NHS
East Kent
Hospitals University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING – FRIDAY 10 FEBRUARY 2017

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place in the **Lecture Theatre, Queen Elizabeth the Queen Mother Hospital, Margate**, commencing at **9.30 am to 1.30 pm**.

AGENDA

1	Chairman's welcome			
2	Apologies for Absence			
3	Declaration of Interests			
4	Patient Experience Story	**Discussion**	**9:30** **BoD 01/17**	Chief Nurse and Director of Quality
5	Minutes of Previous Meeting held on 9 December 2016		**10:00**	
6	Matters Arising from the Minutes on 9 December 2016			
7	Chair's Actions	**To Note**	**10:15** **BoD 02/17**	Chair
8	Chief Executive's Report	**Discussion**	**10:25** **BoD 03/17**	Chief Executive
9	2017/18 Annual Objectives and Strategic Priorities	**Approval**	**10:40** **BoD 04/17**	Chief Executive
10	Full Corporate/Highest Mitigated Strategic Risks Report	**Discussion**	**11:05** **BoD 05/17**	Chief Nurse and Director of Quality
	BREAK		**11:15**	
11	Board Committee Feedback:		**11:25**	Board Committee Chairs
	11.1 Finance and Performance Committee • Revised Terms of Reference	**Approval**	**BoD 06/17**	
	11.2 Quality Committee	**Discussion**	**BoD 07/17**	
	11.3 Strategic Workforce Committee • Ward Establishment Review	**Discussion**	**BoD 08/17**	

	11.4 Integrated Audit and Governance Committee • BAF • Annual Priorities: Quarter 3 • Addendum to Risk Management Handbook • Review Terms of Reference	**Approval**	**BoD 09/17**	
12	Improvement Plans		**11:55**	
	12.1 CQC Improvement Plan and Update	**Discussion**	**BoD 10/17**	Chief Nurse and Director of Quality
	12.2 Emergency Care Recovery Plan	**Discussion**	**BoD 11/17**	Chief Operating Officer
13	Proposal for awareness training to the Board of Directors on Human Factors in Healthcare	**Decision**	**12:20** **BoD 12/17**	Chair Chief Executive Director of Strategic Development and Capital Planning
14	Integrated Performance Report	**Discussion**	**12:45** **BoD 13/17**	Director of Finance and Performance Chief Nurse and Director of Quality Medical Director Director of HR
15	Review of Issues Associated with Overseas and Accident Income Recovery	**Discussion**	**1:00** **BoD 14/17**	Director of Finance and Performance
16	Medical Director's Report	**Discussion**	**1:05** **BoD 15/17**	Medical Director
17	Any other business			
18	**QUESTIONS FROM THE PUBLIC**		**1:15**	
19	Date of Next Meeting Monday 10 April 2017 in Seminar Rooms 1 and 2, Buckland Hospital (9.30 am)			

UNCONFIRMED MINUTES OF THE SEVENTY-SIXTH MEETING OF THE BOARD OF DIRECTORS FRIDAY 9 DECEMBER 2016, 09:30, BOARD ROOM, K&C

PRESENT:

Mrs N Cole	Chair	NC
Mr R Earland	Deputy Chair/Non-Executive Director	RE
Mrs G Gibb	Non-Executive Director	GG
Mr S Adeusi	Non-Executive Director	SA
Mr R Hoile	Non-Executive Director	RH
Mr M Kershaw	Chief Executive	MK
Mr N Gerrard	Director of Finance and Performance Management	NG
Dr S Smith	Chief Nurse and Director of Quality	SSm
Dr P Stevens	Medical Director	PS
Ms J Ely	Chief Operating Officer	JE
Ms L Shutler	Director of Strategic Development and Capital Planning	LS
Mr B Wilding	Senior Independent Director	BW
Mr C Tomson	Non-Executive Director	CT
Mr S Mathur	Non-Executive Director	SM
Ms S Le Blanc	Director of Human Resources	SLB

IN ATTENDANCE:

Alison Fox	Trust Secretary	AF
Sarah Swindell	Assistant Trust Secretary *(Minutes)*	SS
Natalie Yost	Director of Communications	NY

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Keith Palmer	Non-Executive Director *(from 1 January 2017)*	KP
11 members of the public		
2 Governors		

MINUTE NO.		ACTION
92/16	**CHAIRMAN'S WELCOME** The Chair opened the meeting at 9.30am and welcomed the participants to the meeting. The Chair welcomed KP who would be joining the Trust from January 2017 as a Non-Executive Director. NC advised that there would be 15 minutes made available at the end of the meeting so that the public could ask questions about items on the agenda. Other questions could be raised through the website, via email or by mail. NC advised that there would be a private Board session held in the afternoon where matters of a confidential nature would be discussed. She advised that all important decisions would be reported to the Public prior to implementation.	

93/16 **APOLOGIES FOR ABSENCE**

No apologies had been received.

PUBLIC DECLARATION
A member of the public made the following statement:

We are here today to demand that this Board of Directors, whose purpose is to serve the population of East Kent, speak openly and honestly about the STP, which is the Government's tool for further privatisation and the dismantling of our NHS.

East Kent's draft STP outlines the downgrading of services to leave just one A&E site with a trauma unit to provide care for a populous of 1.5m people. This means people will die.

Rife with jargon and terminology, the STP has been designed to be obtuse and inaccessible to the public, so as to present itself as a positive step toward saving the future of our NHS services, when in fact, its purpose is to accelerate Simon Steven's five-year forward view and hasten the privatisation of service delivery.

Nationally, we are seeing the closure of A&E departments and consultant led maternity services. The five-year forward view seeks to centralise the expensive, non-profitable elements of the NHS, separating the good investments from the non-profitable, preparing for large-scale privatisation. We know how fond Stevens is of private healthcare, having been the president of the largest health insurance company in the United States prior to being installed as the head of NHS England by a Tory Government.

Written in jargon and spin, the draft STP seeks to deceive the public into the case for change, and a false sense of security that their NHS will be preserved. The £101m debt that the Trust has accumulated is being presented as an overspend. This is dishonest. The members of this Board must speak out about the de-funding of the NHS and present this debt as it truly is - an underfunding by Central Government.

I quote the STP: Your own bed is the best bed.

What this really means, is there'll be no other bed available for you. Discharged as early as possible, patients will be reliable on social care providers for their recovery. We all know the current unfit state of the privately operated social care sector. The people of East Kent are depending on this Board of Directors to truly have their best interests at heart.

We know the track record of your CEO, Matthew Kershaw, and his attempts at cutting viciously in Lewisham and Brighton. But you know the future of people's lives and health in your hands. The least you owe them is the transparency and honesty to tell them what these plans really mean. Each of you are responsible for ensuring the truth behind these plans is made known.

Don't lie to us. Don't do Simon Stevens' dirty work. No closure, no downgrade, we will not be betrayed.

No closure, no downgrade, we will not be betrayed.

The Chair advised the group that this was a meeting in public and not a public meeting and that they had not asked permission to film, if they wished to make the recording public they would need the consent of all those in the Board room.

The Chair noted her disappointment that the members of the public making the statement had not taken up the offer made by the Board to discuss their concerns ahead of the meeting with the Chief Executive and Medical Director.

She advised that the Board had committed to an open and honest conversation about the STP. She also noted the importance of ensuring that consent was received from all those in attendance at the meeting, in the event that the video was to be made public. She invited a response from the CEO who made the following statement:

First of all, as Nikki said, we did offer to talk to you beforehand and have a more detailed conversation. That offer remains open, and if people wish to take that offer up, then in the spirit of the open and honest conversation that we have about all these matters, we would be very willing to do so.

We clearly are part of the Kent and Medway wide STP. That's a national process as you yourself have set out. We are active participants in that, and that's right, because the health service in Kent and Medway does need to change, does need to improve for the residents and the population that we serve.

We have set out within the document, I think clearly, some initial ideas about what the future health service in Kent and Medway could look like. We haven't, at this point in the process, completed that work, and neither should we have done, because part of that work is going to be conversations with a whole host of interested parties, whether they be other partners in health and social care - other organisations - and crucially, the patients and the public themselves. Any proposals will be subject to full public consultation. That is quite right and proper. And that process is not yet at this point. That point will be in our expectation, about the summer of 2017.

So far from being a secret plan, what we've set out are some initial ideas that we wanted to explain to our partners and to the public, hence the choice to publish the STP. And the further work that will be done between now and consultation, we'll engage with members of the public. That's very important and that's always a cornerstone of this work, and will continue to be so here in East Kent as part of the Kent and Medway wide work. And as I said before, at the start, if people would like to talk to me specifically outside of this meeting, I'm very happy to do so as always.

94/16 **DECLARATIONS OF INTEREST**

RE declared an interest in agenda item 102/6 Item 11.6: Report from the Nominations Committee. He advised that he would abstain from any debate on this item as there may be a perceived conflict of interest.

RH declared that he had been appointed as Medical Director of KIM's Hospital. He noted the possibility that conflicts of interest could arise where there were discussions about links with external providers.

No further declarations were made.

95/16 **MINUTES OF THE PREVIOUS MEETING HELD ON 7 OCTOBER 2016**

The Board reviewed the minutes of the meeting held on 7 October 2016 for accuracy and the following amendment was recorded:

- A typing error was noted under 79/16 - "meters" should read "meetings".

DECISION: The minutes of the meeting held on 7 October 2016 were **approved** with the amendment noted above.

96/16 **MATTERS ARISING FROM THE PUBLIC MINUTES OF 7 OCTOBER 2016**

The Board reviewed the Matter Arising and the following updates were provided:

- Patient Story: complete.
- KPIs for DTOC: JE due to meet internal auditors on 12 December 2016. An update would be provided at the next Board meeting.
- Risk Register update: complete.
- EPR business case: referred to FPC.
- Integrated Performance Report: complete.
- Communications to staff re IDT Challenge and initiatives: complete.
- Confidence threshold for delivery to be included in future emergency recovery plans: ongoing.
- Engagement of retired professionals in R&D: MK and the Dr Tim Doulton the Lead for Research and Development were in discussion with University of Kent and Canterbury Christchurch about joint appointments, and were engaged in the debate relating to the potential for a medical school to be opened in Kent and Medway.

NOTE: The Board noted the updates on the matters arising.

97/16 **PATIENT STORY**

This item was deferred until the next Board meeting.

98/16 **CHIEF EXECUTIVE'S REPORT**

MK provided the following updates to the CEO Report:

- The draft CQC Report had been received. Comments/points of accuracy had been submitted to CQC. Final publication was anticipated prior to Christmas. The reports were consistent with what had been received during informal feedback.
- The contract and business planning process was underway. The deadline for the signing of contracts was 23 December 2016.
- MK congratulated the members of staff who had participated in the Trust Awards Ceremony.

Comments/questions from the Board were noted as follows:

- SA requested information on the increased use of the private sector in Orthopaedics and Ophthalmology. MK advised that there had been positive progress made on the utilisation of internal resource, but there was more to do to further improve efficiency. Capacity had been increased to deal with the backlog in some targeted areas, which included Orthopaedics and Ophthalmology.
- CT asked if Super Discharge Week was being promoted to the public at large. JE advised there were plans to provide daily updates, but the messaging would be carefully considered. NT advised that the Trust was being proactive in working with the media (via radio) about appropriate use of A&E and discharge procedures.
- BW sought advice on the improvements reported around the two-week cancer statistics, noting that the overall performance appeared to be declining on the IPR. JE reported that the two-week wait had been consistently achieved (at a rate of 93%) over the last three months. She noted that the 62-day cancer statistic had deteriorated while the backlog was being cleared.

NOTE: The Board noted the Chief Executive Report.

99/16 **RISK APPETITE SESSION NOTES**

NC sought the views of the Board on the following risk appetite statements:

The Trust has a moderately high tolerance within a context of clear and reliable financial controls for taking financial risk. It will be prepared to allocate resources in order to capitalise on new opportunities and invest for returns, whilst minimising the possibility of financial loss by managing risks to a tolerable level. Value for money will remain the primary concern when making financial decisions.

- NG indicated that while he was generally happy with this statement, he was more cautious and restrained in his appetite around finance given the current position.
- SM concurred with this view. He noted that a key issue for him was affordability of investment (regardless of value for money). He also noted that there needed to be willingness to disinvest where it was appropriate to do so.
- MK noted that few of the decisions made would be based solely on a financial basis, given that quality and performance considerations would also generally be taken into account. When making broader decisions, value for money would not be the only consideration.

DECISION: The Board adopted this statement.

The Trust has a high tolerance for risks to its compliance with regulatory requirements. Although there are regulatory requirements that it must comply with, it must be courageous and willing to defend any subsequent regulatory challenge in situations where it is likely to win. Where there is likely to be adverse consequences, the Trust would prefer not to take risks with compliance unless similar situations elsewhere have been successfully defended.

- AF, BW and CT stated the view that this was an appropriate statement for the Trust.
- PS noted that when clinical practice guidance was based on evidence, it would generally be reasonable to follow this. He acknowledged that occasionally the regulators released guidance that was not necessarily reasonable, and as such he agreed that the statement should indicate that the Trust would not blindly comply with such guidance.

DECISION: The Board adopted this statement.

The Trust has a significant tolerance for risks associated with pursuing innovation system technology developments to support operational delivery and activities to improve quality and outcomes. This will be supported with commensurate improvements in management control and higher devolvement of responsibility for non-critical decisions.

DECISION: The Board adopted this statement.

The Trust has a high tolerance for risks associated with activities to improve quality patient related outcomes. This means it will consider potential delivery options whilst ensuring it complies with standards of clinical and professional practice. But it will not accept any unnecessary risks that will jeopardise the quality of patient care.

DECISION: The Board adopted this statement.

The Trust has significant tolerance for risks to its reputation arising from the implementation of a new clinical strategy and/or its key strategies. Where the potential benefit outweighs those risks, it will pursue new ideas seen as potentially enhancing to the Trust reputation, but it will not otherwise accept risks or circumstances that could cause reputational damage to the Trust.

DECISION: The Board adopted this statement.

The Trust has a significant tolerance for risks to workforce staff engagement. This means it will be innovative in undertaking workforce transformation projects that will offer potentially higher business rewards, but it will not accept risks in relation to suitability of staff.

- BW suggested that the term "business rewards" was not appropriate. It was agreed that the term "better staff and patient outcomes" would be preferable.
- NG suggested there should be references to productivity and efficiency in this statement.
- SM also suggested that there should be reference to broader organisational benefits (e.g. staff, patient and organisational benefits).
- The second sentence was updated as follows:

This means it will be innovative in undertaking workforce transformation projects that will offer potentially higher staff, patient and organisational benefits, but it will

not accept risks in relation to suitability of staff.

DECISION: The Board adopted this statement with the change outlined above.

The Trust has a high tolerance for risk in relation to performance. This means that, as it seeks to meet internal and external performance standards, it will be willing to consider all the potential delivery options that provide an acceptable level of reward and value for money. Where there is likely to be adverse conditions, the Trust would prefer not to take risks with compliance to external performance standards unless similar situations elsewhere have been successfully defended.

- BW suggested that the term "acceptable level of reward" was quite abstract. It was suggested that this could be replaced with "benefit".
- NG suggested that "acceptable level of delivery" could be used.
- PS suggested this should be changed to "patient related outcome measures"
- GG suggested that the comments boxes should be populated so that the decision making process for finalising the statements was clear.

ACTION: Risk Manager to re-work this statement and populate the comments boxes for each statement. SSm

NOTE: The Board identified that there was now a higher tolerance to risk than had been identified during the previous risk appetite session.

ACTION: It was agreed that some statements should be made both internally and externally to identify the higher risk tolerance and the context for this position. MK

100/16 **HIGHEST MITIGATED RISKS**

NC advised that during this section of the meeting, the Board would review the risks, discuss emerging risks and decide whether SRR7 should be closed on the risk register.

- NC asked whether the Trust was on track for the mitigating action for VTE assessments to be completed by the 16 December 2016. PS undertook to provide an update at the next meeting.

DECISION: The Board approved the closure of SRR7 on the risk register.

101/16 **BOARD ASSURANCE FRAMEWORK AND DELIVERY OF ANNUAL PRIORITIES: QUARTER 2**

NC invited comments on this report. These were recorded as follows:

- GG questioned what information this report was providing in addition to the IPR. NC advised that this report enabled the Board to identify how well the Trust was doing against the strategic objectives. She indicated that she would like to see this reported quarterly.

- BW and CT also considered this to be an essential document. BW advised that he would be challenging the robustness of the data.
- AF advised that the data was sometimes difficult to measure and there was not always a current baseline available. She had met with a number of the Executives. Patient Safety Board (PSB) would be considering these issues during their next meeting. The RAG ratings for each metric should also be identified.
- AF advised that the next report would be for Q3 and would include an end of year statement from the holders of the metrics to outline the expected end of year position (and this would be the format going forward).
- GG acknowledged the need to review annual priorities. She noted however, that there was repetition of the same information in other Board papers and suggested that the papers should be a succinct as possible.
- SM noted his view that it was overly-optimistic to identify the overall position as green. NG agreed with the view noting that the Finance Report identified the very high risk associated with hitting the financial targets; and the green rating overall was inconsistent with that reality. He suggested that there was a danger of creating a false impression.
- BW suggested that this was a more important report than the IPR as it identified progress against targets that had been set internally, rather than progress against targets which had been externally set for the Trust. He noted the importance of constructing the report using accurate data.
- Having heard the feedback/comments in particular relating to the financial position, MK acknowledged that the overall position could be better reflected.
- The Chair requested that the IAGC review the report to attain assurance about the accuracy of the underlying data and to identify areas of duplication with the IPR. MK undertook to ensure that he was present at the review meeting.
- CT noted that that the report did not clearly state the difficulties of recruiting doctors as well as nurses.

ACTION: IAGC to review the BAF. MK to attend the session. BW/MK

NOTE: The Board noted the Board Assurance Framework Report.

102/16 **BOARD COMMITTEE FEEDBACK:**

11.1 FINANCE AND PERFORMANCE COMMITTEE

SM took the report as read and re-iterated the fact that the organisation was under considerable financial pressure. The following questions/comments were noted:

- RE advised that the Committee had held a discussion about the Carter Recommendations and had gained assurance that given the maturity of the data, the Trust was doing as much as it could. There would be further scrutiny of performance against the recommendations during the following year.
- SM suggested that the FPC must review its effectiveness as a Committee noting that time available for challenge was limited.
- NC noted the "need to create a vision for ED" which had been identified in

the report. She asked who would be leading this work. SM advised that JE was leading and would be assisted by the Emergency Care Improvement Programme (ECIP) team.

- MK suggested that some wordsmithing of the report may be beneficial as there was no specificity about the nature of the "ED vision". JE advised that the discussions held at FPC had been held in the context of ECIP's observation that the nature of emergency pathways had changed. SM advised that the presentation had shown that the ED was not a standalone entity and only worked properly when it was linked to the rest of the hospital. The "Vision" was about reflecting how ED operated and considering how care could be delivered in a better way.
- PS noted that creating a vision was a complex process which would need to reflect the aging population, the co-morbidity of the population, the acuity of presentation, poor communication between GP and ambulance service, numbers of locum staff, risk averseness about admissions and discharge, closure of nursing homes, delays in assessment and a number of other factors.
- RE acknowledged the system complexities, but also noted that there were a number of things that the Trust could do better. He suggested that the Trust needed to be clear about what they could do internally, it must be able to identify how they were progressing those items.
- NC asked how it was possible for MTW to significantly increase the cost of oncology services. She asked what risk this would pose to the Trust. NG advised that the Trust was at risk of an additional charge of around £800k (for which there was currently no provision). He advised that this was a local service agreement, not a tariff-based service, hence MTW's ability to raise charges.

NOTE: The Board noted the Finance and Performance Committee Report.

11.2 QUALITY COMMITTEE

RH took the report as read and the following questions/comments were noted:

- RE noted the opportunity to improve strands of service in emergency flow and frailty, and in Women's Services. He noted it was likely that the CQC Report would identify these areas for improvement.
- BW noted his view that the recent Quality Committee meeting had been very informative and productive, indicating that the Divisions had not only identified their issues, but had outlined the work being done to resolve them.
- RE and RH acknowledged the work of the Michelle Webb (MW) Associate Medical Director for Patient Safety who was chairing the Patient Safety Board in an open and transparent way. This had laid the foundations for Divisional engagement with the Quality Committee.
- It was noted that LS and FM had provided the Committee with assurance that visibility on Health and Safety issues was at an appropriate level.
- PS advised that there had been a review of Women's Services by the Royal College of Obstetricians and Gynaecology earlier in the year and noted that the issues identified during that review were being addressed. RH advised that once concern was of a lack of engagement between Maternity and the PSB whereby Maternity representatives did not attend meetings or present

reports as requested.
- MK acknowledged the work that was already underway to address the issues raised by the Royal College, and proposed that the concerns raised by MW about engagement could be addressed outside of this meeting (via the Quality Committee).

NOTE: The Board noted the report from the Quality Committee

11.3 STRATEGIC WORKFORCE COMMITTEE

CT took the report as read and the following questions/comments were noted:
- Over the next year, it was anticipated that there would be further improvements following the rollout of the professional people programs.
- The Board had been asked to endorse the submission to reduce agency spending.

DECISION: The Board endorsed the Trust's Reduction in Agency Spending NHSI Checklist Submission.

NOTE: The Board noted the report from the Strategic Workforce Committee.

11.4 INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

BW took the report as read and the following questions/comments were noted:
- There had been slippage on completion of actions identified during Clinical Audit and Internal Audit. Human Resources and Pharmacy were the key areas of concern.

NOTE: The Board noted the Integrated Audit and Governance Committee report.

11.5 CHARITABLE FUNDS COMMITTEE

GG took the report as read and the following questions/comments were noted:
- Board approval had been sought for the Charitable Funds Governance Policy.

DECISION: The Board approved the Charitable Funds Governance Policy.

NOTE: The Board noted the report from the Charitable Funds Committee.

11.6 REPORT FROM THE NOMINATIONS COMMITTEE

RE declared his abstention from discussions on this item.

SA took the report as read and the following questions/comments were noted:
- The Board was asked to endorse a proposal to explore the possibility of RE continuing to participate in consultant appointment panels. PS noted his support for this proposal.
- NC sought delegated authority for her and MK to source suitably qualified and experienced people for nomination as independent lay people for

consultant appointment panels. The Board endorsed this proposal.

DECISION: The Board delegated authority to NC and MK to source suitably qualified people for nomination as independent lay people to sit on consultant appointment panels.

NOTE: The Board noted the report from the Nominations Committee.

11.7 REPORT FROM THE REMUNERATION COMMITTEE

RE took the report as read. There were no questions/comments noted.

NOTE: The Board noted the report from the Remuneration Committee.

103/16 INTEGRATED PERFORMANCE REPORT

The Chair invited questions on the report that did not pertain to items 13.1 or 13.2. The following points of discussion were noted:

- BW observed that there had been minor improvement on the previous month's IPR. MK advised that some of the risks were significant and the position was somewhat balanced given there had also been areas of improvement.
- BW referred to the Caring Section of the report noting that the Sepsis CQUIN delivered percentage had been reported at 90% since June. SSm advised that the only area of under-achievement was related to the ward assessments. She undertook to check the data.
- BW observed that the RAG rating for uncoded spells was inconsistent. It was acknowledged that this data was likely to be inaccurate.
- NC observed the number of incidents under the Reportable Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) and asked if there was a corresponding increase in near misses. LS undertook to check the correlations. NC suggested this information should be included in the session scheduled for January.

ACTION: The January away day the presentation to include information on risk assessment across the sites.

ACTION: SSm to check the Sepsis CQUIN data. SSm

ACTION: LS to check correlation between RIDDORs and increasing near misses. LS

NOTE: The Board noted the Integrated Performance Report.

104/16 **TRUST IMPROVEMENT PLANS:**

13.1 CQC IMPROVEMENT PLAN & UPDATE AND
13.2 EMERGENCY CARE RECOVERY PLAN

These items were discussed together.
SSm took the reports as read and the following questions/comments were noted:

- BW sought confirmation that the recovery plans were working, suggesting it may be time to reconsider the plans given the performance metrics were not improving as expected.
- JE advised that internally, the focus area was ED (patient flow) and there were ongoing reviews and realignments of the plan. There were aspects of the recovery and improvement plans that relied upon changes being made within the whole health economy and she suggested that there needed to be more engagement/ownership and focus externally. Overall, she felt the plan was the right one.
- MK suggested that rather than forming new plans, there could be additions/augmentations of the current plan and a doubling of effort to implement the plan. He suggested that ECIP had demonstrated that the plan remained valid.
- SA suggested that the key leads working with the Trust to drive delayed transfer of care (DTOC) down could provide a presentation at a future awayday on progress.
- PS also considered the plan to be appropriate and noted that the implementation of the plan was the area of challenge. The STP included elements that would assist with the plan. He noted that one of the members of the A&E Delivery Board was not under the control of NHS England (Social Care), and advised that this was problematic.
- CT noted that he would like some assurance that the STP could align patient flow across the whole system.
- GG noted the difficulties that had been experienced in implementing the eCasCard system and noted the importance of learning from this experience to improve future implementation plans.
- MK requested that the Board formally note the work being undertaken by the Trust staff who were continuing to work on improvement plans despite the daily pressures. He asked that the Board provide positive feedback to the staff about their efforts.
- NG noted the importance of demonstrating that the employment of agency and locum staff was productive. He also noted the importance of ensuring that these staff were working with the same ethos as the Trust staff. SM noted that this had been a key point made during the ECIP presentation to Finance and Performance Committee.
- The Board endorsed the continuation of the plan but noted the importance of keeping this under review.

ACTION: Provide a presentation on DTOC at a future away day to focus the Board on what action is being taken and what progress is being made. JE

NOTE: The Board noted the updates on CQC Improvement Plan and the Emergency Care Recovery Plan.

105/16 **COMMUNICATIONS AND ENGAGEMENT UPDATE**

The Chair advised that the Board had been asked to:

- Note the Brand Alignment proposal (internal and external).
- Endorse Governor's Membership and Member's Engagement Strategy.

DECISION: The Board endorsed the Brand Alignment proposal.

DECISION: The Board endorsed the Governor's Membership and Member's Engagement Strategy.

NOTE: The Board noted the Communications and Engagement update.

106/16 **MEDICAL DIRECTOR'S REPORT**

PS took the report as read and the following questions/comments were noted:

- PS highlighted a recent case of tuberculosis within the Trust and outlined the actions that had been taken to protect public health.
- BW noted the observations made in the report about the work of Junior Doctors. PS spoke about the changes to the remit of the work of Junior Doctors in the urgent care centre and perceptions that had arisen as a result. MK advised that this issue tied in with the broader strategic changes about how sites were used and supported.

NOTE: The Board noted the Medical Director's report.

107/16 **MEDICAL REVALIDATION**

PS took the report as read and the following questions/comments were noted:

- PS thanked RE for his support in this area.
- BW noted the drop in performance since the last report. PS advised that he was seeking to ensure people understood that annual appraisal was a condition of the licence to practice.

NOTE: The Board noted the Medical Revalidation Report.

108/16 **FEEDBACK FROM COUNCIL OF GOVERNORS:**

17.1 REPORT FROM THE FULL COUNCIL MEETING HELD ON 24 NOVEMBER 2016

NC took the report as read and no questions/comments were noted.

NOTE: The Board noted the Feedback from the Council of Governors.

17.2 FEEDBACK FROM NEDS ATTENDING COG COMMITTEES

BW provided a verbal update from the CoG Audit and Governance Committee meeting:

- The reappointment of the external auditors had been approved.

RE provided a verbal update from the CoG Quality Committee meeting:

- There was nothing significant to add to the report that had been submitted.

SM provided a verbal update from the CoG Finance and Performance meeting:

- SA advised that there had been a request from the CoG FPC for regular updates on DTOC. JE sought clarification about which data had been requested (all delays or reportable delayed transfers). SA/JE

SM provided a verbal update from the CoG Strategic Workforce meeting:

- There was nothing significant to report.

GG advised that she and NY had attended the Membership Engagement and Communications Committee in December, where they had looked at the progress of the Membership Strategy and the demographics of membership versus the population.

109/16 **ANY OTHER BUSINESS**

SA suggested that the meeting schedule could be reviewed to ensure that the Board was reviewing current data during their meetings. It was agreed that SA could work with NG and SS on reviewing the schedule.

NC acknowledged the work of RH and RE and thanked them for their participation at the Trust Board. She noted that RE had been the longest serving member of the Board and spoke to the Board about some of the work he had engaged in during his period of service which had begun in 2011. The Board registered a formal note of thanks to Richard Earland and presented him with a gift.

ACTION: SA, NG and SS to review current meeting schedule to minimise the discussion old older information. SA, NG, SS

110/16 **QUESTIONS FROM THE PUBLIC**

The following questions were raised:

- Mr Smith thanked RE and acknowledged his work with the Trust.
- Mr Smith asked if the HomeFirst line was now operational. JE advised that the line had opened on the 23 November 2016. She reported that its implementation had made a difference in terms of ensuring better use of community beds and bed capacity. However, there was still insufficient care package capacity. MK summarised that there was improved process, but not improved availability on a consistent basis.
- Mr Smith requested that a glossary be included in the Board Pack to make it easier for the public to understand the acronyms used.
- Mr Sewell observed the fact that the Board had highlighted the pressures on

the ED and Acute Care staff. He asked if the new guidance from NHS England relating to release of beds in anticipation of a flu epidemic would enhance the current process (Black Alert). JE advised that the advice had been to use a standard term (Operational Escalation Level - OPEL) across the hospital sector that would make alerts easier for the public to understand.

- Mr Edel raised the issue of transparency in relation to remuneration. He noted that the Code of Governance detailed the guidance relating to Director remuneration. He referred to Section D12a that indicated there should be a formal and transparent procedure for Executive remuneration, but noted that this did not appear to have been detailed in the report provided at the meeting. The Chair undertook to take the question on notice.
- Mr Edel also noted his concern about the use of acronyms in the Board papers and the delay in accessing the Board papers more generally. The Chair advised that there were two Committees held just before the Board meeting and this was the reason for late access. Mr Edel suggested it was unreasonable to expect the public to read 300 pages a couple of days before the Board meeting.
- Junetta Whorwell congratulated that team on the Trust Annual Awards Ceremony. She thanked the members of staff who had attended. The Chair also acknowledged the hard work of the team who had arranged the event.

ACTION: Chair to respond to remuneration question raised by Mr Edel. NC

The Chair closed the meeting at 12.11pm.

Date of next meeting in public: Friday, 10 February 2017, Lecture Theatre, Queen Elizabeth the Queen Mother Hospital, Margate CT9 4BG

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 10 FEBRUARY 2017

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 9 DECEMBER 2016

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
81/16	7.10.16	**CHIEF EXECUTIVE'S REPORT** Advise the Board of KPIs for DTOC when determined. *Update in December:* JE meeting with Auditors to determine. Update to be provided to the February Board.	 JE JE	 February 17	
84/16	7.10.16	**INTEGRATED PERFORMANCE REPORT** Include update on demand management with external partners within the next report. Appropriate communication to staff re IDT challenges and initiatives being put in place.	 JE JE		
85/16	7.10.16	**IMPROVEMENT PLANS** Confidence threshold for delivery to be included in future emergency recovery plan reports (ED Recovery Plan). Board to be mindful of links between emergency recovery plan and IPR when reviewing performance.	 JE All	 Ongoing.	Currently re-basing as a whole systems delivery plan.
ACTIONS FROM THE LAST MEETING HELD					
99/16	9.12.16	**RISK APPETITE SESSION NOTES** Risk Manager to re-work this statement and populate the comments boxes for each statement.	 SSm	 February 2017	 Action complete.

