP May 21** 1b) Clear lines of accountability and responsibility for the sign off, of the East Kent Transformation (including the PCBC) is identified in the STP/ICS Partnership Board Strategic Priorities. **CEO Mar 22** 1c) Lobby MP's to secure funding, **DCEO Aug 21** 2a) Continue to implement annual investment plan for statutory compliance and monitor in year improvements against the agreed trajectory. **DSD&CP Mar 22**	L4 x S5 = 20	L3 x S5 = 15	L1 x S5 = 5

	5) The Trust's investment programme in statutory compliance is approved by CEMG, FPC and BoD. 6) The Trust wide backlog maintenance plan is approved and reviewed by SIG, CEMG, FPC and BoD.		3) Current estate risks do not map well from Ward to Board.	2b) Prioritise through SIG the investments for backlog maintenance as part of the PEIC capital investment programme. This will be informed by the Six Facet Survey, the work undertaken for NHSE/I on reducing the backlog position and the ARUP report. Investment will be monitored through FPC and BoD. **DSD&CP Ongoing through this financial year** 3) Finalisation of the Site Control Plans, based on the Six Facet Survey and ARUP Report to include a full ward decant and refurbishment programme. **DSD&CP Jul 21**			

21/41.3 – APPENDIX 1

STRATEGIC GOAL: 5) Our Future: (Linked to prioritised Trust Risk No. BAF 29) Develop a Trust wide strategy to deliver cultural change, innovation and improvement**.**							
BAF	**Objective Owner: Chief Executive**						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to deliver the full benefits of the We Care improvement system. **Origin Date:** 26/05/2020 **CRR Ref:** **Source**: CQC / regulator reports; Royal College reports and recommendations; staff survey **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) We Care Improvement Strategy approved by BoDs and implemented across the Trust. 2) EMT leads monthly cycle of the OMS and reports and updates progress on implementation. 3) Executive led workstreams in place (strategic deployment; OMS Frontline / Management; Leadership behaviours; Transformation and Step Change; Centre of Excellence; and Communications) reporting into EMT. 3) IPR linked into We Care and reports monthly to sub Board Committees and BoDs. 4) Monthly PRMs with Care Groups wired in to We Care.	**Int**: 1) Coaching and mentoring in place for Executive Team; Care Groups; and Frontline Teams. 2) Skills matrix agreed for internal Improvement Team, which links to personal objectives. **Ext**: 1) System has been implemented and proven to work in international healthcare systems (USA, Canada, Iceland) and in similarly complex NHS organisations. 2) VFM review undertaken by NHSEI with positive findings reported. 3) Endorsement for the change model from the National Director for Lean Transformation	1) Methodology that links the We Care Improvement Strategy to organisational strategies (such as the Quality Strategy) to be established. 2) Comprehensive plan to transform leadership behaviours across the Trust required. 3) Clear contractual road map established for stage two of KMPG support. 4) Wave 3 wards / clinical areas to be agreed. 5) A further wave of Covid disrupts the programme roll out 6) Year two priorities analysed and agreed.	1a) Methodology to be established and agreed by EMT, sub Board Committees and BODs. **DCEO July 21** 2) Leadership behaviour road map to be agreed for implementation at EMT, alongside the stage two KPMG support. **DoHR July 21** – First phase undertaken. 3) Stage two road map established with KPMG at EMT. **DCEO July 21** 4) Wave 3 wards / clinical areas agreed and dates for FLT coaching and mentoring established. **COO July 21** 5) Look to delay / pause all or certain elements of the programme, depending on severity of the 3rd wave. **DCEO Oct 21** 6) In line with business planning for 22 / 23, TN and Bos reviewed and priorities	L 4 x S 4 = 16	L 4 x S 3 = 12	L 4 x S 1 = 5

	5) Intensive Support process agreed for implementation as and when required.			agree with the BoDs. **DCEO Mar 22**			