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
		Some statements should be made both internally and externally to identify the higher risk tolerance and the context for this position.	MK		This has been discussed with the Risk Manager and Deputy Director of Risk Governance & Patient Safety. Action closed.
101/16	9.12.16	**BOARD ASSURANCE FRAMEWORK AND DELIVERY OF ANNUAL PRIORITIES: QUARTER 2** IAGC to review the BAF. MK to attend the session.	BW/MK	January 2017	Executive attendance was confirmed at IAGC in MK's absence. The Director of Finance & Performance and the Chief Nurse & Director of Quality were in attendance.
103/16	9.12.16	**INTEGRATED PERFORMANCE REPORT** The January away day the presentation to include information on risk assessment across the sites.		January 2017	Closed.
		SSm to check the Sepsis CQUIN data.	SSm	February 2017	CQUIN data has been reviewed and is now reported quarterly as per the submissions methodology has been checked and was accurate.
		LS to check correlation between RIDDORs and increasing near misses.	LS	February 2017	Investigation as to any relationship between near misses and RIDDOR appended to action log (Appendix 1).

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
104/16	9.12.16	**TRUST IMPROVEMENT PLANS** **CQC IMPROVEMENT PLAN & UPDATE AND EMERGENCY CARE RECOVERY PLAN** Provide a presentation on DTOC at a future away day to focus the Board on what action is being taken and what progress is being made.	JE		
108/16	9.12.16	**FEEDBACK FROM COUNCIL OF GOVERNORS** **FEEDBACK FROM NEDS ATTENDING COG COMMITTEES** **COG FPC** COG FPC requested regular updates on DTOC. JE sought clarification about which data had been requested (all delays or reportable delayed transfers).	SA/JE		This action will be progressed through COG FPC.
109/16	9.12.16	**ANY OTHER BUSINESS** **MEETING SCHEDULE** SA, NG and SS to review current meeting schedule to ensure the board was reviewing current data during their meetings.	SA/NG/ SS		The committee schedule was reviewed previously and agreed.
110/16	9.12.16	**QUESTIONS FROM THE PUBLIC** Chair to respond to remuneration question raised by Mr Edel. The issue of transparency in relation to remuneration. The Code of Governance detailed the guidance relating to Director remuneration. He referred to Section D12a that indicated there should be a formal and transparent procedure for Executive remuneration, but noted that this did not appear to have been detailed in the report provided at the meeting. The Chair undertook to take the question on notice.	NC		Action complete.

Summary Report on Investigation as to any Relationship between Numbers of Near Misses and RIDDOR Reports in EKHUFT

The incident data set was obtained from the Datix system for the period 1 January 2014 to 31 December 2016. The data set covered all health and safety incidents, including manual handling and needle stick. It is worth nothing that many "no-harm incidents" occur that are not recorded on Datix.

Comparison of Incidents with RIDDORs as a Percentage	13/14 Q4	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	Total
Reported as RIDDORS (excluding V&A)	10	5	2	4	9	9	7	3	7	1	11	7	75
Potential RIDDORs (excluding V&A)	165	134	170	178	216	199	167	190	164	198	146	182	2109
Percentage of RIDDOR's to Accidents	6.0%	3.7%	1.0%	2.2%	4.0%	4.5%	4.2%	1.6%	4.3%	0.5%	7.5%	3.8%	3.6%

As can be seen from the analysis there is no obvious correlation between the number of reported near misses and RIDDORs (over Qtr's) across the three years of data. The percentage of near misses that become RIDDORs varied between 0.5% to 7.5%, with an average of 3.6%. If the analysis were to be on a monthly basis the range would likely be even more variable. There is also no strong pattern over the period as to the average number of incidents occurring (176 per quarter on average).

In general it is believed the Trust's data set is too small to provide statistically significant information on any relationship between the number of incidents, the number of RIDDOR reports and any general indicators of stress/pressures; this is due to the large amount of variable factors which can affect each statistic.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**PATIENT EXPERIENCE STORY**
BOARD SPONSOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PAPER AUTHOR:	**NURSE CONSULTANT SPECIALIST PALLIATIVE CARE** **DIVISIONAL HEAD OF NURSING**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

The Board of Directors has been using patient stories to understand from the perspective of a patient and/or a carer about the experiences of using our services. Patient stories provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience. This month the story will be told by the wife of the patient at the Board of Directors meeting. Below is a short synopsis of the series of events that form the essence of their experience.

This month's story relates to the experiences of a lady Mrs W whose 57 year old husband after a very short illness with metastatic cancer of the colon sadly died last summer. Most of her husband's care and treatment was managed at the William Harvey Hospital through several teams and departments and although he eventually died in the Hospice, this was on the same day as transfer and was not co-ordinated or communicated well enough which led to a frantic few hours at the end of his life.

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence. They are also welcomed to listen to the narrative at the meeting and to seek clarifications from the Patient's wife.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	If we do not learn from the feedback from patients and their families there is a risk that we do not continue to make improvements to patient experience and outcomes.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	These may be articulated when the Board of Directors hear the story.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence. They are also welcomed to listen to the narrative at the meeting and to seek clarifications from the Patient's wife.

Board of Directors
Patient Experience Story
February 2017

Introduction
This month's story relates to the experiences of a lady Mrs W whose 57 year old husband after a very short illness with metastatic cancer of the colon sadly died last summer. Most of her husband's care and treatment was managed at the William Harvey Hospital through several teams and departments and although he eventually died in the Hospice, this was on the same day as transfer and was not co-ordinated or communicated well enough which led to a frantic few hours at the end of his life.

The Story
Mrs W explained that she was given no sense of how long her husband had to live; there was no obvious review of the plan; her husband became increasingly distressed; and although he was nursed in a side room he saw different doctors every day. Discussion with the Hospice was not coordinated effectively. Whilst the Palliative Care Nurse was wonderful, describing balance between intervention and treatment, this balance did not appear to happen. The doctor from the Hospice did not come to see Mr W, and the family felt that they needed to disturb the doctors for his antibiotics and to discuss blood tests (this was not done proactively). The family did not feel included in any treatment discussions.

Mrs W said: *'I know the Consultant cared very much ... the Palliative Care nurse did everything daily ... but there is a need to join the Hospice team and Hospital, and to link medical intervention and palliative care to better support families to take practical steps leading up to the death of their loved ones..'*

The key issues arising from the story were:
- Poor Communication and co-ordination within and across hospital teams and Hospice;
- Patients admitted under specialist teams receive the appropriate care for the presenting problem but that does not always take into consideration the palliative care nature of the disease which the palliative care team provide once referred by the wards.

The learning from the story includes:
- Clear information at the point of advancing cancer disease is crucial for patients and families to make informed decisions and plans;
- Tools are available to support practice and conversations which we as an organisation need to implement and embed to improve the quality and experience for all our deteriorating patients and their families.

Actions in place include:
- Governance has been strengthened with regard to the End of Life (EOL) Board with Executive, NED and Governor membership that add challenge to deliver improvements and unblock any difficulties;
- An EOL Improvement Plan is in place that is monitored through the EOL Board and CQC Improvement Plan Delivery Board;
- Site based working groups are now in place that include Serco, SECamb and multi-professional teams to operationlise the improvement work. These groups work to the same improvement plan to ensure consistency;
- The Interagency Policy was agreed in August 2016 that describes collaborative working across the health economy in Kent;
- The contractual agreement between the Hospice and Trust is being signed off. This formalises a joint relationship between the two organisations;
- Documentation to support EOL care has been introduced across the Trust. We have seen a marked improvement in completion of the documentation which has had a direct impact on improved care delivered in the ward and departments. This is evidenced through a reduction in complaints and through our 3 monthly audit process;

- There is in place an embedded training programme for all staff across the Trust. E-learning is in place and a proposal to make this mandatory for certain staff groups will be going to Management Board in February;
- In February 2017 the Compassion Project will commence. This is a collaborative piece of work with the Hospices to support staff in recognising patients who require EOL care;
- One hundred EOL link staff are in place across the Trust. All have received the appropriate training for the role;
- A Communications plan is in place with an internet web page with a staff questionnaire to identify where staff require support with EOL conversations and to describe what is going well for them.

The Board of Directors are invited to note the key themes of this story and the actions in place to prevent reoccurrence. They are also welcomed to listen to the narrative at the meeting and to seek clarifications from the Patient's wife.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**CHAIR'S ACTIONS**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**TO NOTE**
APPENDICES	**Quarter 3 Return to NHSI** **Press Release - Throat Cancer MDT**

BACKGROUND AND EXECUTIVE SUMMARY

The following decisions have been taken by the Chair since the December Board of Directors meeting:

- The Trust submitted its Quarter 3 Return to NHSI and a copy is appended to this report for information.

The following decisions have been taken by the Board since the December Board of Directors meeting:

The Trust had to submit its 2016/17 'firm' year end forecast on 24 January 2017.

Any change to the forecast requires completion of a Board Assurance Statement.

The year to date position as at month 9 was a £16.5m deficit which contains very limited risk reserves.

Whilst the last few days have seen some improvement in operational pressures, we have in January so far cancelled 152+ elective operations, a loss of income of c£500k. A change to the Injury Benefits discount rate (over which we have no control) means that we will have to make an additional £400k provision. There is the likelihood of additional Commissioning for Quality and Innovation (CQUIN) risk, and there is no provision for the Maidstone and Tunbridge Wells (MTW) Oncology Service Level Agreement (SLA). Whilst agency costs fell in December, these are expected to rise again in Q4.

Given the position it was recommend that a £23m deficit forecast be submitted. We will be seeking to reach the best possible year end position, but this reflects a realistic assessment of where we stand with 64 days of the year remaining.

This position excludes the outcome of the £6m of Clinical Commissioning Group (CCG) challenge and NHSI are aware that that will not be known at the time we submit

As there was no Finance and Performance Committee or Board meeting, members, after due consideration, confirmed their agreement to the forecast by email.

Working with Partners

A smartphone app designed to cut waiting times at accident and emergency departments in east Kent has been launched by the Kent Community Health NHS Foundation Trust.

The WaitLess app combines current waiting times at all urgent care centres with up to date travel information.

WaitLess is available now, free to download from iTunes and Google Play.

http://www.encompass-mcp.co.uk/got-a-minor-injury-wait-less/

Kent Cancer Trust Annual lecture – sponsored research

I attended lecture which showcased collaborative working between bio-scientists from the University of Kent and clinicians, pharmacy and speech therapy staff from the East Kent Hospitals University NHS Foundation Trust. In particular it was addressing a problem with an inplant that is used to restore speech after a laryngectomy. This was a great example of Kent institutions leading the way with a new standard protocol for patients, developed by this group, being adopted not only across the whole NHS, but as far afield as Australia. In addition there is exciting further research work on how to treat different fungal species, new designs for the implants used for speech to detect infestations and reduce the incidence of infections.

Key activities and meetings

- *Christmas visit to wards:* I had an interesting and thought-provoking time on Christmas day, visiting a lot of consummate professionals focused on delivering the very best care to our patients. I visited 56 wards, where the staff were making the day a bit more special for those people who found themselves in hospital. Thank you for everyone who gave me a warm welcome and for making my day special, too.
- *HFMA Chairs Conference*: This was a sober affair with many Trusts feeling the impact of the winter season. Presentations from Stephen Hay and Stephen Dorrell
- *Chairs Sustainability and Transformation Plan (STP) meeting with Ruth Carnell and Glen Douglas*: This was well attended by the NHS Provider Chairs in the region, but was very light on CCG Chair representation with only one CCG Chair attending. The meeting discussed the structural governance arrangements and the biggest risks facing the STP implementation.

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

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

RECOMMENDATIONS AND ACTION REQUIRED:

(a) Discussion and support with divisional engagement.

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Monthly In Year Financial Reporting Return 31 Dec 2016

East Kent Hospitals University NHS Foundation Trust

Plan data sourced from your latest submitted plan

IYR - Version: 17.9.3.1

Validation errors: 6

*Enter **1** here only if there are errors flagged which your relationship team have been notified of.*

Validation message: Template contains errors to correct prior to submission

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Name:

Job Title:

Signature: i

Your relationship management team at NHS Improvement:

Contact: **Neil Smart**
Email: neil.smart3@nhs.net
Tel: 02037470616

Or: **Neil Smart**
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Content Type: **Trust Return**
Activity: **Monthly Monitoring**

Click to go to index

Summary reconciliation to FTC form

RECONCILIATION OF IN-YEAR MONITORING INFORMATION TO FINANCIAL ACCOUNTS

Financial information submitted in this monthly monitoring form and in the FTC form should be consistent. This table summarises the key information which must be consistent between returns. An additional optional tool has been issued to assist in comparing these summaries.

Where your foundation trust was authorised on or after the 1st May 2016, the summary below includes only the financial performance for the period after you were authorised as an FT.

Please note that the units below have been converted to £'000 from the data entered in £m in your monthly monitoring return. This aids direct comparison against the equivalent sheet in your completed FTC template.

Following submission of the FTC form, no changes should be made to the reported financial performance prior to submission of this return. Should any material errors be identified in the performance reported in your FTC during this time, please contact ft.accounts@improvement.nhs.uk prior to submission of this return.

	Expected sign	YTD post authorisation £000
INCOME & EXPENDITURE		
Operating income		
Total operating income (including discontinued operations)	(+ve)	384,595
- of which STF	(+ve)	4,025
- of which income from Capital Grants & Donations	(+ve)	179
Operating expenditure		
Total employee Costs	(-ve)	(227,989)
- of which Agency (excluding external bank)	(-ve)	(18,414)
Total operating non-pay expenditure	(-ve)	(160,856)
- of which PFI impairments & reversals - DEL	(+/-ve)	-
- of which PFI impairments & reversals - AME	(+/-ve)	-

- of which Donated/granted asset impairments & reversals - DEL	(+/-ve)		-
- of which Donated/granted asset impairments & reversals - AME	(+/-ve)		-
- of which other asset impairments & reversals - DEL	(+/-ve)		-
- of which other asset impairments & reversals - AME	(+/-ve)		(145)
- of which depreciation and amortisation of donated / granted assets	(-ve)		(561)
- of which (increase)/decrease in provision for impairment of receivables	(+/-ve)		260
Non-operating income / expenditure			
Gains / losses on disposal of non-current assets	(+/-ve)		-
- of which capital grants in kind issued	(-ve)		-
PDC dividend expense	(-ve)		(5,443)
Gains / losses from absorption transfers	(+/-ve)		-
Corporation Tax expense	(-ve)		-
Surplus / (deficit) for the year before tax	(+/-ve)	i	(9,849)

PROVISIONS FOR LIABILITIES & CHARGES

Provisions arising	(-ve)	-
Provisions reversed (not utilised)	(+ve)	-
Provisions utilised	(+ve)	204

PFI

Adjustment to remove revenue IFRIC 12 impact (revenue costs of IFRS)	(+/-ve)	-
Adjustment to remove capital IFRIC 12 impact (capital costs of IFRS)	(+/-ve)	-

NET CAPITAL EXPENDITURE

PPE, Intangibles, Investment Properties & Assets held for sale:		
Additions - purchased by FT or bought using donated/granted cash (PPE, Intangibles & Investment Properties)	(+ve)	7,121
Additions - leased (PPE & Intangibles)	(+ve)	-

Additions - donations of physical assets (PPE & Intangibles)	(+ve)	179
Carrying value of asset disposals (PPE, Intangibles, Investment Properties & Assets Held for Sale)	(-ve)	-
Investments:		
Investments acquired	(+ve)	-
Carrying value of investment disposals / sales	(-ve)	-

East Kent Hospitals University NHS Foundation Trust

Quarter 3 2016/17

PERFORMANCE AGAINST STF TRAJECTORIES AND FORECAST

This update sets out the quarter 3 performance against the four main Access Standards for East Kent Hospitals University NHS Foundation Trust. It aims to describe the factors leading to the current performance, the actions being taken to resolve the issues and the forecast position to the end of the financial year.

A&E

Current Performance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%
Actual	84.06%	82.69%	85.40%	82.87%	82.24%	84.29%	79.35%	75.76%	74.23%			

ECASCARD

The Trust has now introduced ecascard into both majors departments at both the William Harvey Hospital (27th September), and into the Queen Elizabeth, the Queen Mother Hospital (from 25th during October). Implementation of this system is aimed to bring real-time recorded activity to the A&E department, and being one of the first organisations in the country to go paperless, and provide up to date, real time tracking of patient journeys through the department.

The implementation plan has highlighted the requirement for clinical staff to use the system in real time and ensure that staffs always fully track patients throughout their pathway. Although 24/7 training and support has been available within the departments there have been issues with staff adapting to using the new system; which have slowed down processes and caused increased breaches, particularly in the evenings and overnight.

Since the implementation there has been a decrease in performance against the 4 hour target; actions have been taken to increase management support, training and speedy resolution of issues. Executive and senior Divisional management are actively monitoring and supporting the situation to resolve issues and compliance to fully using the system to support patient care and flow through the departments. We expect to see an improvement by the end of January 2017.

OUT OF HOURS PRIMARY CARE & NHS 111

Primecare are the providers of the out of hours service and NHS 111. There have been intermittent issues with consistent GP cover on the rota out of hours at weekends and overnight. It has been noted that there was an increase in paediatric attendances in the evenings and weekends. In response to this increase, the ED has booked a senior paediatric doctor to work on the middle grade rota and manage the increase in activity.

East Kent Hospitals University NHS Foundation Trust

ED MIDDLE GRADE VACANCIES

At QEQMH there is an on-going issue in recruiting substantive middle grade doctors. There are now 13 vacant posts resulting in a high dependency on agency doctors. It is recognised that this is not a sustainable position and therefore a business case is being developed to develop advanced nurse practitioner (AHP) posts. This will be a 3 – 5 year strategy to train 8 AHP's per year. In the meantime on-going recruitment will continue, including the development of internal rotations and training programme to enhance the posts.

The on-going risk to delivery of the trajectory is;

- On-going 5% increased demand to ED. These high levels of activity, particularly in the evenings make it very difficult to discharge frail elderly patients home.
- Impact of Primecare, the new out of hour's primary care provider.
- A high % of breaches of the 4 hour emergency access standard relate to implementation of the new ECASCARD system as staff become accustomed to using the system in real time.
- High numbers of patients attending ED in the evenings and weekends who could be managed by primary care, in particular paediatric attendances.
- Poor patient flow due to lack of timely bed availability.
- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.
- Impact on the ED when trying to manage high risk patients attending with a mental health condition, and who are awaiting assessment overnight by the Crisis Team.
- Delays in mental health bed availability.
- Middle grade medical staffing vacancies and unfilled gaps in rotas due to lack of agency or substantive staff. QEQMH is a particular risk due to the geographic location of the hospital.
- Nursing vacancies across the emergency floor at QEQMH.

Mitigating actions

- Increased daily SITREP meetings with Chief Operating Officer or Divisional Director leadership at the 08:00, 13:00 and 16:00 meetings. Action focussed and structured meetings following the Trust Escalation Action Cards.
- Detained reviews of patients on the IDT working caseload and also of all admitted patients to ensure that all patients pathways are being proactively managed.
- Additional management support, at Executive and General Manager on call level has been provided at WHH and QEQMH at weekends and weekday evenings, with escalation to the CCG Executive on call to ensure all external stakeholders were aware and supporting the Acute Trust.
- Greater senior clinical engagement into the Operational Control Centres with peer review and challenge of patient flow issues.

East Kent Hospitals University NHS Foundation Trust

- Additional internal and agency medical staff have been booked to provide senior clinical support in the Emergency Departments and also to enable senior medical review at the weekend.
- Continued support and close working with SECAMB to ensure that patients are handed over safely.
- ECASCARD issues are being monitored, with issues being actioned as a priority in order to make improvements to the system. Increased communication and training has been provided in real time to staff.

Year End Forecast

Due to the following on-going issues with;

- increase in majors attendances
- high acuity patients with respiratory, cardiac, stroke and sepsis conditions
- Continued ambulance surges, particularly in evenings with frail elderly patients
- Increasing DTOC

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%
Actual	84.06%	82.69%	85.40%	82.87%	82.24%	84.29%	79.35%	75.76%	74.23%			
Forecast				N	N	N	N	N	N	N	N	N

Cancer 62 Day

Current Performance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	74.19%	76.40%	77.65%	77.42%	82.72%	85.37%	85.03%	85.49%	85.24%	85.05%	85.44%	85.17%
Actual	71.04%	79.20%	75.42%	70.94%	75.08%	71.50%	70.00%	72.77%	76.15%			

Exception Report

The issues impacting on 62 day performance over 2016/17 are;

- Urology MRI waiting times
- Urology TRUS Biopsy waiting times
- Urology TRUS Biopsy results clinic waiting times
- Colonoscopy waiting times
- Polypectomy waiting times
- Inpatient Hysteroscopy waiting times
- CT colonoscopy waiting times
- MRI awaiting times
- CT Guided Biopsies waiting times

East Kent Hospitals University NHS Foundation Trust

- US Guided Biopsies (Not Breast) waiting times
- H&N elective diagnostic procedures waiting times
- H&N capacity for Skin treatments
- Variations in turnaround times for Histo-pathology
- Variations in turnaround times for Radiology reporting
- Review of results and next stage planning

Mitigating actions

The actions outlines below are agreed to improved performance and help the Trust deliver against the 62 day target

Tumour site	Action	Comment	Deadline
TRUST	2ww waiting time reduction	7 day target. Walk in clinic approach should be considered	10/04/2017
TRUST	Consideration of 62 day flag for target patients	The Trust currently uses the same Cancer pathway flag for Diagnosed and Suspected patients. This urgent flag cover patient being investigated, patient who have received treatment and are under review for all routes. The Trust must consider having a separate 'Suspect Cancer' flag to ensure urgent capacity is used for patients were cancer need to be ruled out or test will support the patient receiving 1st treatment for cancer within 62 days. All other referral types for cancer should be done with 14-20 days and Suspected cancer 7-10 days.	01/03/2017
TRUST	Cancer Pathway flag usage	Clinical staff need education on usage of Urgent flagging and consequences	01/02/2017
TRUST	PTL Actions	PTL actions need to be recorded against the name of staff responsible. All action should be completed within 48hours of PTL meeting. Outstanding actions will be discussed and actioned at the Trust KPI meeting with the COO.	19/01/2017
TRUST	Process of Booking 1st Diagnostic test for patients after 1st seen appointment.	Every patient who remains on a 62 day pathway having a Radiology or endoscopy test should be given that appointment before they leave the hospital after 1st seen appointment. Diagnostic booking staff could be available at Outpatient reception to book appointments and talk patients through any preparations needed. Dates of test can then be reinforced as urgent with the patient and dates agreed within the time frame needed for the pathway to achieve compliance. Levels of carve out of capacity will need to be established.	31/05/2017

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TRUST / Colorectal / Gynae	Review of results planning and information support of process. Introduction of Consultant Cancer PTL	Review of next steps and results of tests has proven to be an issue in Quarter 3. Results need to be reviewed with 24 hours of report ready. Information and Development can support this process for clinicians to review. A Consultant Cancer PTL (which lists their patients and shows if Radiology or histology reports are ready) for quick turnaround on next step of pathway. This can be used for all pathways.	28/02/2017
Colorectal	Support of Endoscopy waiting time reduction. No Polypectomy should take place past 62 day	Work for extra capacity should continue and closer working between Surgery and Medicine to resolve issue of capacity and practice.	31/05/2017
Colorectal	Endoscopy theatre process for cancer pathway biopsy. Orange bag process introduced	A review and audit should be undertaken on clinical areas where biopsies are taken. The process of how patients are identifies as 62 day Cancer pathway and how specimens are flagged at Cancer pathway need to be reviewed urgently. After this review had identified areas of improvement the Orange bag process for Histology should be introduced and monitored weekly. Monitoring brought to weekly KPI.	01/04/2017
Colorectal	CT Colon waiting time	Extra capacity for procedure and reporting need to be introduced	31/03/2017
Colorectal	Reduction of waiting times for Oncology	Waiting times for Lower GI oncology referrals needs to be 7 days from referral to Oncology seen	31/05/2017
Urology	PSA clinic capacity	Ensure that Urology has enough 2ww PSA clinics so PSA referrals are always seen in dedicated clinics. This in turn will support the rest of the pathway in the process of MRI, TRUS Biopsy and results clinic booking all within set time frames. A daily report re set time frames to book to already exists.	01/04/2017
Urology	TRUS Biopsy & result clinic capacity to support 2 week turnaround	Booking of TRUS Biopsy appointments on a 62 day pathway should be made after with the patient after PSA clinic. Capacity work needs to be undertaken to ensure there is sufficient capacity to deliver 14 day turnaround for this test. Staffing to address current backlog need to be addressed urgently. Trust Results clinics appointment or Treatment discussion appointments should never be booked past 62 day.	01/04/2017
Urology	MRI bookings on Prostate patients	Patient requiring TRUS Biopsy test are required to have a MRI test before Biopsy appointment. There will be a 14 day target for the TRUS biopsy to be delivered. Radiology capacity must be able to support the pathway so that the MRI is undertaken and reported within 14 days of request. The TRUS Biopsy appointment must dictate the MRI appointment and reporting.	01/04/2017
Urology	TURP & TURBT	No TURP & TURBT should be TCI past 62 day breach date. Communication and identification of 62 day cancer pathway patients for waiting list staff and escalation loops need to be in place were capacity can be flagged and actioned before any patient is TCI'd if at risk of breaching.	01/02/2017

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Urology	Da Vinci capacity & Nephrectomy capacity	Delivery of Robot procedures should be reviewed weekly and assurances give each week to Divisional Director. Any issues brought to KPI with issue and action.	01/02/2017
Urology	Protocol driven pathways	Pathway protocols have been written by Lead Urologist. Clinical and Operational management must challenge if these protocols are not followed	01/02/2017
Gynae	Planning of TCI at MDT	If TCI capacity is not sufficient to support treatment within target this should be escalated to Senior Operational management. Resolution needs sourced by close working between Clinical and Ops staffing, re working of currently booked lists or extra capacity.	01/02/2017
Gynae	Hysteroscopy waiting times	Capacity need to be in place and sustainable for the delivery of Hysteroscopy within 10 days or less.	01/04/2017
Lung	EBUS capacity	Internal capacity for 10 day turnaround	01/04/2017
Lung	Radiology Reporting of CT scans	Reporting for CT scan should include comment if tumour is accessible for biopsy	01/02/2017
H&N / Thyroid / Skin	Escalation of capacity	No patient for H&N, Thyroid or Skin should be given a TCI beyond 31 days or 62 day target (for 62 day, unless Decision to treat is less that 14 days before 62 day target and is agreed with Divisional Director)..	01/04/2017

Year End Forecast

Based on current identified issues and timeframes indicated for delivery of solutions the Trust currently faces non-compliance for 62 day standard for Quarter 4 2016/17.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	74.19%	76.40%	77.65%	77.42%	82.72%	85.37%	85.03%	85.49%	85.24%	85.05%	85.44%	85.17%
Actual	71.04%	79.20%	75.42%	70.94%	75.08%	71.50%	70.00%	72.77%	76.15%			
Forecast				N	N	N	N	N	N	N	N	N

Referral to Treatment (RTT)

Current Performance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%
Actual	88.56%	87.88%	86.81%	86.65%	85.52%	85.11%	86.03%	85.79%	83.83%			

Exception Report

Throughout Q3 performance against the standard fell to 83.83%. This significant reduction in performance was driven by a combination of factors. Throughout December the Trust planned to reduce clinical outpatient and surgical activity due to the festive period. A surge in an unprecedented number in non-elective demand, led to beds and emergency services coming under extreme pressure. This led to the postponing of some outpatient clinics to release clinician time for inpatient work, and an increased cancellation rate for elective surgery, primarily driven by a

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reduction in surgical bed availability. The Medical Director, Chief Nurse and the Chief Operating Officer are working closely together to make sure all these decisions take into account clinical need, quality of care and patient safety.

In addition to the loss of capacity, as operational focus was directed to unblocking delays and improving patient flow to ensure business continuity, resource was taken away from validation of RTT pathways throughout December. Further challenges were also observed in all specialties, with high vacancy and sickness rates, combined with an inability to recruit short term clinical cover for Gastroenterology services has led to a significant increase in patients waiting over 18 weeks for a first outpatient appointment.

Encouragingly the number of patients who were waiting for treatment for more than 52 weeks as at the end of the month reduced to 12 by the end of December.

Mitigating actions

The Trust, working in partnership with the four local clinical commissioning groups and NHS Elect, has developed a detailed action plan with itemised schemes which is being monitored on a weekly basis. This challenging recovery Trajectory will require significant investment from both the Trust and the CCGs to reduce waiting list sizes to sustainable levels. South Kent Coast CCG have been successful in a bid to NHSE for additional funding to support outsourcing of Gynaecology and Orthopaedic patients directly from the EKHUFT elective waiting list in order to improve performance by the end of March 2017.

Year End Forecast

The Trust maintains its forecast that compliance in this standard **will not** be achieved for the remainder of 2016/17.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%
Actual	88.56%	87.88%	86.81%	86.65%	85.52%	85.11%	86.03%	85.79%	83.83%			
Forecast				N	N	N	N	N	N	N	N	N

DM01

Current Performance

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%
Actual	99.78%	99.87%	99.86%	99.77%	99.56%	99.74%	99.91%	99.88%	99.72%			

Exception Report

Standard compliant; no exception report required.

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Mitigating actions

No immediate actions.

Year End Forecast

The Trust maintains its forecast to achieve compliance in this standard for the remainder of 2016/17.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Trajectory Compliance	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%	99.51%
Actual	99.78%	99.87%	99.86%	99.77%	99.56%	99.74%	99.91%	99.88%	99.72%			
Forecast				Y	Y	Y	Y	Y	Y	Y	Y	Y

Kent cancer trust
Supporting research for Kent

Kent Cancer Trust is a registered charity (No. 1105730) and a company limited by guarantee registered in England and Wales under company reference 4697468. Its registered office is at Lancasters, West End Lane, Henfield, West Sussex BN5 9RB

27 January 2017

PRESS RELEASE

Kent Cancer Trust holds meeting at the University of Kent on Friday 20th January to announce results from the project it has helped to fund aimed at improving the treatment of patients who, because of throat cancer, have had their larynxes removed.

The meeting received a fascinating description of the problems faced by patients who have had to have their larynxes removed and produce voice via small prostheses made from silicone.

We heard how staff from the East Kent Hospitals University NHS Foundation Trust and Kent Community Health NHS Foundation Trust had linked up with the School of Biosciences at the University of Kent to form a multidisciplinary team (MDT). This had defined the problem and recommended a new way of preventing a fungus, *Candida albicans* from colonising the voice prosthesis, causing it to fail. Kent Cancer Trust has made a small, about £30k to date, contribution to the cost of a PhD student to enable this work to go ahead, a contribution that complemented the funding for the project and enabled it to progress. In turn, the multi-disciplinary team has produced a new treatment protocol that achieves considerable benefits based on strong scientific analyses.

Patients are asked to apply a small quantity of carefully selected antifungal medication to the voice prosthesis each day. The guidelines also cover what action is most appropriate at every stage of treatment. The team report that in using these guidelines to prevent Candida growth, patient outcome is greatly improved. Those who normally had their voice prosthesis replaced every 2 to 3 weeks as a result of its failure found that this was extended to in-excess of six months. Naturally this makes a huge difference to patients and helps to prevent some of the other complications that can arise when the voice prosthesis fails, e.g. a chest infection. For the clinical staff, patients have to be seen less frequently. Smaller quantities of antifungal medication are used than before the guidelines existed. All this has a favourable effect on the overall cost of treatment.

The treatment protocol has been approved as a set of guidelines by the East Kent Hospitals Trust and Kent Community Health Trust and after their publication have attracted

significant interest. At the time of writing, and immediately following their publication, the guidelines were sought by 28 NHS trusts in England, Scotland, Wales and Northern Ireland and as far afield as Australia. This is an impressive uptake that demonstrates a need for this treatment protocol and we anticipate further uptake in the coming months. Crucially the Kent MDT will gather data from those hospitals taking up the new treatment regime to ensure quality control and implement further improvements to the pathway.

Rather than sitting on its hands having achieved such a success, the MDT has initiated a number of innovative research programmes to find additional improvements. Would it be possible for the patient to monitor the performance of the prosthetic device from their own home using built in wireless technology that can be read using a mobile phone? Would it be possible to re-formulate the silicone material from which the voice prosthesis is made to reduce the likelihood of it being colonised by fungi in the first place? The MDT is making rapid progress in both these areas. Watch this space!

Overall, the multidisciplinary team has more than accomplished what it set out to do and we in Kent Cancer Trust are in the enviable situation of having backed a winner!

Even more importantly, we have demonstrated that a team of clinical staff and a university scientific team can achieve great things in a short space of time if the right question is asked. Kent Cancer Trust will therefore actively seek other problems that would benefit from scientific study using a similar MDT based approach to provide tangible patient benefit.

For further information, please contact:

Kent Cancer Trust: timbentley.tanglewood@gmail.com

University of Kent: C.W.Gourlay@kent.ac.uk

East Kent Hospitals University Foundation Trust: sarah.stevens@nhs.net

The full recorded lecture can be accessed on you tube using the following link:
https://youtu.be/35CBA1lN8Gw

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

The Chief Executive provides a monthly report to the Board of Directors providing key updates from within the organisation, NHS Improvement (NHSI), NHS England (NHSE), Department of Health and other key stakeholders.

The monthly report from the Chief Executive provides the Board of Directors with key issues related to:

- **IMPROVEMENT JOURNEY / CARE QUALITY COMMISSION (CQC)**
- **FINANCIAL PERFORMANCE**
- **ACTIVITY AND PERFORMANCE**
- **CLINICAL STRATEGY UPDATE AND STP PUBLICATION**
- **LEADERSHIP ASSESSMENT AND DEVELOPMENT PROGRAMME**
- **BME STAFF CONFERENCE**
- **FEEDBACK FROM MANAGEMENT BOARD**
- **GOOD NEWS STORIES**
- **CHIEF EXECUTIVE ACTIVITY**

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks around ED, Financial Recovery are covered in more detail elsewhere on the Board agenda.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	*ED, Financial Recovery, clinical strategy all link to the strategic risk register.*
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Executive Management Team have reviewed the Board Governance Review Action Plan

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

RECOMMENDATIONS AND ACTION REQUIRED:
To note the report.

CHIEF EXECUTIVE'S REPORT

1 EXECUTIVE SUMMARY

1.1 CQC Visit Update/Improvement Journey

As previously reported, the Trust in September 2016. The CQC's report was published in December and showed widespread improvements to the quality of care patients receive.

The Trust was placed in special measures by Monitor (now NHS Improvement) in 2014 when the CQC rated the Trust 'inadequate'. A year later the Trust was upgraded to 'requires improvement' as a result of "big steps forward" witnessed by the CQC. The Trust remained in special measures to allow more time to fully embed the improvements.

This third inspection for the Trust looked in detail at emergency care, medical services, maternity and gynaecology and end of life care at Kent & Canterbury, William Harvey and Queen Elizabeth the Queen Mother hospitals. It also focussed on how "well led" the Trust was.

The Trust now has no "red" inadequate scores and Sir Mike Richards, England's Chief Inspector of Hospitals, has recommended that the Trust be taken out of special measures as a result of "further significant improvements" for local patients.

NHS Improvement (NHSI) will make the final decision about whether the Trust will come out of special measures. The regulator's decision is expected at the end of February.

The CQC held a Quality Summit on 12 January. This was attended by the Chair of Health Overview and Scrutiny Committee, NHSI, East Kent Hospitals Trust and local partners. The CQC presented its findings, the Trust gave an update on further improvements it had made since the re inspection in September and NHSI led a discussion about the next steps, which focussed on partnership working.

CQC Report Findings

Key findings include:

- Safer emergency services at all hospitals Improved medical care at all hospitals
- All hospitals rated 'good' for 'caring' Outstanding practice was found in the Trust's Improvement and Innovation Hubs
- Improved leadership
- Improved staffing
- Better culture within the Trust
- Improved end of life care Improved maternity services

The CQC reports also highlighted further areas for improvement, such as recruiting and retaining more staff, enabling more patients to access treatment sooner, improving the flow of patients through our hospitals, fully embedding early signs of improvement in maternity and end of life care, and making financial savings.

As well as the overall Trust rating the CQC gives an individual rating to each of the Trust's three hospitals inspected this year.

- **William Harvey Hospital, Ashford** - rated 'requires improvement' overall, 'good' ratings for critical care and outpatient and diagnostic imaging.

- **Queen Elizabeth The Queen Mother (QEQM) Hospital, Margate** - rated 'requires improvement' overall, with medical care, critical care, services for children and young people, and outpatient and diagnostic imaging all 'good'.
- **Kent and Canterbury Hospital (K&C), Canterbury** – rated 'requires improvement' overall, with the urgent care, critical care, services for children and young people, and outpatient and diagnostic imaging all 'good'.
- The ratings for the Trust's two hospitals in Dover, **Buckland Hospital**, and Folkestone, **Royal Victoria Hospital**, were rated 'good' in 2015 and not re-inspected in September.

The Trust is committed to continuing its improvement journey and building on the progress it has made with a dedicated team, improvement plan and close working relationship with its partners and regulators.

NHS Improvement is working with the Trust to develop an integrated plan that reflects the actions required by the whole system. This includes our CCG, community, mental health, ambulance and social care colleagues. Performance against the plan will be managed through a new system oversight group chaired by NHSI. The first meeting is planned for late February 2017 ahead of the final decision on the Trust coming out of special measures.

1.2 Financial Performance

The Trust's monthly income and expenditure (I&E) deficit in December (month 9) was £2.5m compared to £1.3m in November. This was roughly in line with the forecast trajectory through to year end driven by income being £2.8m lower in month.

The year to date I&E deficit stands at £16.5 with sustainability and transformation funding (STF) income of £4m relating to Q1 having been received. No further STF is expected.

Pay costs in the month of £28.2m included agency and locum costs of £2.2m which now stand at £20.4m for the year to date against the ceiling trajectory of £18.8m. Spend reduced by £0.4m in December through staff taking leave and fewer working days. Of the December agency spend, 70% related to medical staff. The agency spend is forecast to rise again in Q4.

Total income was £46.9m in month 9. Use of the independent sector increased for the fourth consecutive month to £1.2m driven by Ophthalmology, Endoscopy and Orthopaedics. Against the initial £20m CIPS target, including income, for the year to date £11.7m has been delivered against a target of £13.6m.

The Trust is continuing to discuss its cash requirements with NHSI and to the end of M9 had accessed £12.8 of its approved interim credit facility of £14.6m. The latest forecast submitted to NHSI indicates a requirement for c£28.5m.

The Trust's is working to a year-end forecast that is has as small a deficit as possible and at present a figure of £23m is the most likely position. The Trust has put in place a set of measures following the Board meeting designed to help deliver the year end forecast but has been experiencing, in common with the majority of acute trusts, extreme operational demand-led pressures, with high levels of occupancy, poor flow and an increase in cancelled operations.

The quarter 4 (Q4) position must be a substantial improvement on the year to date performance if forecast position is to be achieved.

The forecast is rated as high risk as a result of:

- Workforce pressures increasing in Q4
- Potential activity and income reductions in Q4
- Continuing and significant demand and activity pressures in emergency care
- High levels of cancelled operations, occupancy rates and delayed transfers of care
- High level of commissioner challenge continues (£6m)
- Oncology Service Level Agreement with Maidstone Tunbridge Wells NHS Trust £0.5m+ risk
- Minimal reserve against fines, penalties and challenges and the crystallisation of those risks

The Trust continues to work with NHSI to review our Financial Recovery Plans.

1.4 Activity and performance Update

The December Integrated performance Report demonstrates continued improvement in the 62 day cancer and referral to treatment targets. There has been marginal increase in the cancer 31 day (diagnosis to treatment) which is now reporting nearly at target.

The 4 hour target continues to be an area of significant challenge for the Trust, with performing reducing further in December to 74.23% compared to 75.76% in November 2016. Support continues to be provided by the Emergency Care Improvement Programme as well as the internal focus and both will remain in place until improvements are realised.

Actions being taken to mitigate risk and improve performance are outlined in detail within the Integrated Performance Report and the Emergency Care Recovery Plan but includes specific internal work as well as a real focus on expanding out of hospital capacity in the immediate future.

2 CLINICAL STRATEGY UPDATE AND STP PUBLICATION

The work that was previously reported as underway to revise the terms of reference for the East Kent Strategy Board has been completed and this has now become the East Kent Delivery Board.

There is an intense programme of Sustainability and Transformation Plan (STP) work with governance meetings in place, with most work streams meeting weekly and holding half day work shop style meetings every other week. This is supporting work to be completed at pace to meet a challenging but deliverable timetable set out in the STP that was published at the end of November 2016.

The hospital transformation work stream, for which I am Senior Responsible Officer, has identified the key services for review and has developed an initial set of evaluation criteria against which the hospital options will be tested. We will be engaging widely on these criteria with our staff and the public over the coming weeks.

3 EKHUFT'S LEADERSHIP ASSESSMENT AND DEVELOPMENT PROGRAMME

In late November, NHSI gave approval for the first phase of EKHUFT's leadership assessment and development programme.

The overall objective of the programme is to ensure that the Trust has leaders who are able to lead turnaround and then transformational change to deliver the vision,

mission and strategic priorities. The aim is to do this by supporting and developing clinical and non-clinical leaders to deliver EKHUFT's current business plans and longer term clinical strategy as well as to align a number of, currently disparate, transformation projects (Cost Improvement Programmes (CIPs), CQC Improvement Plan, Cultural Change Programme).

The programme will be delivered in partnership with EY and Plum Consulting. Initial work involves our partners carrying out an alignment review of our major programmes. From this review they will present the following recommendations to the Executive team:

- a Strengths, weaknesses, opportunities and theats (SWOT) analysis of current leadership challenges to delivery
- a long-list of projects to support turnaround and transformation with indicative timescales
- transformation projects which may accelerate progress
- strengths and weaknesses in the supporting infrastructure relevant to the delivery of the transformation programmes

As part of their own development programme, the Executive team will then decide on and sponsor those projects they consider will have the biggest impact, and support the 200 clinical and non-clinical leaders to deliver them.

The Alignment Review took place during late January and the Executive development programme begins in February. These two components make up the first phase. The aim is to commence the wider programme early in the new financial year pending further financial support from NHSI.

4 BME STAFF CONFERENCE

The Trust held its BME Staff Conference in mid-December 2016. The aim of the conference was to ensure staff felt involved in improving behaviours towards minority staff and patients.

Measures have been put together in the Workforce Race Equality Standards (WRES) Action Plan and staff were asked to feedback whether these have been successful and what changes were needed.

Staff were asked for their support in assessing equality performance using Equality Delivery System 2 (EDS2). EDS2 will see the direction for the future of diversity and inclusion in this Trust by informing the Equality Objectives we set for the next two years.

The Trust has recognised there is work to do and the WRES Metrics will assist us with this. As an example, white candidates are currently 1.5 times more likely to be appointed at interview than Black and Minority ethnic candidates.

Our last staff survey reports that 15% fewer BME staff than white staff believe that we provide equal opportunities for career progression or promotion. Whilst in 2015 over 20% of BME staff personally experienced discrimination at work from their Manager, team leader or other colleagues only 9% of white staff had similar experiences.

I chair the Trust's Diversity & Inclusion Steering group and I sit there alongside a Non-Executive Director, two Executive Directors and all Divisional Directors. The Steering Group is driving forward change in the equality agenda in EKHUFT and will do all it can to eliminate discrimination and is responsible for the WRES Action Plan and leads on the EDS2 to improve services we provide for our communities and

provide better working environments, free of discrimination, for those who work in the Trust.

Inclusive leadership is important to hear all voices to empower all to contribute to the achievement of high quality, continually improving and compassionate care. That includes groups who currently experience high levels of discrimination be it on the grounds of ethnicity, gender, sexual orientation or disability status.

To enable leaders to hear all voices and empower everyone to contribute the trust will provide support to develop the BME Network further by:

- Providing time off for network duties
- Provision of secretarial/administrative support
- Financial support
- Support to communicate the benefits of network membership across the Trust

Support for employee networks explicitly demonstrates the Trust's commitment to diversity and inclusion, and shows that it values all its staff. It highlights that the organisation is a positive career choice, helping to attract and retain talented people.

5 FEEDBACK FROM MANAGEMENT BOARD

Key points of discussion from the Management Board Meeting held on 1 February 2017:

Improvement Plans:

- The Trust is working towards an Integrated Improvement Plan. Key stakeholders will be asked to provide input and reports will be received at future Boards. An update on the current improvement plan is a substantive item for the February 2017 Board.
- NHSI continues to work with the Trust in relation to reviewing the Trust's financial recovery plans. Further detail is reported through the Finance and Performance Committee Chair Report.
- The Trust is looking to move to full implementation of the eCas Card from the start of the new financial year.

Integrated Performance Report

The Report is on the Board agenda. Management Board noted the following:

- Emergency care access remains of real concern but work internally and with our partners externally will continue as a priority
- Work continues to improve the recording of venous thromboembolism (VTE).
- Infection control remains a challenge linked to operational pressures.
- Crude mortality rates have increased, partly due to the time of year.
- Specific work will be undertaken with Heads of Nursing around pressure ulcers rates.
- The Cancer Board is monitoring the 62 day cancer performance.
- Work continues with Divisions and corporate teams around improving appraisal rates, local induction compliance and sickness absence.

Other reports received:

- Business Planning and Contract update was received.
- Commissioning for Quality and Innovation Programme (CQUINS) Update: The recovery plan was discussed, updates were sought from leads, risks and clear actions were identified to take forward.
- Corporate Risk Register: Three new risks were agreed, no further emerging risks were identified. The updated paper will be presented to Board of Directors.
- Updated from Board Development: Divisions were appraised of the outcome of the Board Risk Workshops. Management Board agreed the proposed change that

links should be made to the Quality Strategy. An updated paper will be presented to the February 2017 Board of Directors.
- Board Assurance Framework: The latest report was received.
- Pharmacy Transformational Plan: The plan was agreed following assurances received around work undertaken to date. An action was agreed to look at implementation in the context of other Trust transformational programmes.
- Policy Management: New governance arrangements were agreed for monitoring through the Executive Management Team and Executive Performance Reviews.
- Recruitment and Process Mapping: An update on the mapping exercise was received. Current resource issues within HR were noted. Agreement was reached to escalate issues within an agreed timeframe.
- Strategic Reward and Recruitment: Management Board agreed to pilot the introduction of a Refer a Friend Scheme in the Trust.
- Apprenticeship Update and Proposal: Management Board agreed to recruit 30 apprentice roles in quarter as well as agreeing the recruitment to 4 roles to support the Learning Disability pledge by 31 March 2017.
- Sale of Land, K&C Primary Care Practice: In 2014, a clinically-led workshop concluded that locating an independent GP practice at Kent and Canterbury could deliver significant benefits and optimise patient pathways. Management Board agreed to the sale of land to support this development.
- MRI Replacement: Management Board approved an increased budget cost of the project to benefit patient care. This would be funded as part of the capital programme.
- Management Board Terms of Reference were reviewed and updated.
- Update from the Strategic Investment Group was received.
- Update from the Policy and Compliance Group was received. Management Board agreed the Policy for Patient Identification should follow national guidance.

6 GOOD NEWS STORIES

Dedicated Paediatric Treatment Area

A new paediatric treatment area is in place at Kent and Canterbury Hospital thanks to a recent refurbishment made possible by the Trust's Hospital Improvement Fund.

Before the refurbishment, both adults and children were seen together in the same treatment area. But thanks to a successful bid to the Hospital Improvement Fund earlier this year, the space has since been transformed.

The new 'Cheeky Monkeys Room' is now brightly decorated with children's chairs, furniture and toys, helping our younger patients feel more comfortable and at ease whilst undergoing treatment.

As a result, approximately 50 of the department's youngest patients are now being treated in a dedicated, child-friendly environment every week.

KM Charity of the Year

The Dementia Appeal has been chosen as Kent Messenger's Charity of the Year 2017 for the Kentish Express, in the Ashford and Folkestone area.

This will give the appeal a huge boost in publicity and support. It also gives fundraisers the opportunity to take part in sponsored events throughout the year to raise money for the Appeal.

EKHUFT Shortlisted for Research Awards

East Kent Hospitals was shortlisted for three awards for outstanding research and patient involvement work.

The inaugural Clinical Research Network (Kent, Surrey and Sussex) awards, supported by the National Institute for Health Research (NIHR), recognise hard-working and high achieving researchers, research teams, Research and Development (R&D) departments and other research support functions from across the Kent, Surrey and Sussex region.

East Kent Hospitals staff has been recognised in three of the five award categories:

• Outstanding Contribution to Research in Kent, Surrey and Sussex
• Outstanding Contribution to Commercial Research in Kent, Surrey and Sussex
• Outstanding Patient and Public Involvement and Engagement activity.

Medical Educators Award

Director of Undergraduate Medical Education and Consultant Urologist Nitin Shrotri has been hailed in the annual Academy of Medical Educators Awards for his extensive contribution to undergraduate and postgraduate medical studies over the last decade.

The Academy awards Fellowships to those who are established in and have made significant achievements and played a key leadership role in medical education, something that Mr Shrotri had been achieving and leading during his last 16 years as a consultant with the Trust.

Members and Fellows are identified by the internationally-recognised professional designations of MAcadMEd (Member of the Academy of Medical Educators) and FAcadMEd (Fellow of the Academy of Medical Educators) signifying that they have successfully met appropriate professional standards for medical education practice and are committed to continuing professional development.

Some of Nitin's achievements include:

- Programme Director for Core and Specialist Surgical Trainees 2002-2012
- Educational Supervisor for Foundation Trainees 2005-2010
- Year 3 Teacher for Undergraduate students Kings College London 2005-10
- College Tutor for Kent and Canterbury hospital 2008-2011, demonstrating sustained improvement of Basic Surgical Skills course delivery
- Undergraduate Tutor and Sub Dean for Kings College London students delivering Pastoral care and supervision of Year 3 student teaching and apprenticeship of Year 5 students. Delivery of the Sub Dean Quiz
- Undergraduate Tutor and Director of Medical Education of St George's International school of Medicine, Grenada, West Indies – Pastoral care and supervising delivery of Education to Elective International students
- Recent appointment as joint Director of Undergraduate Medical Education for the Trust

Pioneering Work by the Haemotology Team

Kent and Canterbury Haemotology Team's battle against cancer made a splash in the local papers recently, as the team were praised for their pioneering work which is making a huge difference to patients' lives.

The unit's contribution to global research along with patients' engagement and clinical trial participation has led to international recognition for the unit's commitment to the development of innovative drugs and treatments in this field.

Pioneering T.A.S.E.R.

EKHUFT has achieved a first for patients in east Kent by performing a revolutionary surgical technique, transforming the lives of patients with large, potentially cancerous rectal polyps. The procedure makes it easier and safer to remove these polyps, enabling patients to avoid major surgery and reduce the likelihood of them being left with a stoma bag.

The team at EKHUFT have performed the first set of procedures called Transanal Submucosal Endoscopic Resection (TASER). The technique combines the skills of a therapeutic endoscopist and a laparoscopic-trained surgeon to create a minimally invasive way of removing rectal polyps.

The results from the first patients have been hugely encouraging, with short hospital stays and rapid recovery. The team are really excited about the new technique which will radically transform the lives of patients with large polyps.

7 CHIEF EXECUTIVE ACTIVITY – DECEMBER 2016 AND JANUARY 2017

The following is an example of some of the meetings I, as CEO, have attended during December and January 2017 and their purpose:

- Various meetings with NHSI, including a PRM
- Board of Directors meeting plus Board Development Day
- BME Staff Conference
- NHS Confederation Board of Trustees Meeting
- East Kent Delivery Board
- CCG Contract Meeting
- CQC Quality Summit
- PHSO Visit
- Cancer Alliance Board
- A variety of 1:1s with a range of staff
- Improvement Plan Delivery Board
- Risk Register Sessions
- A number of STP meetings including STP Governance Workshop
- Vascular Amputee Support Group
- Various Tissue Viability Presentations
- Lord Mayor and Sherrif's Christmas Visit
- A&E Delivery Board
- Various meetings with NHSI regarding financial deep dive
- Various CQC Staff Briefings
- Staff Committee
- Kent Public Estates Partnership – Shadow Board Meeting
- Urgent and Emergency Care Meeting
- CRN: KSS Partnership Board meeting

I have also attended the following Board Committees:

- Finance and Performance Committee
- Quality Committee
- Strategic Workforce Committee

I chair the following Executive meetings on a regular basis as part of the Trust's governance structure that ensures upward reporting through Board Committees to Board. I will be reviewing the purpose of each group and assessing how they work before making a judgement about any changes that are necessary as we move into the next stage of the Trust's development.

- Executive Team Meetings (weekly) plus
- EMT/Divisional Director meeting (monthly)
- Management Board (monthly)
- Trust Strategy Group (monthly)
- Executive Performance Review Meetings (monthly)

Matthew Kershaw
Chief Executive

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**2017/18 ANNUAL OBJECTIVES AND STRATEGIC PRIORITIES**
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER**
PAPER AUTHOR:	**TRUST SECRETARY**
PURPOSE:	**APPROVAL**
APPENDIX:	**Appendix 1: The 4 "Ps"**

BACKGROUND AND EXECUTIVE SUMMARY

January 2017 Workshop

The purpose of the January 2017 session was to start the preparation on the 2017/18 priorities and identify any additional risks and / or development needs.

Prior to starting the preparation work on the 2017/18 priorities the Board reviewed the Vision, Mission and Values and agreed these remained appropriate.

The Board also looked at the high level statements against each of the strategic priorities "Patients, People, Partnership and Provision" and made some minor changes due to national and political changes during 2016/17. Following the Development Session the Executive Management Team reviewed the work, as requested, and, as a result would like to suggest an addition to the Patient priority. One of the key strategies for patients is the Quality Strategy as this includes our improvements in safety, quality, experience and outcomes and this is now referenced. All changes to the 4P's are shown in red on Appendix 1.

The Board then considered some "headlines" and "key themes" for 2017/18 to provide the Executive Team with some direction. The Executive team will now be working to develop some specific priorities in each area (4 to 5 per P) along with key performance indicators and, where appropriate, a baseline and a target for the year to March 2018. The timetable for agreeing the 2017/18 priorities is as follows:

- February 2017 Joint Council of Governor and Board of Directors development session – to receive a presentation on work to date;
- February 2017 Board to approve the 4P wording (Appendix 1) and initial thinking in relation to the 2017/18 annual priorities;
- March Board Committees to receive and input into draft 2017/18 priorities per "P" along with proposed metrics / measures;
- March development session to discuss the draft 2017/18 priorities with a view to enabling these to be in place by 1 April 2017;
- Public Board sign-off at April Public Board.

The Executive Team, as noted above, are currently working on these priorities and early thoughts for each of the 4 Ps are provided below. These are subject to more detailed work-up and review through the committee structure as detailed above.

Patients:
The Chief Nurse and Director of Quality and Medical Director are currently consulting with staff on the 2017/18 Quality and Improvement Strategy through the Quality and Innovation Hubs and once this work is complete the Quality Committee will receive their view on the

annual priorities that will support year 2 of our 5 year strategy.

People:
The Strategic Workforce Committee received the People Strategy and Implementation Plan, following consultation with staff, during 2016/17 and this will be a focus for 2017/18. In order to consult on and deliver the Sustainability and Transformation Plan a focus on staff engagement, development, recruitment and retention is required.

Partnerships:
Continued working with our partners to consult on the Sustainability and Transformation Plans, including the development of joint projects with the Community Trust, consolidation of corporate services and continued work on pathology consolidation.

Provision:
With strong links to the Annual Plan, the provision of safe, effective services with good patient experience and outcomes whilst improving efficiency and strong financial management. A focus on delivery against the cost improvement programme, continued reduction of agency usage, reduction in waiting list initiatives with an increased efficiency in theatres.

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

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

RECOMMENDATIONS AND ACTION REQUIRED:
The Board is asked to

- APPROVE the updated strategic priorities attached as Appendix 1 to this report; and
- NOTE the timeline for delivery of the 2017/18 priorities.

Priority one: patients

East Kent Hospitals University NHS
NHS Foundation Trust

We want to enable our patients (and clients who are not ill), as part of our Quality and Improvement Strategy to take control of aspects of their healthcare by 2021.

We will achieve this by:

delivering the 2017/18 Quality and Improvement Strategy to continue our improvement journey

enabling self-management and understanding the importance of health status, exercise, dietary advice and well-being. We intend to offer 25% of our population the ability to self-manage their condition by 2019.

working with our partners, we will pilot a single healthcare professional in each of each of four geographical localities, to act as information and advice integrators by 2018. These integrators will support and monitor self-management by patients in hospital and through to discharge.

considering integration with other health systems, to create a wider population base post 2021.

East Kent Hospitals University NHS
NHS Foundation Trust

Priority two: people

We want to identify, recruit, educate and develop all our staff to be skilled at delivering integrated care and designing and implementing innovative solutions for performance improvement.

We will achieve this by:
becoming the NHS employer of choice in Kent measured by the staff friends and family test, NHS staff survey and other metrics benchmarked to upper quartile performance against peers, by 2019;

ensuring the talent pool is identified and constantly reviewed;

Continuing to reduce levels of staff leaving within first year of employment, by March 2018;

improving the quality and quantity of applicants to the top 5 clinical and non-clinical posts, as measured by successful recruitment and delivery of objectives, by 2018; and

increasing clinical productivity and reducing clinical variation.

We care

East Kent Hospitals University NHS
NHS Foundation Trust

Priority three: partnerships

We want to define and deliver sustainable services and patient pathways together with our health and social care partners, by 2021.

We will achieve this by:

aligning with our partners on joint strategic objectives, including STP, QIPP and CIP.

working directly with the Vanguard to increase community capacity in Canterbury, Faversham and Whitstable to enable the transfer of acute activity to a community setting, by July 2017.

ensuring the health economy has the right capacity and the required supporting infrastructure to deliver a sustainable model of care in East Kent, by 2021.

We care

East Kent Hospitals University NHS
NHS Foundation Trust

Priority four: provision

We want to clearly identify 'what business we are in', 'what we want to be known for' and 'what our core services are'. We need to provide the right services and do it well.

We will achieve this by
engaging with staff and key external partners to define our core services. This work will be annually refreshed to ensure our service provision remains appropriate;

agreeing a transformation programme to deliver a short and long-term sustainable solution for east Kent as part of the STP;

delivering the plans set out in the Communications and Engagement Strategy;

maintaining a net positive balance on press coverage as measured by press, Trust data and social media;

being recognised as provider of high quality care and as a system leader by NHS, social care and other public sector partners, by March 2018;

demonstrating our contribution to sustainability, corporate responsibility and our position as a major local employer and contributor to the local economy; and

being identified as a paper-lite organisation, by 2020.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**DEPUTY DIRECTOR OF RISK, GOVERNANCE AND PATIENT SAFETY**
PURPOSE:	**DISCUSSION**
APPENDICES:	- **Corporate Risk Register (By Residual Risk Score)** - **Highest Mitigated Strategic Risks**

BACKGROUND AND EXECUTIVE SUMMARY

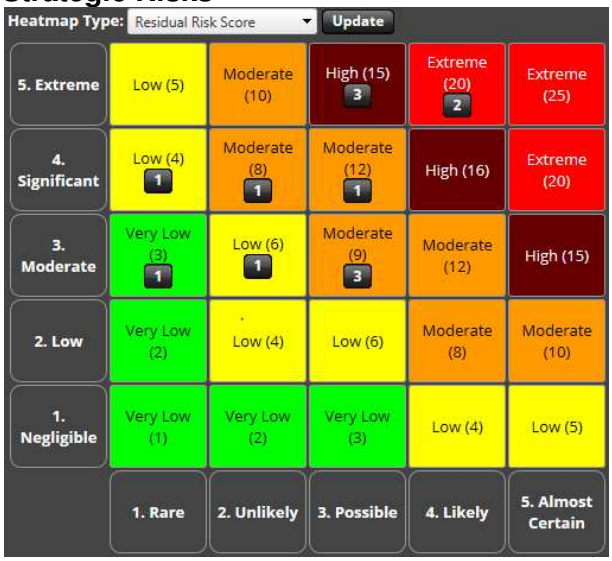
This report provides the Board of Directors with an update on the full Corporate/Highest Mitigated Strategic Risks at 02 February 2017 and new/emerging corporate risks approved for inclusion to the Corporate Risk Register. The risks rated as "high" post mitigation (residual) on the Strategic and Corporate Risk Registers were reviewed by the Board of Directors on 09 December 2016; the full Corporate Risk Register was reviewed by the Board at the January 2016 meeting. The full Corporate Risk Register was last reviewed by the Integrated Audit and Governance Committee on 27 January 2017. At the time of writing the Quality risks were last reviewed and discussed at the Quality Committee on 04 January 2017.

Monthly meetings are being held with the responsible Executive lead to review the scoring, actions and the specific wording for each strategic and corporate risk.

Register Heat Map (by Residual risk score)

Corporate Risks

Strategic Risks



Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register

1 **Risk Ref. SRR 5 – Failure to achieve financial plans 2016/17.** The residual risk score has increased from High (16) to Extreme (20) to reflect the risk impact more

accurately. The importance of data capture is stressed at EPRs. Concerns over e-Cascard largely addressed. The financial position remains challenging with extreme operational pressures over December and into January resulting in increasing costs and reduced income through high agency usage and cancelled operations.

2 **Risk Ref. SRR 10 – Non-delivery of the Sustainability and Transformation Plan that can be resourced.** The residual risk score has increased from Moderate (12) to High (15) to reflect the risk impact more accurately. Non-delivery of the STP will delay the delivery of the Clinical Strategy and may trigger the transfer of emergency services.

Corporate Risk Register

3 **Risk Ref. CRR 1 – Precipitate loss of acute medicine and stroke (including acute geriatric medicine) from the K&CH site.** The risk title has been revised to include stroke and acute geriatric medicine. The risk record has been updated and modified to reflect the changes that were implemented to provision of urgent and emergency care on the K&CH site since July 2016 in response to concerns raised by HEKSS. Subsequent extreme pressures on consultant staffing in particular continue to generate the risk of loss of acute medicine from the K&CH site. This has been reflected in the change of the risk scores. The residual risk score has increased from Moderate (12) to Extreme (20).

4 **Risk Ref. CRR 4 – Failure to recognise or treat patients with sepsis in a timely way.** The residual risk score has increased from Moderate (10) to High (15) to reflect the risk likelihood more accurately. Data for the end of December has not been circulated, but preliminary reports show deterioration in performance in the administration of antibiotics within an hour of arrival at both the WHH & QEQMH and timely consideration for sepsis to be considered if their ViEW scores are greater than or equal to 4.

5 **Risk Ref. CRR 20 – Failure to send timely information to GPs on their patients who have had an outpatient appointment.** The residual risk score has increased from Low (6) to Moderate (8) to reflect the risk likelihood more accurately. This is due to some specialities not meeting the performance standards set. A new action has been added to carry out a review of these Specialities by end March 2017.

New Corporate Risks approved by the Management Board in February 2017 (not included in the appendix)

6 **Failure to meet the Referral to Treatment (RTT) Standard for the Trust) – Executive Lead (Chief Operating Officer)**

This risk is being escalated from the Surgical Services Division risk register (Risk Ref. 333) for oversight at corporate level. It is linked to Strategic Risk Ref. SRR 14 (Inability to meet performance metric/trajectories).

Existing controls in place to mitigate this risk are the Four Eyes Consultancy supporting Divisions to deliver the Cost Improvement Programme (CIP) for theatres, dropped sessions and cancellations; recovery trajectory in place and monitored weekly at Senior Performance meetings; RTT Performance reviewed weekly at KPI meetings and regular contract performance meetings with the CCG.

Actions required include:

- Reviewing the referral management processes and re-direction of referrals to reduce pressure on RTT 18 weeks in conjunction with CCGs and NHS Elect.