21/41.3 – APPENDIX 1

STRATEGIC GOAL: 5) Our Sustainability: (Linked to prioritised Trust Risk No. 2. Infrastructure) **Objective**: Achieve sustainable **financial health**							
	Objective Owner: Director of Finance (DoF)						
Principal Risk	**Key Controls**	**Internal and External Assurance Evidence**	**Gaps in Controls**	**Actions to address Gaps in Control**	**Initial**	**Current**	**Target**
Risk: Failure to deliver the financial breakeven position of the Trust as requested by NHSE/I may result in the Trust not having adequate cash to continue adequate operations of the organisation and will result in reputational damage and non-compliance with regulators. **Origin Date:** 11th May 2021 **CRR Ref:** 102, **Source**: Regulatory target. **CQC:** **Is it Safe** **Is it Effective** **Is it Caring** **Is it Responsive** **Is it Well-led**	1) There is a first half year financial plan in place which will be presented at Board on 27th May 2021. 2) The Director of Finance is the lead for this risk, and it is managed through the Finance and Performance Committee, Clinical Executive Management Group, Finance and Investment Oversight Group, Performance Meetings with Care Groups and Directors. 3) Individual finance reports go to Care Groups on a monthly basis. Finance is monitored through the monthly IPR plus Finance report which goes to Finance and Performance Committee and Trust Board on a monthly basis. 4) Other controls in place; annual business planning process, annual cost improvement programme	**Int**: 1) The plan and monthly performance are monitored and minuted at monthly performance meetings with care groups, with the Finance and Performance Committee, and the Trust Board. **Ext**: 1) The financial performance of the Trust is monitored by NHSE/I through a monthly return. This is approved by the Director of Finance. In addition, the Trust has a monthly oversight meeting with the regional NHSE/I team to discuss financial performance (amongst other agenda items).	1) Plan for second half of the year needs to be developed. 2) Trust doesn't have a medium term or long-term financial plan. The Trust is likely to remain in finance special measures (FSM) until a balanced longer-term plan is developed.	1a) Care Groups to complete business planning cycle **Director of Finance, Jun 21 – Action closed** 1b) NHSEI to release planning guidance for the second half of the year and the Trust should build into expected plan. **Director of Finance,** expected date is **Q3 21** 2) Trust to develop medium term and long-term financial plans in conjunction with NHSEI and Kent and Medway ICS. **Director of Finance**, ~~**Sep 21**~~ – **Q4 21**	L4 x S5 = 20	L3 x S5 = 15	L1 x S5 = 5

	developed, weekly activity review group in place.						

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**COUNCIL OF GOVERNORS**
DATE:	**15 SEPTEMBER 2021**
REPORT TITLE:	**STAFF AND PATIENT EXPERIENCE COMMITTEE (SPEC) CHAIR'S REPORT**
PAPER AUTHOR:	**SPEC CO-CHAIR, BERNIE MAYALL**
PURPOSE:	**TO AGREE**
APPENDICES	**Annex 1: extract from draft SPEC minutes – Real Time Feedback**

BACKGROUND AND EXECUTIVE SUMMARY

This report updates Council on the meeting of the SPEC held on 2 July 2021. Members attending the meeting were myself, Ross Britton, Carl Plummer, Debra Towse and Marcella Warburton. Apologies were given by Liz Baxter, Chris Pink and Sally Wilson. James Casha, Sophie Pettifer and Paul Schofield were also in attendance.

This was the first meeting of the newly formed Staff and Patient Experience Committee and the first order of business was to agree who would take the Chair. There had been some discussion previously about the possibility of introducing a Co-Chairing system and the Committee considered a paper submitted by myself and Ross Britton outlining how that would work. The Committee agreed the principles presented and that myself and Ross would take on the Chair roles. I took the Chair for this meeting. It is hoped that other Council Committees will be interested in using the same system and that the experience from this Committee will help inform that decision.

One of the two main items of business for this first meeting was to receive a presentation from Ross about a process used at Salisbury NHS FT where he used to be a governor – Realtime Feedback. The process worked well at Salisbury and provided a good opportunity for governors to obtain direct feedback from inpatients and effect real change. The Committee would like to recommend that Council consider developing such a system for use in EKHUFT. At Annex 1 is an extract from the draft minutes of the meeting which covers this item as it briefly explains what the process is and covers the questions raised by those present – which are likely to be similar to those which occur to governor colleagues not present at the meeting.