The risk is one associated with Patient safety and a potential financial impact to the Trust.

7 **Failure to deliver CQUIN schemes on flu vaccinations (Chief Nurse and Director of Quality)**

This risk is being escalated from the Finance & Performance Management risk register (Risk Ref. 95) for oversight at corporate level. It is linked to Strategic Risk Ref. SRR 5 (Failure to achieve financial plans 2016/17). Failure to meet the CQUIN schemes 70% national target will result in £1.1m of lost income to the Trust. The second quarter compliance has shown greater risk of failure.

The key control in place to mitigate this risk is that there are designated leads for each CQUIN scheme and an overall CQUIN Manager to ensure delivery.

Actions required include:

- Planning and promotion for achievement of 70% take up of flu jabs by frontline staff.

The risk is one associated with potential staff safety and loss of income to the Trust. This risk is likely to crystallise.

8 **Delays in signing off and implementing Consultant job plans (Medical Director)**

This risk is being escalated by the Head of HR for corporate oversight. There are concerns that job planning has taken considerably longer than expected and may not be aligned with capacity demands. As at 19 January 2017, 182 Consultants' job plans were signed off out of a total of 359. The Trust is unable to take a decision on its ability to fund the job plans until all job plans are finalised.

Actions required include:

- Finalising remaining job plans;
- Reviewing of the job plan policy;
- Detailed analysis of job plans to ensure consistency of approach across the Trust;
- Developing a diary card type review of commitments.

The risk is one associated with Patient safety, the reputation of the Trust and a negative impact on clinical engagement.

Risks for Closing on the Strategic and Corporate Risk Registers

Strategic Risk Register (approved by the IAGC in January 2017)

9 **Risk Ref. SRR 1 – Unable to deliver a clinical strategy that can be resourced.** This risk has been subsumed into **SRR 10 (Non-delivery of the Sustainability and Transformation Plan that can be resourced**).

10 **Risk Ref. SRR 3 – Loss of vascular service.** This remains a low risk to the Trust. Two actions remain outstanding but are being implemented operationally.

11 **Risk Ref. SRR 6 – The contraction of available funds limits the Trust ability to pursue the digital ambitions of the STP.** All actions in the risk action plan have been completed and the target risk of 3 (Very Low risk) achieved.

Corporate Risk Register (approved by the Management Board in February 2017)

12 **Risk Ref. CRR 14 – Delays in supplying equipment required to facilitate and support patients discharge.** All actions in the risk action plan have been completed and the target risk of 6 (Low risk) achieved. This risk has been approved for de-escalation to Clinical Support Services Division/Therapies Risk Register.

13 **Risk Ref. CRR 21 – Local implementation of the new junior doctors contracts fail.** All actions in the risk action plan have been completed and the target risk of 4 (Low risk) achieved. Implementation of the Contracts began in December 2016. The British Medical Association (BMA) withdrew their opposition to implementation and abandoned their threat of strike action. This is no longer a risk to the Trust and has been approved for closing.

14 **Risk Ref. CRR 25 – Failure to recognise sudden deterioration in critically ill or seemingly well children.** All actions in the risk action plan have been completed and the target risk of 8 (Moderate risk) achieved. This risk has been approved for de-escalation to the Specialist Services Division Risk Register.

15 **Risk Ref. CRR 27 – Patients who have been identified using the MUST (Malnutrition Universal Screening Tool) as at risk of being malnourished may not receive timely dietetic management.** All actions in the risk action plan have been completed and target risk of 8 (Moderate risk) achieved. This risk has been approved for de-escalation to the Clinical Support Services Division (CSSD) Risk Register.

16 **Risk Ref. CRR 33 – Poor governance of Patient Group Directions (PGDs).** All actions in the risk action plan have been completed and the target risk of 4 (Low risk) achieved. This risk has been approved for de-escalation to the CSSD/Pharmacy Risk Register.

17 **Risk Ref. CRR 35 – Breakdown of Facilities Management Provider Contract.** All actions in the risk action plan have been completed and the target risk of 6 (Low risk) achieved. This risk has been approved for de-escalation to the Strategic Development & Capital Planning/Estates and Facilities Risk Register.

Risks merged/approved by the Management Board for merging on the Corporate Risk Register

Merged

18 **Risk Ref. CRR 3 (Inability to respond in a timely way to changing levels of demand for emergency and elective services) and CRR 28 (Potential delays in treatment of Patients requiring Emergency Care).** As both risks relate to delays in treatment of Patients that require emergency care, the emergency element of CRR 3 was subsumed into CRR 28 and CRR 3 renamed "**Inability to respond in a timely way to changing levels of demand for elective services"**. This will enable a more consolidated view/better management of these risks.

Approved for merging

19 **Risk Ref. CRR 23 (Delays in first trimester and anomaly obstetric ultrasound scans) and CRR 40 (Lack of robust antenatal and new-born screening programmes).** As both risks relate to antenatal screening programmes, merging will enable a more consolidated view/better management of this risk. This change will be made in the next update of the Corporate Risk Register.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The attached risk registers reflects the corporate risks and the highest mitigated strategic risks facing the Trust and the mitigating actions in place.
LINKS TO STRATEGIC OBJECTIVES:	The corporate and strategic risks align to all of the four Strategic Priorities: **Patients:** Help all patients take control of their own health.

	People: Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the full corporate risks and the highest mitigated strategic risks for the Trust.
RESOURCE IMPLICATIONS:	None specifically identified other than identified in the Risk Register.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	The Risk Group and Management Board review any new corporate risks and the scoring of the existing risks. The IAGC review the Corporate Risks and the Board Assurance Framework.

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

RECOMMENDATIONS AND ACTION REQUIRED:

1. The Board of Directors are invited to review the Corporate Risks and Highest Mitigated Strategic Risks Report that is appended; note and discuss the closed, escalated/emerging risks.
2. The Board is invited to consider the sufficiency of the corrective actions identified in relation to the risks and provide positive challenge where necessary.

Principal Risks Report (Strategic Risk Register)

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	02 Feb 2017
Comparison Date	In the past 30 Day(s)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 5	Failure to achieve financial plans 2016/17 **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 10 Jan 2017 **Latest Review Date:** 12 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Nick Gerrard. New causes and effect added. New control added around the Consultant support. Residual impact increased to reflect the impact of the risk to the Trust. Coding was 100% complete in October. Continue to stress the importance of data capture at EPRs. Concerns over e-Cascard largely addressed. Financial position remains challenging with extreme operational pressures over December and into January increasing costs and reducing income through high agency usage and cancelled operations.	20 Jan 2016	**Cause** Due to: * Failure to reduce the run rate * Poor planning * Poor recurrent CIP delivery * Poor cash management and * Gaps in financial governance * Failure to agree a realistic control total * Inability to collect income due * Operational pressures relating to Emergency Care, High Agency usage * Political climate **Effect** Resulting in * Potential breaches to the Trust's Monitor licence * Adverse impact on the Trust's ability to deliver all of its services * Impact on ability to deliver the longer term clinical strategy * Poor reputation * Impact on organisational form * Potential financial special measures	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	Clinical Workstreams in place to ensure quality of care **Control Owner:** Sally Smith Consultant (Mark Hackett) in place to provide support **Control Owner:** Matthew Kershaw Cost Improvement Plan targets in place with workstream in support **Control Owner:** Nick Gerrard Divisional Peer review of temporary staff savings **Control Owner:** Trish Hubbard Divisional Peer review of temporary staff savings **Control Owner:** Chris Hudson Divisional Peer review of temporary staff savings **Control Owner:** Lesley White Divisional Peer review of temporary staff savings **Control Owner:** Mary Tunbridge Financial governance in place **Control Owner:** Nick Gerrard Financial Recovery Plan **Control Owner:** Nick Gerrard Head of PMO in post **Control Owner:** Nick Gerrard Payment by results infrastructure **Control Owner:** Nick Gerrard	I = 5 L = 4 Extreme (20)	Ensure that the development of the Trust's clinical strategy, "Delivering Our Future" and that of the wider Kent & Medway STP, drive financial improvement and recovery in the Trust through to 2020/21. **Person Responsible:** Nick Gerrard **To be implemented by:** 28 Feb 2017	**10 Jan 2017** The Case for Change is being prepared for February 2017 with a public consultation planned for Summer 2017.	I = 4 L = 3 Moderate (12)
								Respond appropriately to commissioner challenge of activity and cost date. Escalate concerns to NHSI. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017	**10 Jan 2017** Outstanding challenges have been escalated through FD and CEO and now sit with NHSI. Hoping to get an NHSI/NHSE binding arbitration on the issues but CCGs wanting external view.	
								Cash: ensure that NHSI and DH are fully informed of the Trust's cash requirements and that working capital is available when needed. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017	**10 Jan 2017** Continuing discussion with DH and NHSI on cash requirements in Q4.	
								Ensure that the Trust Board and senior management team are fully informed of the Trust's financial position through regular updates, formal FPC papers, etc and that the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017		
								Ensure that all clinical activity is being captured appropriately, coded and costed. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017		
								"Developing the Finance Team - Still Underpowered?" presented to FPC July 2016 setting out how the Leadership Development Programme would be deployed to support financial staff improvement **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017		

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 14	Inability to meet performance metrics / trajectories **Risk Owner:** Matthew Kershaw **Delegated Risk Owner:** Alison Fox **Last Updated:** 12 Oct 2016 **Latest Review Date:** 02 Dec 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Due to the Trust not meeting the STF trajectories the related funding has been withheld resulting in the financial impacts as outlined in the risk description. The risk in relation to operational performance and its effect on patient safety and experience are detailed in other risks.	02 Jun 2016	**Cause** *Trust has not met its Performance trajectories * Lack of capacity - Trust is unable to meet demand with the resources and infrastructure available * Increased local demand for services **Effect** *Resulting in the Trust requiring additional working capital to support the cash position; *The need to find additional efficiencies when the current CIP programme will be a stretch; *Impact on it's ability to deliver it's long-term strategy. *Impact on relationships with Regulators	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	Annual financial plan in place including cost improvement programme. **Control Owner:** Nick Gerrard Emergency Care Recovery Plan in place **Control Owner:** Jane Ely Trajectory for applicable standards agreed with the CCGs and NHSI. **Control Owner:** Jane Ely	I = 5 L = 4 Extreme (20)	Meeting the agreed plans in respect of: Access standards **Person Responsible:** Jane Ely **To be implemented by:** 30 Sep 2016	**11 Jan 2017** Decline in performance targets in respect of Cancer, ED (attendance up by 6%) and RTT. Currently huge number of Consultant and middle-grade vacancies. **01 Dec 2016** STF funding is unlikely to be received due to continuing performance difficulties. Risks in relation to performance are covered fully under other risks.	I = 5 L = 3 High (15)
								Referral management processes and re-direction of referrals to reduce pressure on RTT 18 weeks in conjunction with CCGs and NHS Elect **Person Responsible:** Jane Ely **To be implemented by:** 30 Dec 2016		
								Refresh and implement the Emergency Care Recovery Plan **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2017		
								Meeting the agreed plans in respect of: Annual financial plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017	**12 Jan 2017** Financial position remains challenging with extreme operational pressures over December and into January increasing costs and reducing income through high agency usage and cancelled operations.	

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 8	Inability to attract, recruit and retain high calibre staff to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** Jacqui Siggers **Last Updated:** 10 Jan 2017 **Latest Review Date:** 12 Dec 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Sandra Le Blanc. New control added. Progress notes added. Target risk impact increased to reflect the true impact of the risk.	23 Feb 2016	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust being in special measures, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff **Effect** * Potential negative impact on patient outcomes and experience *High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing.	AO2: People: Identify, recruit and develop talented staff	I = 5 L = 4 Extreme (20)	The Trust has a plan in place that supports the retention of the majority of newly qualified nursing staff locally. **Control Owner:** Sally Smith Divisional Great Place to Work Action Plans in place **Control Owner:** Jane Waters implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Jacqui Siggers New Appraisal Process in place **Control Owner:** Jane Waters New People Strategy agreed by the Board incorporating attraction, retention, engagement and development of staff **Control Owner:** Sandra Le Blanc There is an agreed programme to recruit 50 nurses from the Philippines for 2017/18. **Control Owner:** Jacqui Siggers There is an agreed programme to recruit 90 nurses from EU / India for 2016/17. **Control Owner:** Jacqui Siggers Training plans in place in each division / corporate area that supports staff development. **Control Owner:** Jacqui Siggers Working Group in place to review Consultant vacancies and recruitment **Control Owner:** Sandra Le Blanc	I = 5 L = 3 High (15)	Finalise plan for recruitment to hard to fill roles **Person Responsible:** Jaz Mallan **To be implemented by:** 29 Jul 2016	**11 Oct 2016** Hard to recruit action plan emailed to HRBPs on 3/8 to update plan to include more detail in relation to associated risks of non recruitment to roles identified on the Action plan and what controls the divisions/departments have in place to mitigate any potential risks. This should be completed by 31st October 2016. **19 Aug 2016** The target date for implementation is end March 2017. July 2016 was the start date.	I = 5 L = 2 Moderate (10)
								Audit of new appraisal process to be completed and reported to Strategic Workforce Committee **Person Responsible:** Jane Waters **To be implemented by:** 31 Jan 2017	**13 Jan 2017** Appraisal 'structure' and quality audit to be piloted in appraisal 'hot spot' areas by end March 2017 by HRBPs **12 Dec 2016** A deep dive report of the new trust appraisal system was presented to the SWC on 25 November.	
								Review the recruitment process for all staff - report to MB **Person Responsible:** Jacqui Siggers **To be implemented by:** 31 Jan 2017	**11 Jan 2017** Interim report to go to Management Board on 1st February **10 Jan 2017** Interim report to MB in February 2017	
								Implement Divisional Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2017	**13 Jan 2017** 2016 Staff Survey results received by Picker. Divisional RAG rated reports to be completed and GPTW action plans developed for 2017 by end March 2017 **14 Sep 2016** Divisional Great Place to Work action plans facilitated and developed with support from HR Business Partners. Each division has presented their plan to the Strategic Workforce Committee and are currently implementing the actions. These plans are available for all to access on Staff Zone and will be updated with progress.	
								Implementing a long term workforce plan that enables us to attract and retain high calibre staff **Person Responsible:** Jacqui Siggers **To be implemented by:** 29 Jun 2018	**10 Jan 2017** Resources have been identified from Strategic Development to support programme. Meetings to commence week of 16 January. Worked linked to the Kent & Medway STP. **11 Oct 2016** Paper on future workforce modelling presented to the private BoD meeting on 7/10 detailing progress and future actions.	

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
								To produce and implement a People Strategy that focusses on attracting, developing, engaging and retaining staff. **Person Responsible:** Sandra Le Blanc **To be implemented by:** 01 Apr 2019	**12 Dec 2016** Implementation plan to be presented to the SWC in January 2017 **07 Nov 2016** People Strategy approved by BoD on 7 October. Implementation plan to be produced by end of November. Ongoing monitoring by the Strategic Workforce Committee.	
SRR 1	Unable to deliver a clinical strategy that can be resourced **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Rachel Jones **Last Updated:** 15 Dec 2016 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk to be reported to Board for removal from SRR as this has been subsumed into SRR 10.	15 Jan 2016	**Cause** - Four CCGs having differing agendas; - Lack of stakeholder agreement; - Lack of clear commissioning intentions; - Parliamentary timings may not be conducive to timely implementation **Effect** - Patient care - Emergency transfer of services will become necessary - Reputational damage - Enforcement actions - Trust's provider licence (finance)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	1st phase of NHS England assurance process passed **Control Owner:** Liz Shutler East Kent Strategy Board **Control Owner:** Liz Shutler Financial Recovery Plan **Control Owner:** Nick Gerrard Internal clinical strategy board **Control Owner:** Matthew Kershaw New Kent & Medway-wide Governance structure in place with overarching steering group **Control Owner:** Matthew Kershaw Regular meetings with external partners / MPs / HOSC and within the Trust **Control Owner:** Liz Shutler	I = 5 L = 3 High (15)	To develop programme required to support an emergency transfer of services if required **Person Responsible:** Liz Shutler **To be implemented by:** 30 Sep 2016	**24 Nov 2016** Executive Team met in November 2016 with the Divisions to review options and a further meeting is planned end November to finalise a contingency plan. **13 Sep 2016** Programme unlikely to meet delivery date. Table top exercise planned for middle of October. Risk assessed options and trigger points agreed.	I = 5 L = 2 Moderate (10)
								Agreement of final consultation document by all partners **Person Responsible:** Liz Shutler **To be implemented by:** 30 Nov 2016	**24 Nov 2016** The earliest consultation date will be June 2017 **17 Oct 2016** Programme unlikely to meet target delivery date.	
								NHS England assurance process **Person Responsible:** Liz Shutler **To be implemented by:** 30 Nov 2016	**24 Nov 2016** Clinical Senate date now agreed for April 2017 and Investment Committee May 2017 **17 Oct 2016** Due to NHSE feedback the 8th November date has been delayed	
SRR 10	Non-delivery of a timely Sustainability and Transformation Plan that can be resourced **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Rachel Jones **Last Updated:** 04 Jan 2017 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. Previous SRR 1 has been subsumed into this risk.	01 Jun 2016	**Cause** - STP timescales slip due to national management of the process - Parliamentary timing may not be conducive to timely implementation **Effect** - Delay to EKHUFT clinical strategy - Poor patient care - Emergency transfer of services will become necessary - Enforcement actions - Trust's provider licence (finance)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	East Kent Delivery Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Liz Shutler Financial Plan in place linked to delivery of the STP **Control Owner:** Nick Gerrard Internal Clinical Strategy Group in place **Control Owner:** Matthew Kershaw Kent and Medway STP steering group in place **Control Owner:** Liz Shutler STP submission to NHS England **Control Owner:** Liz Shutler	I = 5 L = 3 High (15)	Develop programme required to support an emergency transfer of services if required **Person Responsible:** Liz Shutler **To be implemented by:** 31 Mar 2017	**04 Jan 2017** Executive Team met in November 2016 to review the options and finalise a contingency plan.	I = 5 L = 2 Moderate (10)
								Submission to Clinical Senate - review of clinical standards **Person Responsible:** Liz Shutler **To be implemented by:** 28 Apr 2017	**17 Jan 2017** Medical Director and CCG Clinical Chair attending Clinical Senate for a stage meeting in January 2017	
								Presentation of the capital requirements to the NHSE Investment Committee **Person Responsible:** Liz Shutler **To be implemented by:** 31 May 2017		
								Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Liz Shutler **To be implemented by:** 30 Jun 2017	**24 Nov 2016** Public consultation delayed until June 2017 at the earliest. **17 Oct 2016** On track for delivery of STP for submission in October, however feedback from NHSE is East Kent will be unlikely to commence consultation in this calendar year.	

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	02 Feb 2017
Comparison Date	In the past 30 Day(s)

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 1	Precipitate loss of acute medicine and stroke (inlcuding acute geriatric medicine) from the K&CH site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 10 Jan 2017 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** This risk has been updated and modified to reflect the changes that were implemented to provision of urgent and emergency care on the K&CH site since July 2016 in response to concerns raised by HEE KSS. Subsequent extreme pressures on consultant staffing in particular continue to generate the risk of loss of acute medicine from the K&CH site.	26 Jan 2016	**Cause** *Lack of adequate substantive consultant cover and enforced reliance on locum consultant cover *Difficulty staffing junior medical staff rotas **Effect** * Patient experience / harm * Loss of acute medical support for all other inpatient services currently provided from the K&CH site * Additional pressures on the Emergency Care pathway in QEQM and WHH * Reputational damage *Loss of income	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	Recruitment of locum medical staff **Control Owner:** Lesley White	Limited	I = 5 L = 4 Extreme (20)	Implementation of the recommendations from the evaluation report **Person Responsible:** Lesley White **To be implemented by:** 01 May 2017		I = 3 L = 3 Moderate (9)
									Consult and implement Kent & Medway Sustainability and Transformation Plans **Person Responsible:** Liz Shutler **To be implemented by:** 28 Feb 2018	**10 Jan 2017** The action is to implement the East Kent Clinical Strategy either as part of the Kent & Medway STP and/or as part of the work of the East Kent Delivery Board following on from a successful public consultation commencing June 2017 **18 Oct 2016** Implementation delayed until final consultation agreed.	

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 28	Potential delays in treatment of Patients requiring Emergency Care **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 23 Jan 2017 **Latest Review Date:** 23 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Joint review of risk by Paul Stevens and Jane Ely to reflect current position.	06 Jul 2016	**Cause** * Overcrowding in the Emergency Departments due to lack of flow through the Emergency Care Pathway *Increased and unplanned local demand for emergency services that the Trust is unable to meet with the resources and infrastructure available *Over time the demography, comorbidity and acuity of ED attendees has changed, together with the rise in number of attendees, resulting in an increased requirement for conversion to admission *Inability to recruit into consultant and middle grade posts * Lack of availability of Consultants due to sickness * Surge resilience plans do not meet unprecedented demand * Lack of robust escalation plans * Failure to respond appropriately to the Operational Pressure Escalation Framework **Effect** * Poor Patient experience * Harm to Patients * Breach of licence * Regulatory concerns * Failure to retain STF funding * Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	Accident and Emergency Delivery Board in place **Control Owner:** Matthew Kershaw	Limited	I = 5 L = 4 Extreme (20)	Implementation of the Safer Bundle in QEQM **Person Responsible:** Paul Stevens **To be implemented by:** 31 Aug 2016	**18 Jan 2017** 75% of patient currently have EDD set, only 20% are discharged before midday, 68% of discharges are either on or before EDD and 31% of patients have LOS> 7days **08 Nov 2016** Difficult to progress this until we see evidence of effective discharge from hospital	I = 5 L = 2 Moderate (10)
						Daily intensive review/bed matching for emergency admissions not placed at time of review **Control Owner:** Jane Ely	Adequate				
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Jane Ely	Adequate		Implementation of the Safer Bundle in WHH **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Aug 2016	**18 Jan 2017** 60% of patient currently have EDD set, only 15% are discharged before midday, 62% of discharges are either on or before EDD and 34% of patients have LOS> 7days **08 Nov 2016** Difficult to progress this until we see evidence of effective discharge from hospital	
						Development of an Acute Medical Model **Control Owner:** Jonathan Purday	Limited				
						Emergency Care Improvement Plan in place **Control Owner:** Jane Ely	Adequate				
						Single Health Resilience Early Warning Database (SHREWD) has been revised . It is expected that when the Trust is under pressure the system will respond with agreed actions **Control Owner:** Jane Ely	Limited		New Operational Plan (Business Plan) to be agreed for 2017 - 2019 **Person Responsible:** Jane Ely **To be implemented by:** 28 Feb 2017		
						Support from the Emergency Care Improvement Programme (ECIP) **Control Owner:** Jane Ely	Limited		Currently Streaming has been devised for the UC Centre for the K&C site. This has been successfully implemented. That Streaming model needs to be slightly re-designed and applied to A&E sites. **Person Responsible:** Jonathan Purday **To be implemented by:** 01 Apr 2017		
						Urgent Care Recovery Plan in place and updated in line with national priorities (Streaming, Access to advise, Ambulatory Care, Patient flow (Safer Bundle) and Discharge (External capacity) **Control Owner:** Jane Ely	Limited		Implementation of an acute medical model on all sites to improve flow and reduce overcrowding in the ED **Person Responsible:** Jonathan Purday **To be implemented by:** 05 Apr 2017		
									Develop a rolling programme for continuous training of staff in the utilisation of the predictor tool for reporting and managing capacity **Person Responsible:** Jane Ely **To be implemented by:** 28 Apr 2017		
									Implementation of the SAFER bundle in K&CH **Person Responsible:** Jonathan Purday **To be implemented by:** 31 May 2017	**18 Jan 2017** Currently 53% of patient currently have EDD set, only 25% are discharged before midday, 60% of discharges are either on or before EDD and 32% of patients have LOS> 7days	
									Facilitate discharge of patients from the acute Trust through implementation of the Kent & Medway STP **Person Responsible:** Jane Ely **To be implemented by:** 04 Dec 2017		

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 8	Lack of timely mental health interventions for Patients with mental health problems **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 18 Jan 2017 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Action updated and risk reviewed.	22 Feb 2016	**Cause** *They are unable to recruit into their current vacancies and they have relied on agency cover to maintain their rotas. *There is a national shortage of in-patient mental health beds. **Effect** *Patients with recognised mental health disorders may not be treated in a timely way. *There are an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. *Other patients and staff are put at risk of harm from violent episodes. *Patients who require in-patient mental health care are managed in acute facilities which are not fit for this purpose.	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	Agency RMN used **Control Owner:** Jane Ely	Adequate	I = 4 L = 4 High (16)	Seek CQC registration for the care of mental health patients in the ED. **Person Responsible:** Alison Fox **To be implemented by:** 31 Jan 2017	**03 Jan 2017** Meeting is being set up for January 2017 with the CQC assessor to provide them with assurance in relation to the new policies and ways of working. **02 Dec 2016** Application made 13/10 2016; CQC assessor contacted the Trust on 22/11/2016 and will be progressing the application.	I = 4 L = 2 Moderate (8)
						Agreed SOP in place to order additional nursing staff when a mental health patient has attended or is admitted. RMN, then RN, the HCA if the others are not available. **Control Owner:** Sally Smith	Adequate				
						Increase in cover arrangements for a 12 hour period across all 3 sites in place **Control Owner:** Jane Ely	Adequate		On-going work with local Commissioners and the mental Health Trust is underway, following a wider health economy improvement plan away day in December 2015. A cogent and coherent action plan is required to ensure cover is provided in line with national timescale. **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2017	**21 Nov 2016** Meeting planned on 1 December to discuss children who police hold under Section 136 of the Mental Health Act. There is still no clarity on Adults under Section 136. **06 Sep 2016** KMPT is now providing a daily report of patients waiting for a mental health bed or assessment. Escalation in this way has allowed for daily communication between the two organisations to maximise responsiveness.	
						Nominated consultant psychiatric cover for each site with Band 7 RMN and 5xBand 6 support to cover 08.00 to 20.00 hours. **Control Owner:** Jane Ely	Adequate				
						Regular escalation and meetings between the Trust COO and the COO of KMPT and the CCGs is in place. **Control Owner:** Jane Ely	Adequate				
						Single point of access for referrals for emergency and urgent patients from 01 April 2016 with a separate crisis team covering this area. Arrangements for other patients, including self-referrals and existing patients set up through GPs and NHS111. **Control Owner:** Jane Ely	Adequate		Plans being formulated to ensure 24 hour cover across the Trust by 2020. Mental Health Commissioner locally is leading the commissioning intentions up to this date. **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2020	**18 Jan 2017** The liaison service is now functioning until 22.00. This has improved the assessment process. **21 Nov 2016** It is the responsibility of Commissioners and KMPT to show interest in how this will be delivered.	
CRR 3	Inability to respond in a timely way to changing levels of demand for elective services **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 12 Jan 2017 **Latest Review Date:** 12 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. Risk renamed to focus on demand for elective services only as agreed at the Quality Committee. As agreed at the Management Board in November 2016, the Emergency element of this risk has been subsumed into CRR 28. No changes to the risk score. Cause, risk controls and actions amended accordingly. This remains a high risk to the Trust.	05 Feb 2016	**Cause** * There is a increased and unplanned local demand for elective services that the Trust is unable to meet with the resources and infrastructure available. * Inability to recruit into Consultant and middle grade posts. *Lack of availability of Consultants due to sickness *Delays in information about Health/Screening campaigns **Effect** * Harm to Patients * Breach of licence * Regulatory concerns * Reputational damage *Failure to retain STP Funding	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Annual business plan in place **Control Owner:** Jane Ely	Limited	I = 4 L = 4 High (16)	New Operational Plan (Business plan) to be agreed for 2017-2019 **Person Responsible:** Jane Ely **To be implemented by:** 31 Jan 2017	**12 Jan 2017** On track	I = 3 L = 2 Low (6)
						Daily intensive review/bed matching in place for elective admissions **Control Owner:** Jane Ely	Adequate		Develop a rolling programme for continuous training of staff in the utilisation of the Predictor tool and reports to manage capacity **Person Responsible:** Jane Ely **To be implemented by:** 28 Apr 2017		
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Jane Ely	Adequate				
						Elective demand - Continuing to alert CCG colleagues to excessive demand and collaborating with them to provide alternatives to referral e.g. advice and guidance **Control Owner:** Jane Ely	Adequate				
						Numerical table of residual gap analysis in terms of capacity reported to Finance & Performance Committee **Control Owner:** Jane Ely	Adequate				

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 26	Regulatory non-compliance in Obstetrics and Maternity **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Graham Ross **Last Updated:** 03 Jan 2017 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** This risk has been reviewed. Some progress has been made (appointment of clinical leads for each unit, improved education and training through the Darzi Fellow and attendance of the Darzi Fellow at Patient Safety Board to follow up obstetric actions), however all of these actions have yet to be detailed and recorded in the action plan.	23 Jun 2016	**Cause** Reports from both the Royal College of Obstetrics and Gynaecology (RCOG) and the Local Supervisory Authority (LSA) identified gaps in regulatory compliance and also other areas for improvement in maternity services. The LSA report specifically highlighted gaps in the statutory supervision of midwives in the Trust. **Effect** Potential harm to patients (both pregnant women in our care and neonates). Reputational loss Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	The RCOG and LSA Combined Action Plan in place **Control Owner:** Graham Ross	Limited	I = 5 L = 3 High (15)	Deliver all the actions in the RCOG and LSA Combined Action Plan **Person Responsible:** Graham Ross **To be implemented by:** 31 Oct 2016		I = 5 L = 2 Moderate (10)
CRR 42	Inappropriate management/use of pre-labelled medicines (over-labelled products) **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Julie Barton **Last Updated:** 05 Dec 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** The contingency of PGDs is complete and where required new PGDs are approriately produced in line with NICE guidance and evidence-based prescribing. The action requiring completion is to remove inappropriate unsafe 'TTO' tablet packs from the wards to remove the risk of unnecessary prescribing	05 Dec 2016	**Cause** *Insufficient control and governance of these medicines across the Trust to meet regulatory & professional requirements (NMC) in response to the Medicines Act. * The Pharmacy Department has been unable to provide a sufficient number of Pharmacists to deliver a safe clinical service. This has led to changes in practice and increase in use of pre-labelled medicines. **Effect** *Poor Patient outcomes *Non-compliance with the relevant regulatory and professional requirements (NMC) in response to the Medicines Act *Complaints from patients and GP's when incorrect quantities / medicines are supplied to take home. *Reputational damage *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	The Pharmacy Department check patient's medicines for discharge from the EDN either at ward level or in Pharmacy. **Control Owner:** Michelle Groom	Limited	I = 3 L = 5 High (15)	Review the use of pre-labelled medicines across the Trust and agree a plan with relevant stakeholders which will create a framework for clinical use within the policy requirements / compliance **Person Responsible:** Michelle Groom **To be implemented by:** 31 Jan 2017		I = 3 L = 3 Moderate (9)
									Roll out a Trust- wide training and education plan for an effective professional development framework which moves nurses from a dependency on PGD's and pre-labelled medicines to an increased number of autonomous independent prescribers **Person Responsible:** Jane Christmas **To be implemented by:** 31 Jan 2017		
									Producing and implementing a new pre-labelled medicines policy **Person Responsible:** Michelle Groom **To be implemented by:** 31 Jan 2017		
CRR 22	Failure to record/carry out timely Venous Thromboprophylaxis (VTE) risk assessments **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Gillian Evans **Last Updated:** 13 Jul 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** We have not been able to introduce VitalPac to the EDs at present but may be able to alert clinicians to those patients who have not had a VTE assessment recorded within 8 hours of admission through the Careflow management system	26 May 2016	**Cause** The move from a paper to an electronic reporting system has resulted in issues with data accuracy and with data capture. VTE assessments either not completed on the Vital Pac system or not captured due to technical difficulties **Effect** Non-compliance with NICE CG92 Non-compliance with NICE Quality Standard (QS3) VTE in adults Harm to patients Reputational damage - Increased Complaints - Legal Claims - Financial Loss	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	Consultants iPads able to access the VitalPAC system **Control Owner:** Paul Stevens	Adequate	I = 5 L = 3 High (15)	Create an alert in the Careflow patient management system from VitalPac when VTE assessment has not been recodered within 8 hours of a patient's admission to hospital **Person Responsible:** Andy Barker **To be implemented by:** 28 Feb 2017		I = 3 L = 2 Low (6)
						No Patient is allowed to leave Clinical Decisions Units/A&E without VTE assessment **Control Owner:** Jonathon Hawkins	Limited				
						No patient is allowed to leave the Theatre recovery area without VTE assessment being recorded **Control Owner:** Nic Goodger	Adequate				
						VTE assessment recording data extracted from the VitalPAc system **Control Owner:** Paul Stevens	Adequate				