Since the meeting further discussions have taken place and this model remains under review and consideration. It has been agreed that further research will be undertaken and presented to the CoG to enable a view to be taken

Unfortunately, Ross is unable to attend this Council meeting. I hope that myself, or other present at the meetings, may be able to answer any questions that you have.

The other substantive item covered at the meeting was the process for drafting of the Governor's Commentary to the Trust's Annual Quality Report. This process was undertaken following the meeting and a draft was agreed by Council via virtual voting. The process accurately described the democratic aspirations of the CoG and of SPEC in that the draft was created by the author and then circulated for comment and drew significant debate and discussion before the final version was approved. It also highlighted the need for governor training to enable an understanding of the required processes and remit involved in the role of governor and in the purpose and remit of the various committees and sub-groups in order to encourage appropriate and timely debate. Going forward I might suggest that we ensure

East Kent Hospitals University NHS Foundation Trust

sufficient time is allowed between creation and publishing to enable a full discussion to take place and that those timeframes are clear and respected to reduce the risk of ongoing or last minute debate without resolution, so supporting a final outcome within the appropriate period of time.

At the next SPEC meeting there will be a de-briefing item on the process this year and agreement reached on a process for drafting the Commentary on the 2021/22 Quality Report. As one of the main objectives for this Committee is to look at issues of quality of service, we expect our discussions through the year to help inform the content of the commentary and make the process a more considered and iterative one. This should help to mitigate some of the time pressures felt on the last two occasions that commentary was drafted.

LINKS TO STRATEGIC OBJECTIVES:	**We care** about... • **Our patients;** • **Our people;** • **Our future;** • **Our sustainability;** • **Our quality and safety.**

RECOMMENDATIONS AND ACTION REQUIRED:

The Council of Governors is asked consider this report particularly with respect to:

1. developing the Real Time Feedback process for EKHUFT; and
2. comments about the drafting process for the Governor Commentary to take into account when the process for 2021/22 is discussed at the next SPEC meeting.

East Kent Hospitals University NHS Foundation Trust

ANNEX 1 – extract from SPEC minutes re:

REAL TIME FEEDBACK

RBr gave a presentation on Real Time Feedback (RTF) which aimed to engage patients and staff in a positive feedback process. [Note: presentation has been added to the papers.] RBr said that he had had experience of using this methodology at Salisbury Foundation Trust where it was developed with the PALS team with support from wards and departments. RTF enabled Governors to have discussions with patients and staff in a safe environment without judgement and anonymously. With agreement from the Committee, he hoped to share this proposal with the Council as a whole.

RB explained that the Governor would visit a ward, gaining permission from the person in charge to speak to appropriate patients. Moving forward an iPad could be used to record responses. RBr presented and discussed the questions used in Salisbury which captured the main concerns patients tended to raise. For example: involvement in discharge planning; understanding of medication; cleanliness of the environment; food temperature; access to assistance with meals; noise levels; and any other concerns / comments. A scale was provided for scoring.

RBr emphasised that getting the process right was paramount to instil confidence and develop trust between those involved. He felt that staff and patients responded more freely to a governor who was unescorted and not introduced; dual governor visits could overcome concerns around chaperoning. Other key factors included ensuring the patient or staff member remained anonymous, not visiting at meal times, exiting the conversation if a medical emergency occurred nearby and providing general feedback to staff at the time of the visit and, if possible, answers to queries raised given, taking care that these were compliant with the Trust's policies and guidance. The governor must be confident that the person being interviewed was compos mentis and happy to be involved. RBr commented that over time ward staff had become very accepting of the RTF visits, particularly as useful feedback was provided.

RBr said that in general it was possible to undertake four to five processes in one visit and this would take around two to three hours. If ten governors undertook one session a week comprising 4 to 5 patient interviews, this would be 2000 to 2500 useful pieces of information in a year, four governors would give a 1000. He would like the Committee to support a recommendation to Council to consider adopting this process. RBr invited comments.