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 4	Failure to recognise or treat Patients with sepsis in a timely way **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Michelle Webb **Last Updated:** 10 Jan 2017 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Data for the end of December has not yet been circulated but preliminary reports are of a deterioration in performance at WHH & QEQMH, performance has been maintained in K&CH	09 Feb 2016	**Cause** The opportunities and systems in place to recognise and manage patients presenting with or developing sepsis are not taken and/or the deteriorating patient is not recognised. Patients with cancer undergoing chemotherapy are susceptible to neutropenic sepsis. Previously fit and healthy adults may compensate clinically until they are critically ill. **Effect** Treatment is not administered in a timely way due to delayed recognition and and patients may suffer adverse outcomes.	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	A local rule base for coding for sepsis and severe sepsis **Control Owner:** Michelle Webb	Adequate	I = 5 L = 3 High (15)	Following recent national ED audit of recording of vital signs in children where both sites were in lowest quartile work needed in A&E to improve this. **Person Responsible:** Lesley White **To be implemented by:** 30 Dec 2016		I = 5 L = 2 Moderate (10)
						All Point of Care testing equipment for blood gas analysis updated to include lactate measurements in EDs and respiratory wards. **Control Owner:** Michelle Webb	Adequate		eCAS card to be rolled out across the two EDs over next two months and will allow for automatic calculation of early warning score in all adults **Person Responsible:** Andy Barker **To be implemented by:** 30 Dec 2016	**29 Dec 2016** eCasCard has rolled out with some outstanding issues. Further changes are planned to introduce more effective EWS tracking in ED. These are not expected to be implemented until February.	
						Clinical staff issued with aide-memoire on sepsis managment and compliance tested using CEM audit and local audit **Control Owner:** Michelle Webb	Adequate				
						Documentation in all EDs revised to consistently record patients vital signs and blood test results **Control Owner:** Michelle Webb	Adequate		Fully implement electronic EWS scoring in the EDs through eCasCard or an equivalent system **Person Responsible:** Andy Barker **To be implemented by:** 31 Mar 2017		
						Sepsis screening in ward patients triggering an EWS of 4 or higher **Control Owner:** Michelle Webb	Limited				
						Staff training in place on the recognition of patients with sepsis in line with national best practice, including primary care and Ambulance service **Control Owner:** Michelle Webb	Adequate		Strengthening mandatory training and opportunities at induction to ensure all staff aware of existing DOPs and local tools for screening and management of deteriorating patient, including sepsis. **Person Responsible:** Michelle Webb **To be implemented by:** 28 Jul 2017		
						VitalPac in place in all inpatient adult areas (exception labour wards) allowing for electronic capture of observations and automatic calculation of early warning risk score. **Control Owner:** Michelle Webb	Adequate				

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 40	Lack of robust antenatal and new-born screening programmes **Risk Owner:** Sally Smith **Delegated Risk Owner:** Rachael Chapman **Last Updated:** 01 Dec 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed. Updates to actions will be followed up with the owner by 20th January 17.	07 Nov 2016	**Cause** *Lack of tracking through the pregnancy adequately *Lack of awareness of infectious diseases and haemoglobinopathy screening programme *Lack of robust fail safe **Effect** *Non-compliance with national requirements including; - Combined screening for chromosomal abnormalities (Down's or Edwards'/Patau's syndromes); - Screening of newborns for congenital dislocation of the hip; and - NIPE (newborn physical examinations) * PACS and RIS have further impacted on the First trimester and Fetal anomaly screening programmes *Potential harm to unborn and new born babies *Legal challenge *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Booking Database in place for infectious diseases and haemoglobinopathy results **Control Owner:** Rachael Chapman	Limited	I = 3 L = 4 Moderate (12)	Carry out audit of Clinic and results checklist **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Jan 2017		I = 3 L = 2 Low (6)
						Escalation process in place for system issues (PACS and RIS) to highlight women due to have scans within timelines **Control Owner:** Rachael Chapman	Adequate		Re-commence Steering Group for all stakeholders of the Screening Programme and agree ToR **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Jan 2017		
						Fail safe tracking system for combined screening for chromosomal abnormalities (Down's or Edwards'/Patau's syndromes) **Control Owner:** Rachael Chapman	Limited		Develop a robust system to track new born abnormality from referral to treatment (RTT) **Person Responsible:** Rachael Chapman **To be implemented by:** 28 Apr 2017	**03 Jan 2017** The Trust's informatics team are attempting to adapt the live tracking system used in A&E. The aim would be to capture women as soon as they 'book' for antenatal care, using 'flag's status when the woman is at the start of the USS screening time frame, about to breech timeframe (if she has not had her USS), and when/if the blood sample has been taken for this screening. Barrier to this is developing a method of retrieving information needed from maternity system E3.	
						Fail safe tracking system for the New born blood spots screening programme (National/Local database) **Control Owner:** Rachael Chapman	Adequate				
						Mandatory Education programmes in place for midwives across the Trust **Control Owner:** Rachael Chapman	Adequate		Reviewing the mandatory training offer to incorporate the national screening committee standards **Person Responsible:** Rachael Chapman **To be implemented by:** 28 Apr 2017	**03 Jan 2017** Mandatory training is in process of being updated. Senior member of the haematology lab is a frequent guest speaker in sickle cell and thalassemia screening with excellent feedback. The future program will include newborn hearing screening with the NHSP coordinator being a guest speaker. The education program is under review by HOM and the ANNB team are waiting for confirmation of how future education program will run.	
						NIPE Smart System in place (tracking fail safe system for new born examination and referral for any abnormalities including hips) **Control Owner:** Rachael Chapman	Limited				
						Screening guidelines in place and available to staff on SharePoint - Antenatal, Post-natal, Infectious diseases etc. **Control Owner:** Rachael Chapman	Limited		Create a robust tracking system to follow women from booking to receiving their results **Person Responsible:** Rachael Chapman **To be implemented by:** 28 Apr 2017	**18 Jan 2017** The Trust's informatics team are attempting to adapt the live tracking system used in A&E. The aim would be to capture women as soon as they 'book' for antenatal care, using 'flag's status when the woman is at the start of the USS screening time frame, about to breech timeframe (if she has not had her USS), and when/if the blood sample has been taken for this screening.	
									Standardise the booking system process across the Trust **Person Responsible:** Jo Olagboyega **To be implemented by:** 28 Apr 2017		

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
									There have been two RCA investigations of the NIPE screening program, one of which was reported on STEIS. An action that is relevant to both investigations, that can mitigate future risks, would be to appoint a nominate person to over see the whole program. This NIPE lead would over see the education, training and development of standard operating procedures and guidelines, lead investigations and ensure babies with abnormalities enter treatment program. The NIPE lead would liaise between trust sites and neighbouring trusts to ensure that all babies in the locality are screening appropriately. Full role description to be developed and agreed by Head of midwifery. **Person Responsible:** Rachael Chapman **To be implemented by:** 30 Jun 2017		
CRR 12	Inadequate Ophthalmology follow up arrangements **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Chris Hudson **Last Updated:** 10 Jan 2017 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Open Eyes software has been successfully introduced to the cataract pathway and is now being rolled out the remaining ophthalmological pathways	23 Feb 2016	**Cause** Due to historic PAS systems, the true patient follow up capacity gap has never been visible. Partial booking has given transparency to the issues facing patients requiring regular follow up. Ophthalmology specialties provide services in predicted high growth areas and these are expected to further increase with an aging demographic. **Effect** There are 7,550 patients waiting for a follow up appointment outside of their required timeframe to be seen. Nearly 1,500 patients are being validated as they are not indicated at speciality level. Therefore nearly 5,500 patients have been escalated as requiring an appointment that is overdue and require urgent follow-up within the specialty. There is a lack of out-patient capacity to manage the backlog and maintain the current patient cohort.	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	A pathway has been developed for the commissioners to enable the safe transfer of stable follow up glaucoma and WET AMD patients into the community **Control Owner:** Paul Stevens	Limited	I = 4 L = 3 Moderate (12)	Recruitment to 6 new consultant Ophthalmology posts **Person Responsible:** Paul Stevens **To be implemented by:** 28 Feb 2017	**08 Nov 2016** 6 Consultants recruited. To start work in early 2017.	I = 4 L = 2 Moderate (8)
						Approximately 1100 high risk patients records have been reviewed and appropriate actions taken **Control Owner:** Chris Hudson	Adequate		Implement the ophthalmology transformation strategy, which involves an increase in staff numbers and new equipment to support these staff. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2017	**08 Nov 2016** Implementation of strategy progressing	
						Open Eyes software has been introduced to facilitate ophthalmological patient flow and follow. **Control Owner:** Paul Stevens	Adequate		Implementation of the next phase of Open Eyes record management software **Person Responsible:** Chris Hudson **To be implemented by:** 31 Mar 2017		
						Proposals for Virtual clinics have been described in the business case for follow up diabetic medical retina patients, with a conservative estimate of 3,000 patients who would benefit from this approach. These clinics are expected to become live in mid-July **Control Owner:** Paul Stevens	Limited				

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 18	Failure to comply with the recommendations in the Mazar's report which include case note review of each and every patient death **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 10 Jan 2017 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** We have not yet received the national tool for mortality review	24 Apr 2016	**Cause** * Insufficient capacity - 2690 deaths reported in 2015/16. Estimate that a minimum of 1345 hours of Consultant time will be required to undertake case note reviews. **Effect** * Potential failure to identify avoidable causes of death and inability to learn lessons from this. * Harm to future patients * Exposure to legal challenge * Reputational loss	AO1: Patients. Help patients take control of their own health	I = 3 L = 5 High (15)	Clinician oversight, using data from HSCIC, of all coded mortality alerting as outliers. Programme of retrospective case note review in place at divisional and corporate levels. **Control Owner:** Paul Stevens	Adequate	I = 3 L = 4 Moderate (12)	Production of a national tool for mortality reviews by the delegated organisations (Innovation Unit of the Royal College of Physicians and the North Yorkshire AHSN) **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2017		I = 3 L = 2 Low (6)
						Established programme of Mortality and Morbidity meetings across all specialties **Control Owner:** Paul Stevens	Limited		Implementation of the national tool for mortality review **Person Responsible:** Paul Stevens **To be implemented by:** 28 Jul 2017		
						Mortality Surveillance Group in place - 1st meeting held in June 2016 **Control Owner:** Paul Stevens	Adequate				
						Review of M&M meetings and a template designed for presentations and for learning **Control Owner:** Helen Goodwin	Limited				

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 34	Inadequate Health & Safety (H&S) systems embedded within the Divisions **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 15 Dec 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No changes to risk scores. Progress notes added. IOSH Training undertaken in some Divisions. Awaiting confirmation of numbers from HR.	09 Sep 2016	**Cause** * Failure to address H&S issues/incidents/themes within Divisions * Lack of appropriate H&S systems *Inconsistency in H&S processes **Effect** *Potential breach of H&S regulations which may result in penalty notices and significant fines *Harm to Staff *Reputational damage *Financial loss *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Annual H&S Toolkit Audit **Control Owner:** Liz Shutler	Adequate	I = 4 L = 3 Moderate (12)	Health & Safety session to Board on Board Development Day **Person Responsible:** Liz Shutler **To be implemented by:** 31 Jan 2017	**17 Jan 2017** The January session has been moved to the March 2017 (After the March review of the Development Plan). **15 Dec 2016** Had a session in December with the QC about H&S. The January session has been moved to the February 2017.	I = 4 L = 2 Moderate (8)
						Divisional H&S structures in place **Control Owner:** Fin Murray	Limited				
						Divisional nominated H&S Link workers **Control Owner:** Fin Murray	Adequate				
						H&S KPIs reported to Board monthly via the IPR **Control Owner:** Fin Murray	Adequate		Implement action plans from the H&S toolkit audit **Person Responsible:** Chris Hudson **To be implemented by:** 30 Jun 2017	**18 Jan 2017** Discussed at the last Strategic H&S Committee. Divisional representatives asked by the Committee to present action plans to address non-compliant areas to the next meeting. **15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	
						H&S module part of mandatory training for all staff **Control Owner:** Jacqui Siggers	Adequate				
						Half yearly H&S toolkit audits for brown areas **Control Owner:** Fin Murray	Limited				
						Internal Audit Acton Plan in place **Control Owner:** Liz Shutler	Limited		Implement training plan **Person Responsible:** Mary Tunbridge **To be implemented by:** 30 Jun 2017	**18 Jan 2017** IOSH Training undertaken in some Divisions. Awaiting confirmation of numbers from HR. **15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	
						Oversight by Trust Board **Control Owner:** Liz Shutler	Adequate				
						Site based H&S Committee in place **Control Owner:** Fin Murray	Adequate				
						Site based Health and Safety Teams in place **Control Owner:** Fin Murray	Adequate		Implement training plan **Person Responsible:** Chris Hudson **To be implemented by:** 30 Jun 2017	**18 Jan 2017** IOSH Training undertaken in some Divisions. Awaiting confirmation of numbers from HR. **15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	
						Strategic H&S Committee in place **Control Owner:** Liz Shutler	Adequate		Implement training plan **Person Responsible:** Lesley White **To be implemented by:** 30 Jun 2017	**18 Jan 2017** IOSH Training undertaken in some Divisions. Awaiting confirmation of numbers from HR. **15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	
									Implement action plans from the H&S toolkit audit **Person Responsible:** Lesley White **To be implemented by:** 30 Jun 2017	**18 Jan 2017** Discussed at the last Strategic H&S Committee. Divisional representatives asked by the Committee to present action plans to address non-compliant areas to the next meeting. **15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
									Implement action plans from the H&S toolkit audit **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Jun 2017	**18 Jan 2017** Discussed at the last Strategic H&S Committee. Divisional representatives asked by the Committee to present action plans to address non-compliant areas to the next meeting. **15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	
									Implement training plan **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Jun 2017	**18 Jan 2017** IOSH Training undertaken in some Divisions. Awaiting confirmation of numbers from HR. **09 Jan 2017** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	
									Implement action plans from the H&S toolkit audit **Person Responsible:** Mary Tunbridge **To be implemented by:** 30 Jun 2017	**18 Jan 2017** Discussed at the last Strategic H&S Committee. Divisional representatives asked by the Committee to present action plans to address non-compliant areas to the next meeting. **15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis.	
									Transfer Divisional H&S risks to 4Risk **Person Responsible:** Lesley White **To be implemented by:** 30 Aug 2017	**15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis. **28 Sep 2016** At EPR on 21 September, the Deputy CEO updated each Divisional Director on the IA actions and they agreed to implement them.	
									Transfer Divisional H&S risks to 4Risk **Person Responsible:** Mary Tunbridge **To be implemented by:** 30 Aug 2017	**15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis. **28 Sep 2016** At EPR on 21 September, the Deputy CEO updated each Divisional Director on the IA actions and they agreed to implement them.	
									Transfer Divisional H&S risks to 4Risk **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Aug 2017	**15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis. **28 Sep 2016** At EPR on 21 September, the Deputy CEO updated each Divisional Director on the IA actions and they agreed to implement them.	

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
									Transfer Divisional H&S risks to 4Risk **Person Responsible:** Chris Hudson **To be implemented by:** 30 Aug 2017	**15 Dec 2016** Progress of action plans will be monitored by the Strategic H&S Committee on a Quarterly basis. **28 Sep 2016** At EPR on 21 September, the Deputy CEO updated each Divisional Director on the IA actions and they agreed to implement them.	
CRR 41	Failure to manage Patients with challenging behaviour (Dementia and other mental health challenges) **Risk Owner:** Sally Smith **Delegated Risk Owner:** Sally Hyde **Last Updated:** 06 Dec 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed. Updates will be sought against actions due before the end of January 17.	07 Nov 2016	**Cause** *Increased number of long-stay Patients/delayed discharge *National shortage of Mental Health Nurses **Effect** *Potential harm to Patients, Staff and Visitors	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Smart tool usage at Wards & Departments with Patients who display challenging behaviour **Control Owner:** Sally Hyde Use of NHSP registered mental health nurses **Control Owner:** Sally Smith Use of Safe Assist to maintain safety of Patients and Staff **Control Owner:** Fin Murray	Limited Limited Limited	I = 3 L = 4 Moderate (12)	Develop Specialling Policy **Person Responsible:** Jane Christmas **To be implemented by:** 17 Jan 2017 Monitor compliance with the Smart tool usage through the Safeguarding & Dementia teams **Person Responsible:** Jane Christmas **To be implemented by:** 31 Jan 2017	**18 Jan 2017** Policy Ratified at the Policy and Compliance Group. **06 Dec 2016** Policy for the next Policy and Compliance Group.	I = 3 L = 2 Low (6)
CRR 32	Inability to share information about children and young people **Risk Owner:** Sally Smith **Delegated Risk Owner:** Trish Hubbard **Last Updated:** 18 Jan 2017 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed. New action described, and the previous action cancelled due to the decisions of the commissioners.	12 Aug 2016	**Cause** * Notice of cessation of the Children and Young Persons Liaison Service by the CCG from September 2016 **Effect** * Potential lack of recognition of frequent offenders and safeguarding concerns going unrecognised * Reputational damage * Legal challenge	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 4 L = 4 High (16)	Information sharing has been agreed across agencies. **Control Owner:** Carol Tilling Interim arrangements in place after the closure of the service - process for identifying children at risk in the EDs by the Child Safeguarding Team. **Control Owner:** Carol Tilling	Limited Limited	I = 4 L = 3 Moderate (12)	New discussions to take place with the CCGs and other stakeholders to address this risk and provide a liaison service. **Person Responsible:** Helen Waymouth **To be implemented by:** 31 May 2017	**18 Jan 2017** Meetings are scheduled for late January.	I = 4 L = 3 Moderate (12)
CRR 39	Delays in Radiological reporting **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Paul French **Last Updated:** 21 Nov 2016 **Latest Review Date:** 03 Jan 2017 **Latest Review By:** Paul French **Latest Review Comments:** Updated	04 Oct 2016	**Cause** *Increased demand *Lack of reporting capacity - Radiologist and Reporting Radiographers *Problems with PACS and RIS *Lack of scan capacity *Gaps in workforce (including staff turn over within Consultant Radiologist team) **Effect** *Failing to consistently meet 2WW and 18 week pathway access standards *Delays in Patients diagnosis and start of treatment *Potential harm to Patients *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Ca pathway and urgent referrals are prioritised by CT/ MRI, **Control Owner:** Paul French Consultant Radiologist has checked the lung referrals and reported many of them to minimise this risk. **Control Owner:** Paul French Engagement of short term locum and fixed term radiologist pending recruitment **Control Owner:** Paul French Reporting of CT & MRI capacity. Review of activity against reporting. **Control Owner:** Paul French	Limited Limited Limited Limited	I = 4 L = 3 Moderate (12)	Source substantive and fixed term radiologist **Person Responsible:** Paul French **To be implemented by:** 31 Oct 2016	**03 Jan 2017** One FTC appointed anticipated start date by April 17 One substantive consultant appointed anticipated start date April 17 Business case being approved for additional radiologist. Agreement to appoint FTC in interim	I = 4 L = 2 Moderate (8)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 7	Potential delayed treatment of patients requiring emergency acute general surgery intervention at the Kent and Canterbury Hospital site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 13 Sep 2016 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Risk reviewed and action changed to reflect the alignment of the East Kent Clinical Strategy with the Kent & Medway STP	10 Feb 2016	**Cause** There is only provision for specialist vascular and urology surgery on the Kent and Canterbury site and the provision for the emergency pathway is restricted to an ECC model providing acute unselected medical take and not a full Accident and emergency service. This situation was widely shared with GP and SECAmb partners over 10 years ago. In the past general surgical intervention, when needed, was covered by vascular surgeons. With the introduction and further development of Specialist Medical Training (Calman Report) the ability of surgeons to be deemed competent to perform procedures outside their registered speciality has decreased. **Effect** Patients requiring acute general surgical intervention are occasionally transferred or self-present to the K&CH site and require subsequent transfer to either the WHH or QEQMH after stabilisation. Some vascular surgeons do maintain core clinical competencies for general surgery but there is no acute general surgical rota at the K&CH site and this can result in delays to treatment.	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Change to SECAmb conveyance criteria to prevent patients with acute general surgical emergencies being conveyed to the K&CH site. These changes became live on the 9th May 2016. **Control Owner:** Paul Stevens	Adequate	I = 5 L = 2 Moderate (10)	Implementation of the East Kent Clinical Strategy through the Kent & Medway STP process **Person Responsible:** Liz Shutler **To be implemented by:** 28 Feb 2018		I = 2 L = 2 Low (4)
						Clarity of the function of the K&CH site as not having the capability to manage general surgical emergencies communicated to external partners including SECAmb and GPs. **Control Owner:** Paul Stevens	Adequate				
						Clear guidance for the transfer of patients with possible surgical pathology to the acute sites (WHH & QEQMH) written, agreed and put in place 10th March 2016 **Control Owner:** Nic Goodger	Adequate				
						Emergency Care Centre re-designed to provide a Primary Care led Urgent Care Centre, a Minor Injuries Unit and an Acute Medical Assessment Unit **Control Owner:** Paul Stevens	Adequate				
						Rapid assessment of patients and transfer out to the WHH and QEQMH or competent vascular surgical intervention at the K&CH, **Control Owner:** Paul Stevens	Adequate				

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 23	Delays in first trimester and anomaly obstetric ultrasound scans **Risk Owner:** Sally Smith **Delegated Risk Owner:** Rachael Chapman **Last Updated:** 01 Dec 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and updates need to be sought by next month. Proposal to merge this risk with CRR40. For Management Board in February 17.	26 May 2016	**Cause** - Obstetric ultrasound capacity utilisation in radiology is currently >95% -Poor Administration / Process management and monitoring **Effect** - Non-compliance with national antenatal and new-born screening programme - Harm to babies/foetus - Reputational loss - Legal claim - Financial loss	AO1: Patients. Help patients take control of their own health	I = 3 L = 3 Moderate (9)	Accommodating requests for first trimester scans when there is a late booking (classified as urgent) **Control Owner:** Rachael Chapman	Limited	I = 3 L = 3 Moderate (9)	Implement workforce and recruitment plans to address staffing shortfalls in imaging and retention of skilled ultra-sonographers **Person Responsible:** Lorraine Young **To be implemented by:** 31 Oct 2016		I = 3 L = 1 Very Low (3)
						Daily review of demand, potential breaches and allocating appointments **Control Owner:** Rachael Chapman	Adequate		Principal Sonographer to review the number of women needing to be recalled for second trimester screening **Person Responsible:** Lorraine Young **To be implemented by:** 02 Dec 2016		
						Escalation plans in place where controls are at risk of being inadequate. **Control Owner:** Rachael Chapman	Limited		Consider electronic solution to replace multiple processes for US requesting. Pilot commencing for all midwives to request scans electronically **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Mar 2017	**01 Dec 2016** plan to roll out full electronic ordering in early 2017. Trial of iPhones as WIFI 'hot-spots' begins December Centralisation of midwifery referral and PAS episode opened by Outpatient is due to start Early 2017. **14 Nov 2016** An IT support midwife is now in post	
						Escalation process in place for Midwives to report any women who have been appointed/ or scanned outside the screening deadline **Control Owner:** Rachael Chapman	Adequate				
						Monthly meetings held between the Screening and Ultrasound Teams **Control Owner:** Rachael Chapman	Adequate		Workforce and recruitment plans to address staffing and create improved resilience within the current service. **Person Responsible:** Helen Bland **To be implemented by:** 31 Mar 2017	**18 Jan 2017** Establishment review carried out at then of 2016 took place. Changes to the establishment are in progress with the aim of completion by the end of March 17. **07 Nov 2016** Rolling recruitment plan in Radiology and Midwifery.	
						Short term planning in place to increase obstetric ultrasound capacity **Control Owner:** Rachael Chapman	Limited				
CRR 19	Delays in the cancer pathway of over 100 days **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Paul Stevens **Last Updated:** 22 Jan 2017 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Key changes are the outsourcing of endoscopy backlog to an agency for 12 months whilst additional internal resource is generated through training and JAG accreditation	24 Apr 2016	**Cause** * Diagnostic delays predominantly in the colorectal and prostate cancer pathways (access to endoscopy and MRI diagnostics) * Lack of outpatient capacity * Lack of treatment capacity **Effect** * Possible harm to Patients * Reputational damage * Regulatory concerns	AO1: Patients. Help patients take control of their own health	I = 3 L = 4 Moderate (12)	Diagnostic capacity is reviewed at the KPI meeting and also within the Clinical Support Divisions **Control Owner:** Trish Hubbard	Limited	I = 3 L = 3 Moderate (9)	Achieve JAG accreditation of WHH endoscopy unit **Person Responsible:** Lisa Neal **To be implemented by:** 31 Mar 2017		I = 3 L = 2 Low (6)
						Increased endoscopy resource achieved through outsourcing using an agency contract which will run for 1 year whilst internal resource is being created **Control Owner:** Lisa Neal	Adequate		Replacement of the MRI scanner in Canterbury **Person Responsible:** Mary Tunbridge **To be implemented by:** 31 Mar 2017	**08 Nov 2016** On track	
						Process outlined for clinicians to complete initial screening of pathway delays **Control Owner:** Jane Ely	Adequate		Complete accredited training for surgeons undertaking endoscopy **Person Responsible:** Nic Goodger **To be implemented by:** 31 Dec 2017	**18 Jan 2017** Newly appointed colorectal surgeons are being trained in colonoscopy with the aim of moving to 7 day availability of this diagnostic service	
						Tracking system in place with an updated position disseminated weekly. **Control Owner:** Jane Ely	Adequate				
						Use of Datix incident reporting for all delayed cancer patients to improve visibility of patient affected. **Control Owner:** Helen Goodwin	Adequate				

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 16	Poor complaints management **Risk Owner:** Sally Smith **Delegated Risk Owner:** Elizabeth Coleman **Last Updated:** 31 Oct 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Assurance Levels reviewed and controls.	24 Apr 2016	**Cause** - The Trust has seen an increase in the number of written complaints following the first CQC inspection. - Delays in first response times - Poor quality of the Trust replies to written complaints -There is an increasing complexity in the scope and nature of concerns raised. - The processes in divisions and within the Patient Experience Team have resulted in delays across the whole pathway. - There is a gap in communication between the PET and the divisional governance teams. - The divisional teams do not receive timely notification of written complaints. - Staff shortages are impacting on the management of complaints. **Effect** - The ability of the Trust to respond to the agreed first response time frame and within the 30 days of receipt is not being met consistently. - The time-frame agreed with the complainant is often being met but the quality of the Trust's response is failing to meet expectation. - Increased number of returners and dissatisfaction - Reputational loss	AO1: Patients. Help patients take control of their own health	I = 3 L = 4 Moderate (12)	Complaints team in place with staff based on the three main sites. **Control Owner:** Jane Christmas	Adequate	I = 3 L = 3 Moderate (9)	Work with HR Systems to ensure training records are captured. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Mar 2017		I = 3 L = 2 Low (6)
						Process is in place to prevent data capture anomalies **Control Owner:** Jane Christmas	Adequate				
						Regular review of the complaint KPIs with Divisional leads **Control Owner:** Jane Christmas	Adequate		Implement a web-based complaints management system to interface with the existing web-based incident system. **Person Responsible:** Helen Goodwin **To be implemented by:** 31 Mar 2017	**18 Jan 2017** Procurement is in progress - date for completion will be conformed by the end of January 17. **06 Dec 2016** Implementation date of the web based system has changed due to delays in procuring the system.	
						The Datix system is used to record complaints and Trust responses. This system can monitor agreed time scales and record satisfaction with the responses. **Control Owner:** Helen Goodwin	Adequate				
						The PET provide support and specific training in the management of complaints to staff in all clinical and non-clinical divisions. **Control Owner:** Sally Smith	Limited		A training programme needs to be developed and implemented for staff according to a training needs analysis. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Mar 2017	**18 Jan 2017** This work is in progress. **07 Nov 2016** The training referred to in this action is the around the complaints process. Discussions afoot with the Divisions and Divisional leads.	
						The Trust responds to its legal and professional duty of candour **Control Owner:** Paul Stevens	Adequate				

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 9	Inadequate Planned Preventative Maintenance of clinical equipment **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Julie Barton **Last Updated:** 10 Jan 2017 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Action edited to reflect what the action should deliver to mitigate the risk	22 Feb 2016	**Cause** * Lack of delivery of a servicing plan * Poor staff capacity to service equipment on a rolling basis * Lack of knowledge of equipment that need servicing **Effect** * Clinical equipment in direct Patient use will have passed their target date for PPM * Potential harm to Patients	AO3: Provision: Provide the services needed and do it well	I = 3 L = 4 Moderate (12)	Each major site has access to an equipment library where items are cleaned and checked before re-use **Control Owner:** Paul Stevens	Adequate	I = 3 L = 3 Moderate (9)	Recruitment to the additional staff outlined within the business case to enable the planned preventative maintenance of clinical equipment. **Person Responsible:** David Attwell **To be implemented by:** 28 Feb 2017	**15 Dec 2016** 15.12.16 four additional staff have been recruited to the EME service, not all these staff are currently in post.	I = 3 L = 2 Low (6)
						High risk clinical equipment is purchased with servicing and support arrangements as part of the contractual terms and maintained throughout the asset life of the equipment. **Control Owner:** Paul Stevens	Adequate				
						Monitoring of compliance formally by the Medical Devices Management Group and also informally by the Improvement Board Delivery Group **Control Owner:** Julie Barton	Adequate				
						The medical device co-ordinators have attended all clinical areas to raise awareness of this issue, and encourage ward / clinical staff to report overdue equipment to EME. **Control Owner:** Paul Stevens	Adequate				
						The Trust purchased a new database (F2) to identify, control and manage all equipment used in the care and management of patients. Wards and departments have access to the F2 database through the departmental device register link on all trust computers - this enables ward / dept managers to monitor and manage the maintenance of equipment in their areas. **Control Owner:** Paul Stevens	Adequate				
CRR 30	Failure to implement the Accessible Information Standard **Risk Owner:** Sally Smith **Delegated Risk Owner:** Bruce Campion-Smith **Last Updated:** 21 Oct 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed, and assurance levels re-appraised.	12 Aug 2016	**Cause** * No implementation plan * Failure to identify and recorded information and communication needs with service users **Effect** * Legal challenge from service users, support groups and charities * Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 3 L = 4 Moderate (12)	Action plan in place with monthly monitoring at the meetings. **Control Owner:** Bruce Campion-Smith	Limited	I = 3 L = 3 Moderate (9)	Implement Accessible Information Standard Action Plan **Person Responsible:** Bruce Campion-Smith **To be implemented by:** 31 Mar 2017	**18 Jan 2017** PAs has been updated with a 'flag', so that communication needs are made visible to the staff.	I = 3 L = 2 Low (6)
						Audit tool developed and circulated to relevant individuals for completion. **Control Owner:** Bruce Campion-Smith	Adequate				
						Diversity and Inclusion Steering Group in place. **Control Owner:** Bruce Campion-Smith	Adequate				

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 13	Inability to fund an adequate asset replacement programme for high cost and high risk medical equipment approaching the end of their asset life **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 23 Nov 2016 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Liz Shutler. No changes to risk scores.	23 Feb 2016	**Cause** There has been a reduction in the capital allocation for replacement and updating of high cost essential clinical equipment. **Effect** Items of clinical equipment has reached the end of its asset life and requires increased maintenance and support in order to ensure that safety is maintained and reduce the likelihood of failure.	AO1: Patients. Help patients take control of their own health	I = 3 L = 4 Moderate (12)	Prioritised list of high cost medical equipment in place **Control Owner:** Fin Murray	Adequate	I = 3 L = 3 Moderate (9)	Recruitment up to new agreed establishment for EME **Person Responsible:** Julie Barton **To be implemented by:** 30 Dec 2016	**15 Dec 2016** Some progress made - recruited 4 staff but not all in post.	I = 3 L = 2 Low (6)
						Risk based approach to re-prioritising the capital programme in place **Control Owner:** Liz Shutler	Adequate				
						The Medical Devices Group prioritises the replacement programme using a risk-based model outlined in the Medical Devices Policy. **Control Owner:** Liz Shutler	Adequate				
						The Planned Preventive Maintenance Programme identifies and manages equipment used in the care of patients **Control Owner:** Julie Barton	Adequate				
						There is an annual capital allocation, under the auspices of the Medical Devices Group that make decisions on the priorities for purchase and replacement. **Control Owner:** Fin Murray	Adequate				

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 36	Inadequate Adult Safeguarding training arrangements Trust-wide **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 17 Oct 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Reviewed and new action developed.	09 Sep 2016	**Cause** *Lack of access to current training data *Failure to prioritise training attendance *Reduced staffing levels in the Adult Safeguarding Team **Effect** *Regulatory concerns *Legal challenge *Reputational loss	AO2: People: Identify, recruit and develop talented staff	I = 3 L = 4 Moderate (12)	Adult Safeguarding training delivered by e-Learning **Control Owner:** Helen Goodwin	Limited	I = 3 L = 3 Moderate (9)	Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Liz Mount **To be implemented by:** 31 Mar 2017	**31 Jan 2017** Compliance at Dec 16 was 39%. The Division will review Women's Health where the lowest compliance is. The TNA will be reviewed in time for the Feb 17 EPR. **18 Jan 2017** Obtaining compliance figures by the 25th January 17, and the action will be updated.	I = 3 L = 2 Low (6)
						Monthly training sessions on all sites **Control Owner:** Helen Goodwin	Limited				
						Training needs analysis and Training Programme in place **Control Owner:** Helen Goodwin	Adequate		Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Heather Munro **To be implemented by:** 31 Mar 2017	**31 Jan 2017** Surgical Compliance at Dec 16 is 81%. This is reviewed at every EPR. **30 Jan 2017** Surgical Division- Adult Safeguarding Level 2 - Compliant Adult shows Aug 76%, Sept 83% Oct 83% November 82% Dec 81%. the division will as per email from SH review the managers whom should undertake training and then update the risk	
									Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Elisa Steele **To be implemented by:** 31 Mar 2017	**31 Jan 2017** UC&LTCs compliance is 83%. This will be reviewed at EPR in February 17. **18 Jan 2017** Obtaining compliance figures by the 25th January 17, and the action will be updated.	
									Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2017	**31 Jan 2017** Compliance of CSSD is 85%. **18 Jan 2017** Obtaining compliance figures by the 25th January 17, and the action will be updated.	
									Recruit to the Safeguarding Team vacancies following revised QIA and once the Resourcing Team have advertised the required posts. **Person Responsible:** Helen Goodwin **To be implemented by:** 30 Apr 2017	**18 Jan 2017** Quality Impact Assessments are completed. Some recruitment has taken place. Learning Disability post and latest vacancy yet to be recruited to.	

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 25	Failure to recognise sudden deterioration in critically ill or seemingly well children **Risk Owner:** Sally Smith **Delegated Risk Owner:** El-Hussein Rfidah **Last Updated:** 06 Dec 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Target risk score achieved - proposal to remove from corporate and place on Divisional for monitoring.	10 Jun 2016	**Cause** - Undiagnosed condition - Incorrect calculation of Paediatric Early Warning Scores (PEWS) in ED at both acute hospitals sites. **Effect** - Increase incidence neonatal and infant mortality - Reputational loss - Increased complaints - Legal challenge	AO1: Patients. Help patients take control of their own health	I = 4 L = 3 Moderate (12)	Deteriorating Patient and Escalation Policy in place **Control Owner:** El-Hussein Rfidah	Adequate	I = 4 L = 2 Moderate (8)	**Person Responsible:** **To be implemented by:**		I = 4 L = 2 Moderate (8)
						Learning is shared across the Division. Matron has a system in place. **Control Owner:** Vivienne Millbank	Adequate				
						Paediatric Early Warning Scores (PEWS) in place in ED department. Practice development sister has delivered training and this will be a continuous process. **Control Owner:** Vivienne Millbank	Adequate				
CRR 37	Potential negative impact of PAS system implementation on 18 weeks Referral to Treatment (RTT) **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 12 Jan 2017 **Latest Review Date:** 12 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Jane Ely. No change to risk score. No revised date for PAS implementation. Next project meeting on 21 January 2017.	04 Oct 2016	**Cause** *Reduction of clinics for outpatients **Effect** *Potential harm to Patients *Reputational damage *Financial loss *Regulatory concerns (linked to Trust License)	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Advise received from other Trusts that have implemented PAS - reduction of number of Patients booked into clinics 50% week 1, 25% week 2 and 25% week 3 (except cancer clinics) **Control Owner:** Julia Bournes	Adequate	I = 4 L = 2 Moderate (8)	Review existing controls in light of the new PAS Implementation date. **Person Responsible:** Jane Ely **To be implemented by:** 30 Dec 2016	**12 Jan 2017** No date agreed yet for Project implementation. Next project meeting on 21st January. **19 Dec 2016** No date agreed yet for Project implementation. Next project meeting on 21st January.	I = 4 L = 2 Moderate (8)
						Detailed Information Database linking back to demand and capacity model that quantifies activity and the plans to bring the activity forward and any alternative provision if unable to do so **Control Owner:** Julia Bournes	Adequate		Implementation of eCasCard lessons learned report required **Person Responsible:** Andy Barker **To be implemented by:** 28 Feb 2017		

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 31	Exposure to Cyber Security Attacks **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Bob Nelson **Last Updated:** 24 Nov 2016 **Latest Review Date:** 02 Feb 2017 **Latest Review By:** Bob Nelson **Latest Review Comments:** Work continues in this area to strengthen boundaries but there are no significant changes within this period.	12 Aug 2016	**Cause** * External hacking *Staff non-compliance with internal processes * New attack techniques being developed against XP **Effect** * Loss to Trusts systems confidentiality and availability * Reputational damage * Potential financial and legislative penalties * Financial loss	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Boundaries, firewalls and internet gateways in place **Control Owner:** Bob Nelson	Adequate	I = 4 L = 2 Moderate (8)	Implement Internal Audit recommendations **Person Responsible:** Bob Nelson **To be implemented by:** 31 Mar 2017	**24 Nov 2016** Scoping meeting held with MW 23/11 to investigate best ways to address action plan - In progress	I = 3 L = 1 Very Low (3)
						Information Sharing Agreements (ISAs) in place with some third parties for access to Trust information **Control Owner:** Michael Doherty	Limited		Provide cyber security education/information to all staff **Person Responsible:** Michael Doherty **To be implemented by:** 31 Mar 2017	**18 Jan 2017** National Cyber Security Training is being developed by the HSCIC for deployment by 31/3/2017 md	
						IT introduced many new security features based on latest best practice e.g. dual skin firewalls, Intrusion Prevention Systems and scanning **Control Owner:** Bob Nelson	Adequate		Board Development session on Cyber Security Risk to identify the scale of risk **Person Responsible:** Andy Barker **To be implemented by:** 31 May 2017		
						IT Protocols in place for reporting on cyber incidents **Control Owner:** Bob Nelson	Adequate		Review of the requirements of the new General Data Protection Regulation (GDPR) including the ISAs process **Person Responsible:** Michael Doherty **To be implemented by:** 30 Mar 2018		
						Malware protection in place **Control Owner:** Bob Nelson	Adequate				
						New smart desktop is fully managed with automated patching, AV and attack monitoring **Control Owner:** Bob Nelson	Adequate				
						Regular audits of electronic access to systems **Control Owner:** Michael Doherty	Limited				
						Secure configuration in place **Control Owner:** Bob Nelson	Adequate				
						Statutory Information Governance Training in place for Staff **Control Owner:** Michael Doherty	Adequate				
CRR 20	Failure to send timely information to GPs on their patients who have had an outpatient appointment **Risk Owner:** Jane Ely **Delegated Risk Owner:** Mary Tunbridge **Last Updated:** 12 Jan 2017 **Latest Review Date:** 12 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. The risk likelihood has increased due to some Specialities not meeting the performance standards set. A new action has been added to carry out a review of these Specialities by end March 2017.	24 Apr 2016	**Cause** * Lack of knowledge of performance standards * Lack of consistent monitoring of performance standards * Gaps in administration workforce e.g. ENT **Effect** * Failure to meet performance standard - our current year to date performance is 65.7% compliance. * Patients ongoing care is delayed * Reputational damage * Potential harm to Patients	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 2 L = 5 Moderate (10)	Deep-dives carried out with corresponding action plans in place **Control Owner:** Mary Tunbridge	Limited	I = 2 L = 4 Moderate (8)	Implement GP Letters Action Plans **Person Responsible:** Mary Tunbridge **To be implemented by:** 01 Dec 2016	**19 Dec 2016** Plan is ongoing. Progress reported monthly to MB and reviewed at EPR. Stock take at January 2017 EPR to see if focus needs to be made on specific areas of risk.	I = 2 L = 2 Low (4)
						Performance standards for response times agreed and monitored against the standards **Control Owner:** Mary Tunbridge	Limited		Roll-out OpenEyes system to enable letters to Ophthalmology Patients be produced in a timely manner **Person Responsible:** Andy Barker **To be implemented by:** 31 Jan 2017	**12 Jan 2017** First stage of rollout complete in Cataracts. Next phase to be implemented by 31 March 2017. **29 Dec 2016** First stage of rollout is complete in cataracts.	
						Regular feedback from GPs highlighting concerns **Control Owner:** Mary Tunbridge	Adequate				
						Typing of letters outsourced to an external provider with clear turnaround targets **Control Owner:** Mary Tunbridge	Adequate		Review of Specialities with inconsistent improvements in performance **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2017		

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 27	Patients who have been identified using the MUST (Malnutrition Universal Screening Tool) as at risk of being malnourished may not receive timely dietetic management. **Risk Owner:** Sally Smith **Delegated Risk Owner:** Julie Barton **Last Updated:** 18 Jan 2017 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Target risk score achieved, for recommendation to de -escalate to the Division (CSSD).	23 Jun 2016	**Cause** - Inability of dietetic staff to access the patient details with MUST scores of 2 or more on VitalPac and ensure timely patient intervention - Technical issue with the code for this specific assessment - Inability of the system to pull off a report accurately **Effect** - Fewer patients being referred to the dieticians - Harm to Patients	AO1: Patients. Help patients take control of their own health	I = 4 L = 4 High (16)	Electronic Malnutrition Universal Screening Tool (MUST) in place **Control Owner:** Julie Barton	Adequate	I = 4 L = 2 Moderate (8)	**Person Responsible:** **To be implemented by:**		I = 4 L = 2 Moderate (8)
						Referral process in place for high scoring Patients. **Control Owner:** Julie Barton	Adequate				
CRR 6	Ineffective Clinical Audit Programme (including National Audits, Audit of the implementation of NICE guidance, compliance of NCEPOD recommendations and key local audits) **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Robin Ufton **Last Updated:** 18 Jul 2016 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** The further requirement here is that individual departments provide timely reports to their divisional governance boards and that the divisional governance boards provide equally timely updates to the Trust audit team	09 Feb 2016	**Cause** * Lack of consistent participation in all areas of the national clinical audit programme * Limited audit of implementation of NICE guidance and compliance with NICE Quality Standards * Limited audit of compliance with NCEPOD recommendations * Inconsistent completion of divisional clinical audits **Effect** * The Trust is unclear of the areas where improvements are required * Loss of opportunities to learn from audits * Reduced standards of care	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 3 L = 4 Moderate (12)	Monthly review of progress against the Clinical Audit Programme **Control Owner:** Robin Ufton	Limited	I = 3 L = 2 Low (6)	Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Jonathan Purday **To be implemented by:** 31 Mar 2017		I = 2 L = 2 Low (4)
						NICE Implementation Committee **Control Owner:** Paul Stevens	Adequate		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** El-Hussein Rfidah **To be implemented by:** 31 Mar 2017		
						There are other quality improvement programmes in place that are nationally, regionally and locally driven that support the Trust clinical audit activity e.g. Renal Registry Returns, National Diabetes Returns **Control Owner:** Paul Stevens	Adequate		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Anne Greenhalgh **To be implemented by:** 31 Mar 2017		
						There is an annual clinical audit programme aligned to the national clinical audit programme agreed with each division **Control Owner:** Paul Stevens	Adequate		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Nic Goodger **To be implemented by:** 31 Mar 2017		
CRR 14	Delays in supplying equipment required to facilitate and support Patients post-discharge **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 20 Dec 2016 **Latest Review Date:** 19 Dec 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No outstanding action. Report received from NRS on 16 Nov 2016. Target risk achieved and recommended for de-escalation to CSSD/Therapies.	23 Feb 2016	**Cause** * New contract and contractor set up * Poor Internal processes **Effect** * Harm to Patients	AO3: Provision: Provide the services needed and do it well	I = 3 L = 3 Moderate (9)	A selection of staff on each ward trained in the system (stand-alone system) **Control Owner:** Sally Smith	Adequate	I = 3 L = 2 Low (6)	**Person Responsible:** **To be implemented by:**		I = 3 L = 2 Low (6)
						Daily Integrated Discharge Team (IDT) caseload is reviewed and highlights equipment delays **Control Owner:** Jane Ely	Adequate				
						Monthly meetings held with new Provider **Control Owner:** Jane Ely	Adequate				

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 35	Breakdown of Facilities Management Provider Contract **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 17 Jan 2017 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. Actions implemented. Target risk score achieved. Recommended for de-escalation to Facilities Risk Register.	09 Sep 2016	**Cause** *Government's decision to introduce a new National Living Wage (NLW) legislation in April 2016 *The Trust's Soft FM provider (Serco), has incurred additional payroll costs (circa £2million), which they are seeking to pass onto the Trust. Given that Serco had already exercised an Onerous Contract Provision (OCP) on the contract (which sought to write-off reported losses of £5.6m over the remaining term of the contract). **Effect** *Financial loss *Poor operational performance *Poor service delivery by the Contractor *Notice served by the Contractor	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 3 L = 4 Moderate (12)	Agreed programme of activity to December 2016 **Control Owner:** Liz Shutler	Adequate	I = 3 L = 2 Low (6)	**Person Responsible:** **To be implemented by:**		I = 3 L = 2 Low (6)
						Board approved negotiation approach to be taken **Control Owner:** Liz Shutler	Adequate				
						Initial Report to the Finance Performance Committee and Trust Board of Directors (June 2016), highlighting the potential risks / consequences (contractually and financially), should the NLW issue remain unresolved with Serco (i.e. they might walk away from the Soft FM contract), for what they describe as being an unexpected change in Government legalisation. **Control Owner:** Fin Murray	Adequate				
						Jointly reviewed the financial exposure at the Partnership Board **Control Owner:** Fin Murray	Adequate				
						NLW Steering Group with Serco **Control Owner:** Liz Shutler	Adequate				
CRR 10	Lack of preparedness for the new European Data Protection Rules **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Michael Doherty **Last Updated:** 18 Jan 2017 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Michael Doherty **Latest Review Comments:** Reviewed risk and the scores reflect the current situation.	22 Feb 2016	**Cause** European Privacy Law is highly likely to become part of UK statute in 2018 placing specific responsibilities on all organisations for the use of personal data; this will affect patients in the main, but staff records will be included within the regulations. **Effect** The Trust may not have the necessary infrastructure in place to deliver against the following key areas: 1. Obtaining individual consent for disclosure 2. Privacy Impact Assessments to enable the organisation to understand the risks to personal data and privacy. 3. The Trust will need to establish systems to ensure that protection of personal data are included in all areas of business. 4. The Trust will need to be transparent in reporting externally all breaches of security and confidentiality to regulators and the persons affected. 5. A process is required to give individuals the right to be forgotten. 6. There is a financial penalty, up to 4% of turnover is possible, equivalent to £20million	AO1: Patients. Help patients take control of their own health	I = 5 L = 3 High (15)	IG Team actively engaging with national Information Governance Alliance, which is co-ordinating efforts to implement compliance as and when government guidance emerges. **Control Owner:** Michael Doherty	Limited	I = 5 L = 1 Low (5)	Comprehensive review of the IG function and succession planning arrangements to identify core gaps internally. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2017	**26 Jun 2016** No further update required at present. This risk is being monitored closely.	I = 4 L = 1 Low (4)
						The IG Manager is actively engaging nationally with peer and national leaders in order to assess accurately the impact of the proposed changes to legislation within the Trust. **Control Owner:** Michael Doherty	Adequate				
						The Trust has an Information Governance function within the corporate team to support the changes required **Control Owner:** Michael Doherty	Adequate				
						The Trust is registered with the Office of the Information Commissioner and reports IG breaches locally and nationally **Control Owner:** Michael Doherty	Substantial				

Corporate Risk Register Report (By Residual Risk Ranking)

East Kent Hospitals University NHS
NHS Foundation Trust

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 33	Poor governance of Patient Group Directions (PGDs) **Risk Owner:** Sally Smith **Delegated Risk Owner:** Will Willson **Last Updated:** 06 Dec 2016 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Target risk achieved. Recommendation to remove from the CCR and place Pharmacy risk register.	15 Aug 2016	**Cause** * Out of date PGDs * Poor processes around PGDs * PGD Policy does not reflect NICE guidelines **Effect** * Potential harm to Patients * Regulatory non-compliance * Reputational damage * Legal challenge * Breach of Professional Code of Practice	AO3: Provision: Provide the services needed and do it well	I = 4 L = 3 Moderate (12)	Governance arrangements in place to manage PGDs in a safe way. **Control Owner:** Will Willson Patient Group Direction Policy in place **Control Owner:** Sally Smith Review of outdated critical PGDs complete **Control Owner:** Sally Smith	Adequate Adequate Adequate	I = 4 L = 1 Low (4)	**Person Responsible:** **To be implemented by:**		I = 4 L = 1 Low (4)
CRR 21	Local implementation of the new Junior Doctors contract fails **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jacqui Siggers **Last Updated:** 18 Jan 2017 **Latest Review Date:** 18 Jan 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** Implementation began on 1/12/2016. BMA withdrew their opposition to implementation and abandonded their threat of strike action	24 Apr 2016	**Cause** As the implementation process progresses Junior Doctors oppose the continued process **Effect** 1. Further industrial action by Junior Doctors will lead to disruption of services for patients. 2. Lack of implementation of the contract will delay construction and implementation of safer working practices leading to potential patient safety compromise.	AO1: Patients. Help patients take control of their own health	I = 3 L = 3 Moderate (9)	Guardian of Safe Working has been appointed to oversee the consequences of implementation of the new contract **Control Owner:** Paul Stevens In the event of further industrial action cancellation of all non-urgent trust activities and use of all qualified staff to assist in clinical care **Control Owner:** Jane Ely Robust emergency planning in place led by the COO and medical director. Divisional emergency plans in place monitored within each specialty. **Control Owner:** Jane Ely	Adequate Adequate Adequate	I = 2 L = 2 Low (4)	**Person Responsible:** **To be implemented by:**		I = 2 L = 2 Low (4)

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT**
BOARD SPONSOR:	**FINANCE AND PERFORMANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE FINANCE AND PERFORMANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES	**Appendix 1 – FPC ToR**

BACKGROUND AND EXECUTIVE SUMMARY:

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. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan, delivery of any financial undertakings to NHSI in place, and medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance overseeing financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and oversight of the capital programme
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The Committee also has a role in monitoring the performance and activity of the Trust.

3 JANUARY 2017 MEETING

The committee reviewed the following matters

- **Review of Terms of Reference (ToR) (attached Appendix 1)**
  - The ToR was reviewed in light of the need to establish a new Commercial Incomes Board.
  - The timing of meetings may impact the FPC's ability to review financial accounts before the Integrated Audit and Governance Committee (IAGC) and Board reviews.
  - The FPC recommended the revised ToR be approved by the Board.

- **Support Services Presentation**
  - Deficit year to date for M8 of £0.337M. Income is below plan but above prior year.
  - Cost pressures on MRI outsourcing and Isotope purchasing, pathology consumables and externally run pathology tests.

- Expecting some additional income (circa £296K) from GE to give a forecast of circa £0.2M-£0M deficit at year end.
- Problems in Radiology were discussed due to demand outstripping capacity. The Division are attempting to reduce expensive agency spend reporting on scans by using trained Radiographers and back filling these staff.
- There are issues recruiting consultants to cover Histology cancer related work.
- Therapy staff were TUPE'D out of the Trust during the year. We are delivering a reduction on outpatient (OP) work in Therapies.
- The Division were asked what could be done to improve finances. Some vacancies are not being filled, GE are being billed for cost pressures they caused and Agency use is being scrutinised and the team are recruiting to areas where Agency cover is currently high.
- Agency spend is down £0.4M on prior year. Medicines management has not saved as much as expected with no gain share agreement with Clinical Commissioning Groups (CCGs).
- An equipment replacement procurement initiative with Abbot to reduce costs is also now underway.
- The Division is working on a large Pathology Transformation project but progress requires other Trusts involvement which now is being driven by the Sustainability and Transformation Plan (STP) as a result of NHSi and Carter analysis.

- **Performance**
  - Due to the operational pressures it was agreed that Committee members should email any urgent questions.
  - It was noted that in the previous 8 weeks, occupancy levels had only reduced once below 100%+, to 98.5% in Christmas week. A&E performance was c75%. This situation was being repeated in many other parts of the country.

- **Finance at Month 8**
  - A letter from NHSi was presented. NHSi will be performing another review of Trust Finances during January which is in addition to a report from Mark Hackett.
  - The rising demand was highlighted this was critical to understanding the financial picture.
  - M8 income and expenditure (I&E) deficit is £1.3M (£0.3M better than M7) in month and £14M year to date.
  - M8 saw the highest income of the year (£49.7M).
  - Year end forecast – NHSI target £19M deficit, likely £24M deficit and worst case £30M deficit.
  - Agency usage was at its highest all year in M8 particularly driven by medical staff at 74% of the total spend, which is more than twice that seen in other trusts. Highest Divisional spend remains ULTC. Agency is £1.1M over NHSi ceiling YTD and is likely to overspend by year end.
  - All options are being taken to manage Agency. Additional overseas recruitment processes will be targeted and medical productivity measures will be considered. Rostering is being reviewed. Retention is improving but retirements are increasing.
  - The Trust is on outlier in having such high medical vacancies and the difficulties were discussed.
  - Independent sector spend was high in month at £1.15M to address

referral to treatment standards.
- Cost Improvement Programmes (CIPs) – The shortfall of 2016/17 plans of £3.8M (risk adjusted) was discussed. The additional actions possible already shared with the Board were discussed but options to close the gap are very limited.
- There was a discussion about possible alternative care sites for patients ready to leave the Hospital.
- Cash, up to the agreed borrowing level, will be drawn down in January. Further cash drawings of £13M will be needed in March and has been highlighted to NHSI. NHSI has not yet agreed this request but is aware of the amount and timing.

- **Financial Risk Review**
  - Healthcare Resource Group 4+ (HRG4+) Risk has been resolved with initial £11M impact on 2017/18 now reduced to £1.1M.
  - Contract has now been agreed at £393.9M giving cash in 2017/18 slightly above planned levels.
  - Ongoing risks include:-
    - CIP delivery both 2016/17 and next 2 years (where £25M needed per year to deliver NHSI target)
    - 2016/17 contract challenges remain circa £8M going to mediation.
    - Additional activity is required particularly in Surgery given the impact the non-elective (NEL) activity is having on their original plans.
    - Securing suitable working capital support. NHSI have agreed January requirement of £3.3M.

- **2 Year Operation Plan Update (2017/18 and 2018/19)**
  - The plan was submitted on 23 December 2016 and the control targets were accepted. These are a deficit of £6.5M for 2017/18 assuming £14m STF and £25m of CIPs.
  - These targets only leave £1.7M for developments which is outstripped by requests.
- **Action:-**
  - Board to Approve revised FPC ToR.

RECOMMENDATIONS AND ACTION REQUIRED:

Discuss and note the report and approve the revised FPC ToR.

APPENDIX 1

East Kent Hospitals University NHS
NHS Foundation Trust

TERMS OF REFERENCE
FINANCE AND PERFORMANCE COMMITTEE

1 CONSTITUTION

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

2 PURPOSE

2.1 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. This will include:-

- Overseeing the development and maintenance of the Trust's financial and performance plans and medium and long term financial strategy
- Overseeing the development of specific financial plans as may from time to time be required by NHSI including financial recovery plans, and other financial undertakings
- To consider the impact of Kent and Medway STP plans on the Trust
- reviewing and monitoring financial plans and their link to operational performance
- ensuring that there is good triangulation between financial, performance, quality and safety and workforce plans
- overseeing financial risk evaluation, measurement and management
- scrutiny and approval of business cases and oversight of the capital programme
- maintaining oversight of the finance function, key financial policies and other financial issues that may arise

2.2 As a committee of the Board of Directors, it will:

- Make recommendations to the Board.
- Develop policy.
- Monitor and hold to account.

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

3 OBJECTIVES

3.1 Financial Strategy

3.1.1 To consider the Financial Strategy, ensuring that the financial objectives are consistent with the strategic direction and quality priorities.

3.1.2 To review long term financial models and strategies including the impact of the Kent and Medway STP

3.1.3 To review annual operational plans including efficiency targets and savings projects

3.1.4 To review key medium term planning assumptions

3.1.5 To review NHSI/LAT /CCG/NHS England, etc publications around financial and operating environment and their link to planning assumptions and models

3.2 Monitoring Performance

3.2.1 Monitor the achievement of the financial strategy, and financial targets, associated activity targets and how these relate to the performance of the trust in non-financial domains such as patient safety and effectiveness.

3.2.2 Monitor balanced scorecard, and activity and financial performance.

3.2.3 Monitor cost improvement and savings targets

3.2.4 To scrutinise financial and non-financial performance, trends, projections and underlying data on a monthly basis so that assurance can be sought around any action plans that address emerging patterns in finance or activity.

To oversee the development of financial and non-financial performance reporting, to include:

3.2.5 Greater emphasis on interpretation of the financial position and development of corrective plans where necessary.

3.2.6 Structuring monitoring reports around the key performance statements.

3.2.7 Developing high level metrics to focus the Committee on areas where corrective action may need to be developed

3.2.8 Linking the narrative to implications of compliance with the FT licence, in particular the financial risk rating and other licence conditions

3.2.9 Monitoring agreed actions

3.2.10 To consider the annual reference costs and review profitability analyses.

3.2.11 To review the annual accounts prior to IAGC and Board approval (see section 12)

3.3 Financial Risk Management

To review financial risk and advise the IAGC and Board accordingly:

3.3.1 Review and evaluate key financial risks e.g. tariff changes, contract penalty considerations, CCG/SCG Commissioning intentions, achievement of savings, control of recruitment (and hence pay bill), costs and benefits of underlying additional activity

3.3.2 Development of risk management process around the evaluated risks linking to Board Assurance Framework providing assurance around active financial risk management [Note: the formal link between the finance risk register and Corporate Risk Register will be through the Risk Management and Governance Group)

3.4 Business Case consideration and Capital Programme management

3.4.1 To perform a preliminary review of proposed major investments.

3.4.2 To establish the overall controls which govern business case investments, using NHSI's guidance on Risk Evaluation for Investment Decisions, and to approve the Trust's Business Case Procedure. In accordance with the Business Case Procedure (ref FPP/B1) and Scheme of Delegation rigorously review and approve business cases. (see section 5.2 below)

3.4.3 To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.

3.4.4 To ensure testing of all relevant options for larger business cases prior to detailed workup

3.4.5 To focus on financial metrics within cases e.g. payback periods, rate of return etc.

3.4.6 To oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action, and report to the Board accordingly.

3.5 Commercial Income

3.5.1 Ensure new income generating opportunities from non-clinical activities are identified, appropriately vetted and safely implemented;

3.5.2 Ensure mechanisms are in place to provide assurance that all income generating projects are implemented timely and safely;

3.5.3 Review current income streams from all non-clinically related activities;

3.5.4 Ensure a database of all contracts and service agreements are in place and updated regularly;

3.5.5 Benchmark the Trust's commercial income against other NHS providers;

3.5.6 Ensure all potential opportunities are entered on the Aspyre CIPS management system;

3.5.7 Ensure that robust processes are followed, to evaluate, scrutinise and monitor implementation of income generating opportunities so that benefits realisation can be confirmed;

3.5.8 Commission internally supported market opportunity reviews.

3.6 Other Matters

3.6.1 To provide an opportunity for examination of fitness for purpose of the finance function compared to the scale of the financial challenge

3.6.2 To consider ad hoc financial issues that arise (e.g. Private Patient Cap, estate revaluation etc.)

3.6.3 To develop the Trust's Treasury and cash management policies in line with NHSI guidance on Managing Operating Cash. To scrutinise arrangements for a working capital facility and other long terms loans if required, and investment of surplus cash.

3.6.4 To periodically consider changes required to Trust Standing Financial Instructions due to structural change within the Trust, developments in the NHSI regime and the wider statutory/regulatory framework.

3.6.5 To oversee arrangements for outsourced financial functions and shared financial services.

3.6.6 To consider such other matters and take such other decisions of a generally financial nature as the Board shall delegate to it.

4. MEMBERSHIP AND ATTENDANCE

Members

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

Chair

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

Attendees

4.3 The Chief Nurse/Director of Quality, Medical Director, Director of Strategic Development and Capital Planning and Deputy Finance Director may attend.

Quorum

4.4 Business will only be conducted if the meeting is quorate. The Committee will be quorate with at least two Non-Executive Directors and One Executive Director present. If the Trust Chair is in attendance, this will count towards the quorum.

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

Attendance by Members

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

Attendance by Officers

4.7 The Committee will be open to the Chair, Chief Executive and Trust Secretary to attend.

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

Voting

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

5. FREQUENCY

5.1 Meetings of the Committee shall generally be held monthly. At the discretion of the Chair, other meetings may be held to fulfil its main functions.

6. AUTHORITY

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

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

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

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

7 SERVICING ARRANGEMENTS

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

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

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

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

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

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

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

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive minutes for scrutiny from the following meetings:

- Private Practice Committee
- Strategic Investment Group
- Management Board (Finance / operational matters)

9.2 Council of Governors Finance and Performance Committee.

10 MONITORING EFFECTIVENESS AND REVIEW

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

10.2 A survey will be undertaken by the members on an annual basis to ensure that the terms of reference are being met and where they are not either; consideration and

agreement to change the terms of reference is made or an action plan is put in place to ensure the terms of reference are met.

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

12. JOINT COMMITTEES

12.1 The Committee shall meet annually in May, jointly with the Integrated Audit and Governance Committee (IAGC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

12.3 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

12.4 All members of the FPC and IAGC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

12.5 A quorum shall comprise Chairs of both IAGC and FPC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

12.6 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.