As it became clear that there were a number of governors who wished to speak, it was agreed that comments would be collated and the responses provided after the meeting and included in the Chair's report to Council. The Chair commented that this would give time for reflection and a full exchange of views.

CPl raised a concern about delivering feedback directly to the ward team. These could be about operational issues and therefore outside of governors' remit and should not be done at the time, but to senior managers later. Guidance on what feedback could be provided would be needed, especially if governors were made aware of a serious issue.

RBr said that he had a slightly different view having been involved in such visits for some time. The Salisbury the PALS team had collated the general feedback from the visits to take forward. He agreed that the governors were not operational and must provide the feedback for the staff to take action. A good rapport had been built with staff.

SPe highlighted that patients were already invited to complete the Friends and Family test (FFT), prior to discharge, to feedback on their experience during their hospital stay and suggested that this would provide the information the governors were seeking. SPe said that if a concern about patient care was identified then the governor would be duty bound to share this information at the time of the visit. If patients shared a concern and no action was taken then they would become disenfranchised with the process. If action was needed, this had to be taken.

SPe also suggested that it would be better to ask ward staff to provide a list of patients who it was appropriate to approach. Governors could then choose who to speak with, rather than be directed. SPe added that staff should also be included in the interviews as they would have useful feedback. For example, an improvement could be made if the main meal and dessert could be served separately rather than at the same time.

DTo commented that RTF gathered different information to the FFT and for a different purpose. She identified that a very clear governance structure would be required, probably reviewed by the Trust legal team. There were existing feedback systems for staff to raise concerns, including systems specifically for student nurses, and the RTF process would need to recognise those and work in synchronised way. DTo said that RTF would mainly identify lower level risks that could, and should, be ameliorated quite quickly. DTo said that the questions might need some further thought; for example the information a patient could be expected to have about their discharge depended on how close they were to leaving hospital. DTo suggested that given the numbers suggested by RBr, it would be important to record outcomes electronically to facilitate analysis. There must be a clear declaration around consent. It would need to be clear to participants that consent could be withdrawn at any stage.

JCa confirmed that there were a number of systems available for staff to raise concerns, which could be anonymous if wished, and gave brief details. He commented that the governor statutory role was to represent the views of patients and staff, so he believed it was a legal requirement for Council to have a system to collect feedback, with proper governance and subject to the usual data protection requirements. If an electronic system was used access had to be controlled. JCa commented that the RTF process would help fill in the gaps given that the FFT was undertaken quarterly.

MWa commented that it was important to speak with staff also and to have questions designed for that, while recognising the time pressures on staff may mean fewer interviews could be undertaken. MWa suggested that if this was taken forward the questions should be reviewed - additional questions the governors could consider were: do you have access to the appropriate care staff when you need it at mealtimes and do you receive help to mobilise?

RBr highlighted that the RTF process had gone had been fully endorsed by the Board and CoG at Salisbury and had gone through vigorous testing and approvals before being launched. The process had been in operation for several years and was very well received by Wards and Depts.

RBr was concerned that implementing this as a new process could take longer than necessary given that approval was needed from Council before action could be taken and

those meetings were quarterly. The Chairman recognised this concern and proposed that the SPEC members liaised outside of the meeting, perhaps via a Whatsapp group, to work up the proposal so that it could be presented as a fully detailed plan to the next Council meeting. This was agreed by the Committee.

ACTION: Whatsapp group set up so that the RTF process can be refined for presentation to Council.

The Chair commented that in her view the RTF process would provide an additional and valuable mechanism for staff feedback, especially for those who may be wary about using the existing Trust systems. It would also give the Council a higher profile in the organisation.

She summarised the comments for response, recognising that there were some other specific points which would be captured in the minutes:

- Management of expectations – being clear and open about what the process would be and how it would happen;
- How to include a 'You said, We did' element to the process;
- Clear process for escalation if major concerns are raised;
- How to manage data collection, downloading and theming issues;
- Clarity and recognition of the governance structure, including a disclaimer; and
- Being clear about the different focus and purpose between the RTF and the FFT.