Approved by the Board of Directors: February 2017

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**QUALITY COMMITTEE CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE QUALITY COMMITTEE**
PURPOSE:	**DISCUSSION**
APPENDICES	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

The following provides feedback from the January and February 2017 Quality Committee meetings. The report seeks to answer the following questions in relation to the quality and safety performance:

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

MEETING HELD ON 4 JANUARY 2017

The following went well over the period:

- 97% of our patients would recommend the Trust to their friends and family.
- This month there was a reduction in the number of mixed sex breaches reported.
- Complaint response times as agreed with the client was above the Trust standard.
- Compliment to complaint ratio was 31:1.
- Number of overall complaints and concerns received decreased by 26% this month.
- Overall inpatient real-time patient experience improved compared to last month.
- Harm Free Care experienced in our care (New Harms only) in November was higher than national average which means that our patients are receiving care that causes less harm than is reported nationally.
- Avoidable category 2 pressure ulcers reported were equal to last month and there were no deep ulcers reported. Indeed we met our Trust objective in relation to deep ulcers for November.
- Clinical incident reporting remained at a similar level to last month at around 1300 reports.
- Overall, mortality indices continued to show much better results in comparison to our peers.
- Despite the challenges engendered by bed occupancy, patient demographic and comorbidity our staff continue to be able to provide and evidence very good care to our patients.
- Actual vs planned staffing levels had improved this month.
- In particular the staffing levels reported on the heatmap in maternity were improved compared to last month.
- Paediatric real-time inpatient feedback ('pants posters' – negative comments and 'vests posters' – positive comments) was very positive this month demonstrating a high level of patient satisfaction.

- In Obstetrics the Trust was starting an integrated teaching programme with midwives learning alongside obstetricians and was rolling out a human factors training programme. A fully worked up patient safety plan was being pulled together.

Concerns highlighted over the reporting period:

- The Trust was under significant pressure across the clinical areas, with staff under substantial pressure resulting in the system being significantly strained.
- Radiology was a key challenge for the Trust. Ultrasound and CT interventions (mainly 2 week wait) were not meeting the 2 week wait targets due to radiologist numbers and skill sets. Cologram access and reporting was an on-going problem. The Radiology Consultant workforce business case had been approved and the Trust was putting in place innovative ways to recruit to these roles. A workforce development plan had also been implemented within radiology. The challenge around recruiting to clinical roles was not unique to the Trust and was a challenge nationally. Demand in radiology continued to increase.
- There had been an increase in the number of falls. Every fall was assessed by Matrons.
- Wrong tooth removed (never event – second this financial year). Error recognised at time of procedure and re-implanted.
- Infection control indices were within the limits set but overall performance in this area has slipped in comparison to last year.
- VTE assessment recording had maintained last month's level and performance in the National data for Q2 had also seen an improvement in comparison with other acute Trusts. This still required much better performance and needs further work with prevention of hospital associated thrombotic events.
- Although the rate of new harms experienced by our patients was better than the national our combined harm free care was slightly worse than national and slightly worse than the acute hospital comparison.
- Despite the recorded drop in mixed sex breach occurrences the Trust still needs to work on reducing the number of occasions it breaches the mixed sex standard although dignity and privacy are always maximised when these breaches occur.
- Patient experience in the Emergency Departments reported by the Friends and Family test remained below national average. Comfort rounding was in place to ensure patients received refreshments, information and pain control when they needed it.
- The number of complaint responses sent out within 30 days was still below the Trust standard.
- There was still IT issues surrounding the real-time inpatient survey. Next month feedback should be received from all inpatient wards. This month showed that the Trust needed to address the way it explained care to patients which was flagging in November.
- The Clinical Decision Units (CDUs) were flagging with friends and family test patient satisfaction lower than the other wards. This related to the operational pressures the CDUs were experiencing at present and was being managed by the Matrons and Divisional Head of Nursing. Specific improvement actions would be taken and the FFT would be monitored.

Other topics discussed where concerns or actions were taken:

- The Committee received a Clinical Audit (Controls and Processes) Assurance report. There was a robust discussion regarding the report and the need for this to clearly identify and provide assurance to the Committee that the controls and processes were in place for clinical audit and that what needed to be done was being addressed. It was agreed that the format and style of the report would be reviewed and revised for future presentation to the Committee. In future the report would include an executive summary commentary highlighting where the key risks were and what was being done to address these. Along with an updated key and explanatory briefing on the RAG rating. There needed to be timely and seamless flow of information from the Clinical Divisions to the Clinical Audit Team as well as

positive engagement and input.

RECOMMENDATIONS AND ACTION REQUIRED:

Discuss and note the report.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE**
BOARD SPONSOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PURPOSE:	**DISCUSSION**
APPENDICES	**APPENDIX 1: WARD ESTABLISHMENT REVIEW**

BACKGROUND AND EXECUTIVE SUMMARY

The Committee is responsible for providing the Board with assurance on all aspects relating to the workforce, including strategy, delivery, governance, risk management.

This report presented reflects Committee activity for the January 2017 meeting.

The report seeks to answer the following questions in relation to workforce:

- What went well over the period reported?
- What concerns were highlighted?
- What corrective action was sought?

Issues from November Integrated Performance Report were discussed:

- The sickness rate for November had increased further to 4.25%,with stress quoted as the major cause. The Director of Human Resources and HR Business Partners were working with Divisions to ensure that Occupational Health support and Return to Work systems were used when appropriate.
- Turnover in November was static at 12.6% and was on a continuing upward trend. Work was underway to understand the underlying reasons which could include nurse early retirement. It was likely that the Trust would not meet its target of 10% for turnover by March 2017. Year 1 leavers have declined.
- Statutory training compliance had stayed stable at 88% and is green.
- Analyses of the staff who had 'never completed one or more statutory training courses' showed a reduction from 753 in April to 671 in December (141 of which were new starters). This continued to be a challenge for the Divisions as new staff regularly joined and added to the list if they did not complete one or more of their statutory training programmes within the first months of employment. The data continued to be monitored at executive performance review meetings.
- Reporting of local induction for temporary staff was at 14.3%. An audit that had been undertaken showed that there was an issue around awareness and recording of local induction and there was a separate action plan to address this.
- Appraisal rates had improved from the September position to 82% and work was being progressed to meet the Trust's target of 90%.

The following concerns were highlighted:

- Recruitment Plan. The SWC received an update report on the recruitment plan. It was noted that the Trust had been challenged by NHSI around its gaps in resources and how to address these. There was concern regarding the resource gaps in radiology and radiology consultants, as well as the level of consultant sickness absence that was exacerbating the issue around recruiting.
- Medical Engagement Scale (MES) Survey – Action Plan. The SWC received a report on the survey that showed overall an improvement in medical engagement and 51% of doctors would consider a leadership role. The non-consultant career grade doctors were the least engaged, and 'Good Interpersonal Relationships' was the biggest area of concern and a key element in taking forward this engagement work.

The Committee received the following reports and assurances:

- Ward Establishment Review. The SWC received the six monthly update on the ward staffing review, the progress along with the challenges around this. There was a planned recruitment drive to be undertaken in targeted areas and some areas of concern where the Trust is unable to staff to plan. Attached Appendix 1.
- Staff Survey. The SWC discussed the results of the survey and agreed that Picker would be invited to present to more Trust leaders on what rates of further improvement could be achieved. The results identified a stronger position and reflected significant progress in certain areas but there was still further work required to move EKHUFT above an average position nationally.
- Medical Education. The SWC received a medical education report and noted the good progress that had been achieved with HEKSS. Mostly positive feedback had been received from the trainees regarding the teaching programme. A bid is under development for a Medical School. The level of pressure operationally for the front line Training staff and departments was acknowledged.
- Apprenticeship Project. The SWC received an update report on apprenticeships and the target of posts required to be in place in the Trust in relation to the levy allocated to be spent within the next two years. There were a number of Champions throughout the Trust and work was being progressed with departments around the opportunities and benefits of having in place apprenticeships.
- Guardian of Safe Working. The SWC received a report on Guardian of Safe Working that is a requirement of the new junior doctor contract 2016.
- Annual Priorities and Board Assurance Framework (BAF). The SWC reviewed the annual priorities and BAF and were assured with the report and the updates provided.
- Use of and support to Volunteers would be reviewed at a future meeting.

ACTION:

To note and discuss the report from the Strategic Workforce Committee**.**

REPORT TO:	**REPORT TO BOARD OF DIRECTORS AS RECEIVED BY STRATEGIC WORKFORCE COMMITTEE**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**WARD ESTABLISHMENT REVIEW UPDATE NOVEMBER 2016**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**ASSOCIATE CHIEF NURSE**
PURPOSE:	**Discussion**

BACKGROUND AND EXECUTIVE SUMMARY

Regular six monthly ward staffing reviews have been undertaken since 2013 to fulfil the requirements set out by the NHS Quality Board to report to the Trust Board.

In July 2016 the National Quality Board published updated guidance, building on the 2013 guidance, to provide an updated safe staffing improvement resource. Annual staffing reviews are required, previously six monthly, and the next full review, reporting April 2017, will be reported to the Strategic Workforce Committee in July 2017.

This report provides:

- A summary of the updated guidance and a gap analysis on current Trust compliance;
- A progress update on the recommendations from the previous ward staffing review (May 2016) reported to the Strategic Workforce Committee in July 2016 specifically:
    a. The key priorities identified from the findings of the review;
    b. The Emergency Departments, Neonatal Intensive Care and Midwifery

Priorities identified from this review update are:

1. Annual staffing reviews are now required with six monthly updates to the Strategic Workforce Committee;
2. Care Hours Per Patient Day (CHPPD) should be included in the ward Quality Heatmap from January 2017;
3. To improve alignment of staffing required to demand by developing the business case aligned to the workforce CIP programme to implement Safe Care. This is underway and external visits are planned to learn from other organisations who are using it to explore realistic and robust benefits realisation.
4. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
5. Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation will be reported to the Strategic Investment Group in February 2017.
6. Successful implementation of the Nurse Associate role to support safe

staffing. The pilot is due to commence in April 2017.
7. Phased recruitment to the investment approved into NICU. Further work to be undertaken to explore further investment required into Maternity and ED.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Continued vacancy factor and reliance on temporary staffing will require further innovative recruitment approaches to enable recruitment ahead of turnover.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR8 Ability to attract, recruit and retain high calibre staff to the Trust.
RESOURCE IMPLICATIONS:	Adequate staffing levels impact on the achievement of the of the required performance indicators, non-compliance with contractual obligations attract financial penalties. This includes 2016/17 CQUINs which are valued at 2.5% of actual outturn, or around £10m.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Divisional Heads of Nursing meeting

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

RECOMMENDATIONS AND ACTION REQUIRED:
The board is asked to note the update and priorities identified.

WARD ESTABLISHMENT REVIEW UPDATE (November 2016)

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Appendix 1 – National Quality Board 2016 expectations on safe staffing

1. INTRODUCTION

Regular ward staffing reviews have been undertaken since 2007/08 to ensure they are fit for purpose. Regular six monthly ward staffing reviews have been undertaken since 2013 to fulfil the requirements set out by the NHS Quality Board.

In July 2016 the National Quality Board published updated guidance, building on the 2013 guidance, to provide an updated safe staffing improvement resource.

This report provides:

1. An update on the updated guidance and a gap analysis on current Trust compliance;
2. A progress update on the recommendations from the previous ward staffing review (May 2016) reported to the Strategic Workforce Committee in July 2016 specifically:
    a. The key priorities identified from the findings of the review across all areas
    b. The Emergency Departments, Neonatal Intensive Care and Midwifery

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2. NATIONAL QUALITY BOARD EXPECTATIONS ON WARD STAFFING

2.1 Recommendations for greater transparency of ward staffing levels has followed the Francis report on Mid Staffordshire (2013), the Keogh review (2013), the Berwick report on improving the safety of patients in England (2013) and the NHS England report on Hard Truths; The journey to putting patients first (2013).

As a result, in 2013 the NHS Quality Board published guidance 'How to ensure the right people, with the right skills, are in the right place at the right time' which identified new requirements in providing assurance on safe staffing. The requirements were related to three main areas of action:

- To clearly display information about the nurses, midwives and care staff present and planned in each clinical setting on each shift. Displays should be in an area visible to patients, families and carers and explain the planned and actual numbers of staff for each shift as well as who is in charge of the shift.

  Staffing boards have been in place since April 2014 in all inpatient wards.

- The board should receive monthly reports containing details and summary of planned and actual staffing on a shift-by-shift basis, is advised about those wards where staffing falls short of what is required to provide quality care, the

reasons for the gap, the impact and the actions being taken to address the gap.

Actual against planned staffing hours, by inpatient area, is reported to the Board as part of the monthly Integrated Performance report. This report is accessible to patients and the public on a dedicated area of the Trust website and is published on the relevant hospital profile on NHS Choices.

- The Board should receive a report every six months on staffing capacity and capability which has involved the use of an evidence-based tool (where available), includes the key points set out in the National Quality Board guidance and reflects a realistic expectation of the impact of staffing on a range of factors.

2.2 In July 2016 the National Quality Board (NQB) published updated guidance 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' building on the 2013 guidance to provide an updated safe staffing improvement resource.

The priorities reflect the NQB expectations in three areas; Right staff, right skills and right place. A gap analysis has been undertaken against this recently published guidance and the following key areas of work have been identified:

- Annual staffing reviews, using a triangulated approach (i.e the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans, should be reported to Trust Boards. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

  The previous requirement was six monthly full reviews. The next review, reporting April 2017, will be reported to the Strategic Workforce Committee in July 2017.

- Care Hours Per Patient Day should be included in the local quality dashboard. This is reported every month to the Quality Committee and up to the Board of Directors. We are working on including these data in the Quality heatmap.

- The current approach to improve alignment of staffing required to demand focusses on the further development and embedding of live capture, reporting and escalation of staffing status through the dedicated safer staffing tool within Qlikview which enables the capture of daily planned, actual and required staffing linked to acuity and dependency. However, this system is not sufficiently sophisticated to enable live view of patient acuity dependency and skill mix linked to the Healthroster to enable optimised deployment of staff. A business case aligned to the workforce CIP programme to implement Healthroster Safe Care is underway and external visits are planned to learn from other organisations who are using it to explore realistic and robust benefits realisation.

3. PROGRESS IN IMPLEMENTING RECOMMENDATIONS FROM THE PREVIOUS REVIEW

The following key priorities were identified from the findings of the previous review:

3.1 Alignment of staffing required to demand though the Shelford Safer Nursing Care Tool

The Shelford Safer Nursing Care Tool (SNCT) is based on the critical care patient classification (Comprehensive Critical Care 2000). These classifications have been adapted to support measurement across a range of wards and specialties.
The dimensions of patient dependency and acuity are important variables in determining nursing workload and the SNCT is applied to study current nursing workload in all wards to calculate ward establishment. The updated Shelford SNCT (2013) reiterates the requirement for assessment over a longer period and wards are now capturing daily with quality control provided by matrons who consistency check submissions for all their wards. Further consistency checking is provided by a senior nurse to ensure common understanding and appropriate application of the criteria.

The capture of the dependency and acuity of patients moved from paper-based to electronic in 2015/16 with the development of a dedicated safer staffing tool within Qlikview. This enables capture, reporting and escalation of staffing status with daily planned, actual and required staffing linked to acuity and dependency. However, this system is not sufficiently sophisticated to be linked to Healthroster to readily allow reallocation to staff to areas of high demand.

In May-16 calculation of establishments using the SNCT method taking account of nursing workload associated with patient acuity and dependency demonstrated some correlation between calculated and actual establishment for most wards. However, Cambridge J, Sandwich Bay, St Margarets and Mount McMaster Wards saw an increase in acuity and dependency of patients matched by professional judgement.

Average acuity dependency over quarter 3 (September to December 2016) is seen in figure 1 which indicates that three of these wards have seen no further increase but Mount McMaster saw a further increase in acuity dependency which was linked to caring for a bariatric patient for an extended length of time during this period.

The Shelford tool is not applicable to paediatric wards but has been adapted to enable daily capture of nursing workload in a similar way to the adult wards. For paediatric wards the staffing required is calculated against the current RCN (2013) recommendations of nurse:child ratios of 1:3 for children <2 years of age and 1:4 for children >2 years of age during the day and night. This captures the nursing workload associated with ward beds only and shows acuity dependency in autumn / winter activity over quarter 3 which indicates higher staffing levels may be required. A full review of paediatric wards will be included in the next review in April 2017.

Figure 1. Average acuity dependency Nov-16 compared to May-16

Nov-16					
Specialty	**Ward**	**Full Est (WTE)**	**Shelford May-16**	**Shelford Nov-16**	**Comments**
CDUs	**CDU WHH**	72.53	58.14	68.57↑	SNCT does not capture bed utilisation and high turnover of patients. The K&C CDU is difficult to assess due to the combined establishment with ECC. Increase in acuity dependency at WHH is seen.
	CDU, QEQM	47.17	42.73	42.19	
	ECC (incl. CDU)	86.16			
Medical	**Cambridge J**	44.64	72.64 ↑	58.31	Increase in acuity dependency is seen on Mount McMaster, St Augustines and Cambridge M1.
	Cambridge K	34.69	32.39	32.33	
	Cambridge M2	27.08	29.66	29.19	
	Minster Ward	31.77	34.41	34.41	
	Oxford	23.91	23.34	23.71	
	Sandwich Bay	27.62	33.73	33.73	
	St Margarets	26.72	42.67 ↑	42.67	
	Deal	35.41	43.13 ↑	43.56	
	Harvey ward	27.50	27.37	27.37	
	Invicta	29.92	30.75	34.14	
	Treble ward	29.41	18.91	22.14	
	Mount McMaster	29.99	39.80 ↑	45.03↑	
	St Augustines	34.03	40.81	43.49↑	
	Cambridge M1	24.60*	25.29	34.3↑	
Stroke	**Fordwich Ward**	37.72	37.43	39.06	Increase in acuity dependency is seen on Kingston but is in line with funded establishment.
	Kingston	40.43	31.76	36.57	
	Richard Stevens Unit	40.63	41.55	39.44	
Frailty	**Harbledown**	35.08	54.45 ↑	55.76	Slight increase in acuity dependency on Harbeldown but professional judgement in May-16 did not indicate insufficient staffing.
	Cambridge L	38.22	43.10	43.62	
Coronary Care	**Taylor KCH**	14.07	7.78	8.57	No change
	CCU QEQM	22.90	18.29	18.39	
	CCU WHH	32.00	17.33	17.36	
Renal & Haematology	**Marlowe**	55.12	27.67	34.61↑	Increase in acuity dependency on Marlowe but inline with funded establishment
	Brabourne	16.26	5.11	9.42	
Gynaecology	**Birchington**	32.71	17.10	18.15	No change
	Kennington ward	23.91	9.56	10.45	
Paediatrics	**Padua**	48.19		54.4	Acuity dependency indicates higher staffing levels required than current
	Rainbow	39.23		46.9	
Surgery	**Rotary**	35.34	16.44	17.04	No change
	Cheerful Sp Female	39.51	30.15	29.54	
	Clarke	44.33	37.26	38.8	
	Cheerful Sp Male	36.72	31.04	28.89	
	Kent	33.28	20.20	23.36	
	Kings B	35.15	36.67	34.63	
	Kings A2	25.26	22.65	23.77	
Trauma & Orthopaedic	**Kings C1**	36.30	42.92 ↑	36.76	No change
	Kings C2	34.97	24.09	24.70	
	Kings D male(1)	62.28	57.08	59.09	
	Kings D female (2)				
	Quex	25.35	19.49	21.35	
	Bishopstone	33.99	34.50	35.87	
	Seabathing	35.73	32.14	35.7	

3.2 Deliver against the trajectory for agency reduction aligned to the EU recruitment programme.

As part of the NHSI Agency Rules and as part of NHSI best practice recommendation a Trust Wide Agency Reduction Programme has been created. This plan describes 31 projects that will reduce Agency Expenditure and usage across the divisions and the wider Trust. The Trust Wide Agency Reduction Programme is comprised of 31 strategic and operational actions.

Part of the plan is the implementation of a SMART Agency Action Plan, by Division, across the Trust. The SMART agency Action Plan identifies the Specific, Measurable, Achievable, Realistic and Targeted activities/work that the divisions are managing in order to reduce the use of agency staff and associated expenditure. In addition the plan presents the forecasted savings and a means to track the expected reduction in expenditure. The SMART Agency Action Plan provides a tool to capture, assess and monitor this work.

The plans will be shared with the Agency Reduction Programme Board (formerly Agency Pay Control Group) and will be reviewed at the Divisional Monthly Executive Performance Review. This provides transparency and the means for critical challenge at Executive Level as well as Senior Management Level.

The SMART plan is owned by the Divisions and is assessed monthly and exception reports generated and escalated to the Executive Performance Review. This commenced in January 2017.

3.3 Further reduce the vacancy levels for registered nurses by continuing the implementation of a robust recruitment and retention plan.

There are currently 176 WTE band 5 vacancies across the organisation.

Planned recruitment initiatives during 2016/17 were developed and implemented to plan for a substantial reduction in vacancies and to reduce agency following modelling of the expected movement and numbers of wte Band 5 nursing staff in late 2015.

In order to be fully established within Band 5 nursing and to keep pace with turnover and maternity cover, recruitment of approximately 160 wte nurses during 2016 over and above the current expected intake of overseas nurses and newly qualified recruitment was planned. Five overseas recruitment trips have been undertaken to Romania and Croatia and 72 employment offers were made. 36 subsequently withdrew and 33 were recruited (21 in July-16, 4 in Aug-16 and 8 in Oct-16). 3 are expected to join us in January / February 2017. A further campaign to India resulted in 112 offers and up to 85 applicants are currently within the recruitment process which includes the requirement to achievement level 7 IELTS before they arrive. A further campaign to the Phillipines is planned for February 2017.

Supply of nurses is influenced nationally and locally and the main challenges are:

- Although % of newly qualified nurses who take up their first post with EKHUFT has fallen since 2013, this improved to 78% in September 2016 but fell to only 38% expected in April 2017.

- Number of applicants to the pre-registration nursing programme has fallen by 20% (and locally by 15%) following bursary removal and the introduction of self funding for students

EKHUFT is leading a partnership for the early implementation of the Nurse Associate (band 4 role) commencing in April 2017 through a grant funded programme. This is expected to convert in to an apprenticeship route from September 2017 through the use of the 0.5% apprenticeship levy.

The nursing workforce plan will inform future recruitment plans and is under development currently.

3.4 Evaluate the impact of the investment into ward staffing and identify if further investment is required:

Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation will be reported to the Strategic Investment Group in February 2017.

4. PROGRESS IN IMPLEMENTATING RECOMMENDATIONS IN THE EMERGENCY DEPARTMENTS, NEONATAL INTENSIVE CARE AND MIDWIFERY

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4.1 Emergency Departments

A business case was submitted to the Strategic Investment Group in December 2016 and the preferred option 2 was agreed in principle, yet to be taken through the Trust processes for approval of any investment. The aim of the Business Case is to ensure a future proofed robust nursing workforce to enable a patient focussed safe service.

Emergency Department (ED) attendances have been rising every year since 2001/02, with an increase in conversion to admission. This coupled with overcrowding largely as a result of exit block and significant delays in ambulance handover have had a profound effect on the Emergency Departments and its ability to deliver a timely, safe quality service and maintain adequate flow.

Staffing concerns within the two Emergency Departments (ED) and the Minor injuries Units (MIU) have been highlighted by the Emergency Care Improvement Programme Team (ECIP) who advise that there should be a band 7 Nurse in Charge 24/7. This nurse works alongside the senior doctor to provide a safe quality service and a supervisory role for the nursing staff in all areas of the department.

Additionally they advise Emergency Nurse Practitioners (ENP) should be working at band 7 level and that there should be a stand-alone ENP service. This would provide a minor injuries service in the two EDs staffed by appropriately trained practitioners from 8am to midnight 7 days a week. The benefits of this service would be comparable to those at Kent and Canterbury and Buckland Hospitals minor injuries units.

In order to improve patient flow and streaming at the front door new ways of working are being introduced nationally and locally we have adopted improved assessment pathways for our patients. This is to ensure that they are seen in a timely manner by the most appropriate clinician. These new ways of working also require additional resources.

In order to deliver the above mentioned staffing resource the department relies heavily on agency staff, whilst it is understood the large financial impact of these additional staff it should be noted there are other issues in relying on agency staff in terms of quality, training and the constraints of a transient workforce.

A staffing review was undertaken and it highlighted the following points:

- There is no national tool available to adequately determine appropriate staffing levels, therefore professional judgement and benchmarking with other Trusts was undertaken.
- A need to increase the establishment by 30 wte nurses during times of escalation. The UCLTC Division manage this risk by covering the EDs with additional temporary staff.
- The review showed that when benchmarked against similar Trusts we broadly have the correct establishment assuming a business as usual context in relation to nursing staff at bands 6 and below.
- The Review proposed that we need an uplift of the band 7 ENPs and nurse in charge roles in order to bring us in line with other similar Trusts.
- Overcrowding and flow issues are being actively managed internally and also externally through a number of improvement plans and mitigating actions including:
    - 3 times daily site meetings
    - Site situation and risk assessment monitoring
    - Senior support by Site Operations Managers, Matrons, General Managers and a dedicated Head of Nursing for the EDs
    - Roster changes to manage peak attendance patterns
    - New models of ambulatory care led by consultant nurses
    - Ensuring patient safety during overcrowding in the departments
    - Monitoring quality and safety.

The preferred option is to:

1) Increase the establishments at QEQMH and WHH to ensure band 7 available 24/7, it is proposed that this be 6 wte who are able to undertake this role. This is a slight increase to the usual 5.69 wte required for 24/7 cover to take into account the increased training requirements that ED nurses require. This equates to an increase of:
    - Nurse in charge at QEQMH - 3.0 wte
    - Nurse in charge at WHH - 1.0 wte
2) Increase the banding of all ENPs Trust wide to band 7 provided they achieve the appropriate competencies. This will ensure that we are in line with national standards where ENPs are banded at band 7as a minimum and to increase the establishment of ENP posts at QEQMH and WHH only to provide a 8am to midnight service 7 days a week with 3 ENPs covering this time period in a staggered shift pattern. In addition a band 2 technician at BHD MIU to bring this in line with the other MIUs across the Trust. This equates to an increase of:
    - ENP at QEQMH (including increased service cover) increase 3.5 band 6 to band 7 and an additional 1.2 wte band 7

- ENP at WHH (including increased service cover) increase 3.7 wte band 6 to band 7 and an additional 2.43 band 7 posts
- ENP at K&CH increase 10.71 wte band 6 to band 7
- ENP at BHD increase 3.48 wte band 6 to band 7
- Band 2 technician at BHD 2.80 wte

3) Increased establishment to safely staff the increased demand on the ED service and to ensure appropriate streaming and assessment at the front door. This equates to an increase of :
   - Band 5 at QEQMH of 8.53wte
   - Band 2 at QEQMH of 5.69 wte
   - Band 5 at WHH of 8.53wte
   - Band 2 at WHH of 5.69 wte

Should the case be successful having been through the approval processes within the organisation, it is proposed that the staffing for this option be managed in a phased approach as follows:

Phase 1:

- Ensure band 7 nurse in charge role to cover 24/7 period, likely to take 3-4 months to enable recruitment of new pots to take place. (WHH & QEQMH)
- Recruit to increased ENP posts at band 7 and increase existing band 6 posts to band 7 likely to take approximately 6 months for recruitment to pots and ensuring competencies met to upgrade staff. (All sites)

Phase 2

- Recruit to band 5 and band 2 posts at WHH & QEQMH in a phased way over a period of 1 year.

Phase 3

- Recruit to the band 2 posts at BHD minor injuries unit, this will make this come in line with equivalent staffing levels to the other minor injuries units across the Trust, also taking into account the increasing number of attendances there.

The costs of each option is detailed below. The preferred option 2 was agreed and investment of £1.5m will be off-set by a reduction in nurse agency expenditure of £1.3m with the shortfall met through a reduction in medical staff agency utilisation.

	Op 1	Op 2	Op 3
Capital Investment	£ -	£ -	£ -

Income	£ -	£ -	£ -
Direct Costs	£ 720,000.00	£ 1,504,565.09	£ 635,276.69
Other Costs	£ -	£ -	£ -
Cost Savings	£ -	(£ 1,318,000.00)	(£ 418,000.00)
I&E Surplus/ (Deficit)	**(£ 720,000.00)**	**(£ 186,565.09)**	**(£ 217,276.69)**

Implementation of Phase 1 has commenced with the numbers required and the job descriptions written pending approval of the investment.

4.2 Neonatal Intensive Care

A comprehensive nurse staffing review was undertaken for Neonatal Services in East Kent and indicated that investment is required in the WHH NICU and the QEQM SCBU. A business case for phased investment has been agreed. Phase 1 will increase the nursing establishment by 6.9 wte at WHH, 4.7 wte at QEQM and additional administrative support to compliment the nursing team and patient care and to enhance parental experience. A further phased increment of staffing levels has been approved over 2017/18 and 2018/19 dependent on a range of operational performance triggers based on unit activity, reduction in frequency of unit closures, reduction in the use of agency staff and improvements in staff sickness levels.

Currently, EKHUFT does not meet national recommendations for staffing levels within its 2 neonatal units. This has an impact on the services' ability to maintain activity and deliver optimum care without the use of expensive agency nurses. Furthermore, the Neonatal Units frequently have to close to admissions because there are insufficient qualified nurses on the units to maintain safe services. As a result, the Trust is losing valuable income and families have to travel further afield to receive the neonatal care they need.

Inadequate neonatal nurse staffing levels have been shown to be associated with increased neonatal mortality. Alongside the potential risk to patient safety, inadequate neonatal nurse staffing also continues to adversely impact on:

(i) Trust finances (through on-going requirement and use of expensive agency nurse staff- figure from year 2015/16 £249,000 and through loss of income by not being able to provide neonatal intensive care services);

(ii) neonatal and maternity unit closure and ability to provide intensive care for local population; and

(iii) staff morale and sickness level.

Without adequate investment in neonatal services, the on-going provision of neonatal intensive care within East Kent is likely to come under threat based on proposed reconfigurations of neonatal services (which will be based, amongst other things on nurse staffing levels and activity).

The business case is predicated on the fact that, within EKHUFT, neonatal staffing levels are inadequate in comparison to national recommendations (British Association of Perinatal Medicine) and national published guidelines (NICE, Department of Health (2009) Toolkit for High Quality Neonatal Services, Bliss (2011) The Bliss Baby Charter Standards).

Three options to address these issues have been considered and appraised.

1) Do nothing – continuing to use off-framework agencies to fill nursing rotas

2) Phased investment in staffing over three years to ultimately achieve BAPM staffing levels with an immediate recognition to staff in alignment with "professional judgement" (preferred option)

3) Cease the use of off-framework agency nursing staff

The cost of each option is detailed below. The preferred option 2 generates an operating surplus of £165,825 per annum.

Following detailed consideration of the possible alternative options, the preferred option sought approval to invest in a phased recruitment programme to increase nursing establishment by 6.9 WTE at WHH (3.8 Band 6 QIS and 3.1 Band 5) and 4.7 WTE at QEQMH (2.0 Band 6 and 2.7 Band 4) over 2016/17 (numbers based on professional judgement). The preferred option also sought approval to recruit additional administrative support to compliment the nursing team and patient care and to enhance parental experience. In addition, a further phased increment of staffing levels is sought over the following two years to better approximate nurse staffing levels with the BAPM standards.

Implementation of the second phase of recruitment will be dependent upon a range of operational performance "triggers" (based on unit activity, reduction in frequency of unit closures, reduction in the use of agency staff, finances and improvements in staff sickness levels).

	Op 1	Op 2	Op 3
Capital Investment	£ -	£ -	£ -

Income	£ -	£468,873.56	(£227,731.29)
Direct Costs	£249,141.00	£332,367.36	£ -
Other Costs	£ -	£14,280.47	(£578.26)
Cost Savings	£ -	(£43,599.68)	(£145,332.25)
I&E Surplus/ (Deficit)	**(£249,141.00)**	**£ 165,825.40**	**(£81,820.78)**

The activity is funded through NHS England Specialist Commissioning and is not new income to the health economy. This activity is already happening however because we currently do not have the necessary nursing staff to maintain safe clinical services the NICU and SCBU have to close to new admissions. As a result this activity and the income is going to other NHS Trusts in the South East of England.

Recruitment to phase 1 posts is in progress.

4.3 Midwifery

A full Birthrate Plus assessment was reported in May-16 which indicated that current staffing levels meet or exceed recommended levels for clinical midwives and support staff. However, the outcome of the review suggests additional staff are required to provide a sustainable resource for specialist midwifery support roles e.g Safeguarding, bereavement, obesity, ante-natal, per-natal care which are currently undertaken by clinical staff. Priorities are focused currently on up- skilling band 2 and 3 support workers to enable release of midwives to provide greater clinical contact

time with women.

Engagement and discussion with midwifery staff was undertaken to seek suggestions and views on adjusting current working patterns and shift times to provide improved cover with the existing resource. A consultation has been completed on working hours that has resulted in releasing 2.9 WTE midwifery time across the acute sites with the change in hours that commences on 1.4.17. These results and the shortfall that was identified in the Birthrate Plus will be reported to the Board to discuss the additional resource that will be required to sustain the specialist roles that are required that are currently still being undertaken in clinical time.

The average Midwife to birth ratio in May-16 was 1:28 but has reduced to 1:32 in December 2016 due to a rise in current vacancy to 21.49 WTE across the Midwifery Bands 5-7.

Midwife:Birth Ratio	
PredictedBirths	7,080
Bands 5-7	216.83
Ratio	1: 32.7

Midwife:Birth Ratio	
PredictedBirths	7,080
Bands 3-7	232.63
Ratio	1: 30.4

An on-going recruitment programme has been successful and there are 5.64 WTE commencing in January 2017. There is also on-going work being undertaken with support worker training in the acute units and five band 3 support workers have transferred into community settings to release midwifery clinical time by providing breastfeeding support and improving national screening compliance with booking blood tests.

5. Priorities identified from this review update are:

1. Annual staffing reviews are now required with six monthly updates to the Strategic Workforce Committee;
2. Care Hours Per Patient Day (CHPPD) should be included in the ward Quality Heatmap and is being worked up;
3. To improve alignment of staffing required to demand by developing the business case aligned to the workforce CIP programme to implement Safe Care. This is underway and external visits are planned to learn from other organisations who are using it to explore realistic and robust benefits realisation.
4. The completion of the 2017/18 Nursing Workforce Plan to inform recruitment and retention planning against current and expected vacancies to support the agency reduction programme;
5. Evaluation of the impact of previous investment through reductions in sickness absence, reductions in use of temporary staff and improvements in patient safety through benefits realisation will be reported to the Strategic Investment Group in February 2017.
6. Successful implementation of the Nurse Associate role to support safe staffing. The pilot is due to commence in April 2017.

7. Phased recruitment to the investment approved into NICU. Further work to be undertaken to explore further investment required into Maternity and the Emergency Departments.

Appendix 1. Updated NQB 2016 expectations

https://www.england.nhs.uk/ourwork/part-rel/nqb/

	Expectations		Compliance
1	Right staff ➢ Evidence based workforce planning ➢ Professional judgement ➢ Compare staffing with peers	➢ Annual strategic staffing review using a triangulated approach (evidence-based tool, professional judgement and comparison with peers) which takes account of all professional groups and is in line with financial plans. This should be followed by a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. ➢ Review of comparative data on actual staffing which provides context for differences in staffing requirements such as case mix, patient movement and acuity and dependency. ➢ Local quality dashboard for sustainable safe staffing which triangulates comparative data on staffing with other efficiency and quality metrics to include Care Hours per Patient Day (CHPPD).	The next full review based on April 2017 will be reported to the SWC July 2017. A triangulated approach will again be used including these methods. CHPPD will be included in the Quality dashboard from January 2017.
2	Right skills • Mandatory training, development and education • Working as a	➢ Staffing establishments take account of the need for staff to undertake mandatory training and continuous professional development. ➢ Sufficient time allocated for team leaders to discharge	Average 22% headroom is included in budgeted establishments currently. Investment in the ward manager assistant role has supported.

	multi-professional team • Recruitment and retention	supervisory responsibilities ➢ Commitment to investing in new roles and skill mix to enable nursing and midwifery staff to spend more time using their specialised training to focus on clinical duties and decisions about patient care. A strong multi-professional approach avoids placing demands solely on any one profession. ➢ Flexible and effective strategies to recruit, retain and develop staff as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Future Workforce Steering Group has been implemented to take forward standardisation of expectations and education preparation for Advanced Clinical Practice roles.
3	Right place and time • Productive working and eliminating waste • Effective deployment and flexibility • Efficient employment and minimising agency	➢ The organisation uses lean working principles such as the productive ward as a way of eliminating waste ➢ The organisation designs pathways to optimise patient flow ➢ Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs ➢ Systems for managing staff use responsive risk management processes, from frontline to board level, which clearly demonstrates how staffing risks are identified and managed. ➢ Clinical capacity and skill mix are aligned to the needs of patients thus making the best use of resources and facilitating effective patient flow ➢ Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing	Productive ward principles are embedded within wards. Identification and management of staffing risks are part of the role of the matron. Current system does not enable live view of patient acuity dependency and skill mix to enable deployment of staff. Business case aligned through workforce CIP programme to implement Safe Care is planned.

		levels, and take appropriate action to ensure staff are available to meet patients' needs	
		➢ Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of steps to take where capacity problems cannot be resolved. Report, investigate and act on red flag incidents.	Daily site situation and escalation report identifies patient flow, bed status and staffing appropriateness.
		➢ Meaningful application of effective e-rostering policies is evident.	Improvement required to the use of the NHSP interface.
		➢ The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements.	To be included in the April 2017 review.
		➢ The organisation is working to reduce and eradicate the use of agency staff in line with NHS Improvement's nursing agency rules.	Service improvement team led project Smarter Agency Reduction

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
BOARD SPONSOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK** **APPENDIX 2: Q3 ANNUAL PRIORITIES** **APPENDIX 3: RISK MANAGEMENT HANDBOOK** **APPENDIX 4: IAGC TERMS OF REFERENCE**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

Positive assurance received in relation to:

- Board Assurance Framework (BAF). The IAGC received the latest BAF and was assured that this had been further improved upon, there was more clarity on actions and the responsible leads along with the addition of comments with updates regarding progress. It was agreed that in future there needed to be the inclusion of a description noting if items had slipped and the reasons for this. The Committee recommends the closure of SRR3 (loss of vascular services) and SRR6 (availability of capital funds for digital STP). In addition it recommends the amalgamation of SRR1 and SRR10 in relation to the STP. The Committee also reviewed 2 new risks and recommends their inclusion: "Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes". Provided as Appendix 1.
- Grant Thornton Well-Led Review. The IAGC received an update report and received assurance that good progress had been made against the 24 recommendations with improvements achieved. There were three areas where there was work still to be done, which was acceptable. One area remained problematic that was regarding clinical audit and further work was being done to address this.
- Deep Dive: CRR1 Risk – Precipitate loss of acute medicine from Kent and Canterbury Site. The IAGC received a positive report regarding this risk and was

assured that a robust review of the risk had been carried out.

Concerns in relation to assurance identified:

- Sustainability and Transformation Plan (STP) Governance. The Committee acknowledged that the STP needed its own governance, which may evolve over time. All organisations within the STP footprint would need to be mature and positive around progressing the STP, as well as being flexible and willing to compromise. It might be beneficial to move to committees in common at a later stage once the STP had evolved further and to be open minded regarding governance in the future. It was agreed that a briefing paper would go to the SWC outlining the development plans for STP leaders. It was also agreed that a positioning paper would go to the FPC outlining possible payment systems funding arrangements for the STP. The IAGC supported the need to provide clear delegations to those on the various governance boards and to ensure the Board retained the decision making in relation to the strategic direction. The suggestion in relation to the need for an MOU was discussed and it was agreed that the inclusion of a section on dispute resolution and termination was supported. The IAGC recommends to the Board that they receive and sign-off on the final governance arrangements for the STP and remain able to ensure that the Board remained sovereign and able to influence the east Kent model of care.
- Corporate Risk Register. The IAGC acknowledged that really good progress had been made, there had been improvements in relation to providing assurance but there were still some gaps. It was agreed that there would be a session at the next IAGC meeting regarding the Risk Maturity Index.
- Annual Priorities: Quarter 3. The IAGC noted that there was still further work required in terms of the timeliness and adequacy of the data that supported the measurement of the annual priorities. It was noted that some improvement had been made. Attached Appendix 2.
- Addendum to Risk Management Handbook. The IAGC noted the minor amendments that had been made to the handbook. Attached Appendix 3.

Other reports discussed:

- Review of IAGC Terms of Reference (ToR). The IAGC reviewed and approved the latest ToR and no amendments were required. Attached Appendix 4.
- A verbal update was received regarding the in-year review of quarterly Self Certification to NHS Improvement: Q2. The IAGC received assurance of the Trust's current and future position, there was not a requirement for a significant submission to be completed going forward. It was agreed that this would be removed as a regular item for future IAGC meetings.
- Single Tender Waiver report for Q3 2016/17 highlighted no particular concerns.
- A Progress Report was received from RSM Risk Assurance Services LLP (Internal Audit). Partial assurance was received regarding temporary staffing that was around the use of agencies outside of the Procurement Framework. It was noted that follow-up actions had greatly improved.
- A Progress Report was received from KPMG (External Audit).
- An activity report was received from TIAA (Local Counter Fraud).

RECOMMENDATIONS AND ACTION REQUIRED:
The Board is asked to:

- Approve the Terms of Reference.
- Agree the closure of SRR3 and SRR6; and the amalgamation of SRR1 and SRR10
- Note the progress made against the 2016/17 Annual Priorities; and
- Note the actions in relation to the STP

Board Assurance Framework

East Kent Hospitals University NHS
NHS Foundation Trust

Report Date	18 Jan 2017
Risk Status	Open
Risk Register	1. Strategic Risk Register
Action Status	Outstanding

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 2	Failure to action and deliver our regulatory requirements **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 06 Dec 2016 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk updated.	**Cause** Failure to action and deliver some of the NHS standards **Effect** - Loss of autonomy; - Impact on staff morale; - Reputational problems; - Decline in pace and development of service; - Financial special measures is a risk.	I = 4 L = 4 High (16)	Emergency Department Recovery Plan (agreed with partners and submitted to NHSI) 12/2015 **Control Owner:** Jane Ely	ED Plan updated by Urgent Care and Long Term Conditions	- report to Executive Team on a weekly basis for information - UCLTC update on actions at Executive Performance Reviews - discussions at both Quality and Finance Committee in relation to impacts on safety, quality and finance - monthly BoD report showing progress against plans	Health Economy ED Recovery Meeting NHSI review of ED plan Improvement Director oversight of plan Emergency Care Improvement Programme working with the Trust (Sept 15).	Adequate	Clear understanding of the ED pathway and how the plans start to resolve the key issues.	I = 4 L = 3 Moderate (12)	Work with NHSI to deliver on the assurances required to meet our regulatory requirements and exit from special measures, whether it be quality or financial. **Person Responsible:** Sally Smith **To be implemented by:** 28 Feb 2017	**18 Jan 2017** **Sally Smith** CQC Improvement Plan Delivery Board is meeting on Friday 20th to develop the new high level plan.	I = 4 L = 2 Moderate (8)	Quality Committee
				Now have an interim Improvement Plan in place with supporting Divisional plans whilst we await final report. **Control Owner:** Sally Smith	Emma Kelly manages the updates to the Improvement Plan on at least a monthly basis.	Improvement Board monitor progress (meets monthly) BoD receives exception and progress reports (bi-monthly)	NHSIProgress Review meetings - provides challenge over progress of Trust in meeting deadlines CQC Inspection 07/15 - improved rating Internal Audit on CQC readiness completed - adequate assurance given. CCG assurance provided monthly	Adequate	Internal Audit on Risk Management / Improvement Plan (04/16)					
				The 2yr Operational Plan (2017/18 - 2018/19) submitted to NHSI 23 December 2016 **Control Owner:** Nick Gerrard	Signed off by the Executive Team.	Board of Directors sign off prior to submission to plan.		Limited	NHSI feedback expected					

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 4	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 15 Dec 2016 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Liz Shutler. No change to scores.	**Cause** - Backlog of work (£30million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** Resulting in poor patient and staff experience, potential breaches to health & safety standards and legislation, inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	I = 3 L = 5 High (15)	An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Liz Shutler	Deputy Director of Estates and Director of Capital receive information from all areas of the Trust regarding maintenance and undertake a first pass at prioritisation. Capital PLanning Group - review the prioritisation exercise	FPC receive reports about Backlog maintenance showing the risks.		Adequate		I = 3 L = 3 Moderate (9)	Develop a six monthly report to the board around the Capital Projects, Estates and Statutory compliance. **Person Responsible:** Fin Murray **To be implemented by:** 28 Oct 2016	**27 Sep 2016** **Dorothy Otite** This will now be done in April 2017 as it is not on the Board agenda for October 2016. **13 Sep 2016** **Dorothy Otite** Board workshop held on 9/9/16. Agreed a set of Estates KPIs. 1st Estates report to Board due October 2016.	I = 3 L = 2 Low (6)	Quality Committee
				Interim Estates Strategy in place **Control Owner:** Fin Murray		- Strategy approved by the Trust Board - New NED in place to provide challenge		Adequate						
				Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Liz Shutler	Management Board receives reports from Director of Strategy and Capital Planning. Business cases are received on an ad-hoc basis - some of which require improvement to infrastructure	FPC and Trust Board receives quarterly reports on capital spend.		Adequate			Deliver prioritised Patients Environment Investment Committee action plan **Person Responsible:** Fin Murray **To be implemented by:** 31 Mar 2017	**17 Jan 2017** **Dorothy Otite** Significant degree of expenditure in Q4. SIG requested to ensure expenditure is deliverable and realistic. Report to February SIG. **15 Dec 2016** **Dorothy Otite** As of Q3 we're on track for expenditure		
				Risk assessed condition survey carried out every 5 years (rolling interim plan every 18months) **Control Owner:** Fin Murray	Reviewed by Estates Managers Meeting (Chaired by Head of Engineering and Compliance)	Expenditure against plan reported to SIG	Stock Condition Survey by External Company Independent District Valuer reviews	Adequate						
				Statutory Compliance dashboard in place **Control Owner:** Fin Murray	Reviewed by Executives monthly	6 monthly review by IAGC	Independent Authorised Engineer	Adequate	Not reported to Board yet					

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 6	The contraction of available capital funds limits the Trust ability to pursue the digital ambitions of the STP **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Andy Barker **Last Updated:** 15 Dec 2016 **Latest Review Date:** 15 Dec 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed. One action remaining to implement by end December 2016. Target risk achieved.	**Cause** * Trusts financial position **Effect** * Poor patient experience * Poor staff experience * Inefficient processes such as contemporaneous	I = 3 L = 3 Moderate (9)	5 year plan of investment agreed by Board **Control Owner:** Andy Barker	Director of IT manages the new and replacement programme on a day to day basis	- Information Development Group manages delivery of replacement and new IT - Finance and Performance Committee receives reports on the capital programme as a whole monthly.	Approved by NHS Improvement	Substantial		I = 3 L = 1 Very Low (3)	**Person Responsible:** **To be implemented by:**		I = 3 L = 1 Very Low (3)	Finance & Performance Committee
				Business case approved for EMR **Control Owner:** Andy Barker		Approved by MB		Adequate						
				Prioritised replacement programme has been agreed to the level required to maintain good performance. **Control Owner:** Andy Barker				Adequate						

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 9	Lack of integration between quality and safety, finance, performance, activity and workforce management **Risk Owner:** Matthew Kershaw **Delegated Risk Owner:** Alison Fox **Last Updated:** 12 Oct 2016 **Latest Review Date:** 04 Jan 2017 **Latest Review By:** Alison Fox **Latest Review Comments:** Updated risk controls to include DD/EMT meeting and overview given by CEO drawing all elements together at Board. Added progress on outstanding action	**Cause** Due to a number of competing priorities which may have the potential to be discussed in isolation at the Board Committees, there is a risk that not all aspects (quality and safety, finance, performance, activity, workforce) will be considered. **Effect** This may lead to decisions or direction being given from one source to contradict or negatively impact on decisions or direction given in another.	I = 4 L = 4 High (16)	CEO provides an overview at each Public / Development meeting to ensure the Board is sighted on current issues. This report puts the context around these issues in terms of what is being done to address them whilst taking into account quality, safety, activity, performance, finance and workforce. **Control Owner:** Matthew Kershaw	Discussions at EMT and EMT / DD Meetings to ensure all aspects are discussed.	Management Board and Trust Board receive the IPR with the Chief Executives Summary the resulting discussions are minuted.	Progress Review meetings with NHSI provide the opportunity for these issues to be discussed with the regulator	Adequate		I = 4 L = 2 Moderate (8)	Mini well-led review: Following the implementation of the Grant Thornton recommendations a "peer review" of governance will be arranged to provide assurance that the governance systems overall are working effectively. This will provide independent assurance. **Person Responsible:** Alison Fox **To be implemented by:** 31 May 2017	**04 Jan 2017** **Alison Fox** Trust Secretary to work with other South East Trust Secretaries to identify whether as a body they could provide governance challenge to improve self-assessment CEO attending a meeting with the Nightingale Group on 8/9 Feb 2017 to agree ways of supporting various issues including the idea of peer review well-led governance reviews. **01 Dec 2016** **Alison Fox** CEO will discuss with peer group to determine timescale and scope. Depending on the outcome the "implemented by" date may need to be moved.	I = 4 L = 2 Moderate (8)	Quality Committee
				Chair reports from each Committee to advise of key decisions / actions requested provided to each Board meetings to allow for triangulation **Control Owner:** Alison Fox	Reports drafted by the NED Chair with support from the secretariat. (occurs monthly)	Review of Committee reports at Board on a bi-monthly basis.		Adequate	Ensure the NED's pull out areas where there is potential crossover.					
				Divisional Director / EMT monthly meetings to discuss issues that our cross-divisional to ensure that safety, quality, finance, and workforce matters are integrated in decision making. **Control Owner:** Matthew Kershaw	Agendas / action notes provided for the meeting. Exec and Division input into the agenda.	Any areas of concern feed into Management Board agenda and are fully discussed at that point.		Adequate						
				Executive Performance Review Scorecard - information is provided from the Divisional Scorecard (which flows into the Trust level IPR). Issues are highlighted and discussed in the context of quality, safety, performance, staffing and finance. **Control Owner:** Matthew Kershaw	Each Division discusses their scorecard at their business and governance meetings; Each EPR has a standing agenda that is consistent.	Exec led discussion with Divisions on their scorecard at the Executive performance Review. Any cross divisional elements are highlighted to go to Management Board for wider discussion.		Adequate						
				Public Board agenda order refreshed to ensure all improvement plans are discussed together; the Quality Improvement Plan, ED Recovery Plan and the Financial sustainability plan are under an item on Trust Improvement Plans **Control Owner:** Matthew Kershaw	Chairman and Chief Executive agree the agenda	Board of Directors - Chairman ensures the threads are discussed with a view to pulling the conversations to consider all aspects of the business		Adequate						

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Quality Impact Assessment on all CIP's that have a quality aspect **Control Owner:** Sally Smith	Chief Nurse and Medical Director review the QIA's as they are received	Management Board and Quality Committee receive updates on the number reviewed.		Adequate	An audit of the process would provide assurance that the process is working well.					
				The Integrated Performance Reports has now been fully embedded into the Board and Committee reporting cycle. The Chief Executive's summary draws the various strands in relation to quality, safety, activity, performance and finance to give a clear view of the Trust's position for the reported month. This stimulates a discussion that includes the various strands. **Control Owner:** Matthew Kershaw	Report is produced by the Information Team and circulated for inclusion in the Board and Committees. Each Executive lead reviews the information and provides a commentary.	Divisional Director / Executive Management Team meeting added to structure to focus on key topics to facilitate communications from ward to board / board to ward. (10/2016) The Board and Committees discuss in detail the performance which is drawn together at Board through the use of the IPR and Chair reports.		Adequate					

AO2: People: Identify, recruit and develop talented staff

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

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 8	Inability to attract, recruit and retain high calibre staff to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** Jacqui Siggers **Last Updated:** 10 Jan 2017 **Latest Review Date:** 12 Dec 2016 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Sandra Le Blanc. New control added. Progress notes added. Target risk impact increased to reflect the true impact of the risk.	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust being in special measures, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff **Effect** * Potential negative impact on patient outcomes and experience *High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing.	I = 5 L = 4 Extreme (20)	The Trust has a plan in place that supports the retention of the majority of newly qualified nursing staff locally. **Control Owner:** Sally Smith	*Dedicated Practice Development Nurse lead for supporting students on placement. *Progress monitoring and clinical support of all students. *Mentor support and training	*Regular meetings with Canterbury ChristChurch University - Contract monitoring meetings, faculty learning placement committee, curriculum group attended regularly. *100% students who apply to work with us are offered a post. *Monitoring of numbers of newly qualified nurses recruited and reported within N+M workforce plan. This demonstrates an improvement from 50% to 70% since 2014.		Adequate		I = 5 L = 3 High (15)	Finalise plan for recruitment to hard to fill roles **Person Responsible:** Jaz Mallan **To be implemented by:** 29 Jul 2016	**11 Oct 2016** **Jaz Mallan** Hard to recruit action plan emailed to HRBPs on 3/8 to update plan to include more detail in relation to associated risks of non recruitment to roles identified on the Action plan and what controls the divisions/departments have in place to mitigate any potential risks. This should be completed by 31st October 2016. **19 Aug 2016** **Dorothy Otite** The target date for implementation is end March 2017. July 2016 was the start date.	I = 5 L = 2 Moderate (10)	Strategic Workforce Committee
				Divisional Great Place to Work Action Plans in place **Control Owner:** Jane Waters	- Plans available for all to access on Staff zone - Reviewed at the Divisional Management Boards	Progress of Plan reviewed annually at the SWC		Adequate						
				implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Jacqui Siggers	Discussed at the Workforce CIP meeting	Regularly reviewed at SWC		Adequate			Audit of new appraisal process to be completed and reported to Strategic Workforce Committee **Person Responsible:** Jane Waters **To be implemented by:** 31 Jan 2017	**13 Jan 2017** **Jane Waters** Appraisal 'structure' and quality audit to be piloted in appraisal 'hot spot' areas by end March 2017 by HRBPs **12 Dec 2016** **Dorothy Otite** A deep dive report of the new trust appraisal system was presented to the SWC on 25 November.		
				New Appraisal Process in place **Control Owner:** Jane Waters	Trust-wide Communication HR BPs carried out audit on the process	- Regular monitoring through a number of routes - Divisional Governance Boards, EPR meetings and Strategic Workforce Committee - Report of audit to SWC in December 2016	Annual staff survey results	Limited						
				New People Strategy agreed by the Board incorporating attraction, retention, engagement and development of staff **Control Owner:** Sandra Le Blanc	People strategy agreed by Board in October 2016	Implementation plan to be presented to SWC in January 2017	Diagnostic phase supported by external consultancy. Staff survey published and benchmarked annually.	Limited	Not yet implemented					
				There is an agreed programme to recruit 50 nurses from the Philippines for 2017/18. **Control Owner:** Jacqui Siggers	Head of HR leading on the programme with nominated leads at Divisional level	Strategic Workforce Group with formal strategy in place		Adequate			Review the recruitment process for all staff - report to MB **Person Responsible:** Jacqui Siggers **To be implemented by:** 31 Jan 2017	**11 Jan 2017** **Jacqui Siggers** Interim report to go to Management Board on 1st February **10 Jan 2017** **Dorothy Otite** Interim report to MB in February 2017		

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				There is an agreed programme to recruit 90 nurses from EU / India for 2016/17. **Control Owner:** Jacqui Siggers	Head of Strategic Resourcing and Acting Chief Nurse and Director of Quality leading programme with nominated leads at division level.	Strategic Workforce Group with formal strategy in place		Adequate	Sustainability of model for overseas recruitment in the medium to long-term unclear		Implement Divisional Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 31 Mar 2017	**13 Jan 2017** **Jane Waters** 2016 Staff Survey results received by Picker. Divisional RAG rated reports to be completed and GPTW action plans developed for 2017 by end March 2017 **14 Sep 2016** **Jane Waters** Divisional Great Place to Work action plans facilitated and developed with support from HR Business Partners. Each division has presented their plan to the Strategic Workforce Committee and are currently implementing the actions. These plans are available for all to access on Staff Zone and will be updated with progress.		
				Training plans in place in each division / corporate area that supports staff development. **Control Owner:** Jacqui Siggers				Adequate						
				Working Group in place to review Consultant vacancies and recruitment **Control Owner:** Sandra Le Blanc	- Monthly meeting led by HR Director and Deputy Medical Director - Action log in place to evidence this			Adequate						
											Implementing a long term workforce plan that enables us to attract and retain high calibre staff **Person Responsible:** Jacqui Siggers **To be implemented by:** 29 Jun 2018	**10 Jan 2017** **Dorothy Otite** Resources have been identified from Strategic Development to support programme. Meetings to commence week of 16 January. Worked linked to the Kent & Medway STP. **11 Oct 2016** **Jacqui Siggers** Paper on future workforce modelling presented to the private BoD meeting on 7/10 detailing progress and future actions.		

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
											To produce and implement a People Strategy that focusses on attracting, developing, engaging and retaining staff. **Person Responsible:** Sandra Le Blanc **To be implemented by:** 01 Apr 2019	**12 Dec 2016** **Dorothy Otite** Implementation plan to be presented to the SWC in January 2017 **07 Nov 2016** **Dorothy Otite** People Strategy approved by BoD on 7 October. Implementation plan to be produced by end of November. Ongoing monitoring by the Strategic Workforce Committee.		

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 12	Insufficient capacity and capability of the leadership team (Executive and Divisional Directors) to develop and deliver key strategies and recovery plans **Risk Owner:** Matthew Kershaw **Delegated Risk Owner:** Sandra Le Blanc **Last Updated:** 09 Jan 2017 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk jointly reviewed by Chief Executive, COO and Head of HR. No change to risk scores. Risk title slightly amended to reflect what the risk is to the Trust. Control and Assurance information strengthened. Progress notes added.	**Cause** Large number of complex priorities that need to be delivered in 2016/17 including the sustainability and transformation plan, turnaround plan, cost improvement plans as well as business as usual (in short period of time without the relevant experience) **Effect** * Inability to achieve strategic priorities * Failure to come out of Special measures * Further Regulation action/concerns * Reputational damage * Financial loss * Negative impact on patient safety / care / experience * Reduced staff morale * Failure to meet operational performance standards (RTT/A&E/Cancer) * Failure to meet regulatory requirements (CQC / NHSI)	I = 3 L = 4 Moderate (12)	Business Partnering roles in place (finance, HR & Information) together with support from central governance team. They are an integral part of the Divisional Leadership Team (Capacity) **Control Owner:** Jane Ely	- BPs exist with clear job descriptions - Line Management appraisals in place	Support within divisions EPRs and overall process - meeting		Adequate	Not trained as a business team with a shared purpose Lack of consistency in use of BPs	I = 3 L = 3 Moderate (9)	To finalise the Trust–wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme. **Person Responsible:** Jane Waters **To be implemented by:** 29 Jul 2016	**09 Jan 2017** **Dorothy Otite** in progress - expect to have agreed framework by end March 2017 **02 Dec 2016** **Alison Fox** Business case approved by NHSI end of November 2016.	I = 3 L = 2 Low (6)	Strategic Workforce Committee
				Each Divisional Director is responsible for one of the national Performance Standards e.g. Cancer, ED, 18weeks (Capacity) **Control Owner:** Jane Ely	Reviewed at 121s	Reviewed at EPR monthly	Regular contract performance meetings with the CCGs	Adequate			Formalise review of capacity and capability of direct reports of Divisional Directors **Person Responsible:** Jane Ely **To be implemented by:** 31 Oct 2016	**19 Dec 2016** **Dorothy Otite** Action has been delayed. So far, the Divisions have agreed a set of job plans for each grade of staff to ensure staff are working to the right level.		
				External Consultancy Support (Four Eyes Consultancy, ECIP, Mark Hackett) supporting Divisions and the Corporate Team to deliver transformation programmes (Capacity) **Control Owner:** Jane Ely	Regular reports through the Executive Team meetings / reports to Divisions	Reviewing at Board Sub-Committees and Executive Performance Reviews	Peer review and Benchmarking	Adequate						
				Leadership Development Plans and targeted development plans for individuals in place (Capability) **Control Owner:** Sandra Le Blanc	- Senior Leadership has 6 monthly objectives and appraisals - Executive review succession plans and talent pipeline for Senior Leadership and key posts quarterly	- Nominations Committee review the Appraisals, objectives and Talent pipeline six monthly - The CE has 6 monthly objectives and appraisals - done by Chair of the Board SWC - regular updates and reports on Leadership development	NHSI to review progress of the Leadership & Transformation Programme by EY Plum	Adequate	Fully populated succession plans to ensure short-term and long-term position is secure.		Staff on the Talent pipeline taking up Leadership Development Programmes **Person Responsible:** Jane Ely **To be implemented by:** 31 Oct 2016	**09 Jan 2017** **Dorothy Otite** It is expected that they will share learning from programmes with wider staff groups **19 Dec 2016** **Dorothy Otite** In progress - 2 completed and will present to the Trust Board on their experience. 1 started and 1 deferred to 2017.		
				Outline Programme Plan in place for the Leadership Development Programme (Capability) **Control Owner:** Sandra Le Blanc	Reports to MB	Reports to SWC	NHSI review				Identify line reports that need support to implement Performance management **Person Responsible:** Jane Ely **To be implemented by:** 30 Nov 2016	**09 Jan 2017** **Dorothy Otite** Will be picked up by the Leadership Development Programme and work with the Executive Team **19 Dec 2016** **Dorothy Otite** To take this forward with L&D once staff identified.		
				Substantive staff in place for Executive and Divisional Directors (Capability) **Control Owner:** Sandra Le Blanc	* Currently no vacancies exist			Adequate						

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
											Conduct training needs analysis to identify developmental needs **Person Responsible:** Jane Ely **To be implemented by:** 30 Nov 2016	**19 Dec 2016** **Dorothy Otite** Action has been delayed by 6 weeks. So far, the Divisions have agreed a set of job plans for each grade of staff to ensure staff are working to the right level.		
											Better utilise Business Partnering role **Person Responsible:** Jane Ely **To be implemented by:** 30 Nov 2016	**19 Dec 2016** **Dorothy Otite** This is ongoing. Started to consider how Divisional Directors can work better with Business Partners. Clarifying the Line Management and accountability of the Business Partners will be the next step.		
											Development of senior, middle and clinical and non clinical leaders against the EKHUFT leadership framework **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Mar 2017	**12 Dec 2016** **Dorothy Otite** Business case approved by NHSI end November 2016 **07 Nov 2016** **Dorothy Otite** Business case with NHS I for approval.		
											Working with the CEO to implement an Executive Team Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 30 Jun 2017	**10 Jan 2017** **Dorothy Otite** In progress - alignment review to be complete end January 2017 **12 Dec 2016** **Dorothy Otite** Business case approved by NHSI end November 2016		

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
											Design and deliver the Executive Development and Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Jul 2018	**09 Jan 2017** **Dorothy Otite** Alignment review to be complete end January 2017 **12 Dec 2016** **Dorothy Otite** EY/Plum will be completing the alignment review by end December 2016		

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

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

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 5	Failure to achieve financial plans 2016/17 **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** **Last Updated:** 10 Jan 2017 **Latest Review Date:** 12 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Nick Gerrard. New causes and effect added. New control added around the Consultant support. Residual impact increased to reflect the impact of the risk to the Trust. Coding was 100% complete in October. Continue to stress the importance of data capture at EPRs. Concerns over e-Cascard largely addressed. Financial position remains challenging with extreme operational pressures over December and into January increasing costs and reducing income through high agency usage and cancelled operations.	**Cause** Due to: * Failure to reduce the run rate * Poor planning * Poor recurrent CIP delivery * Poor cash management and * Gaps in financial governance * Failure to agree a realistic control total * Inability to collect income due * Operational pressures relating to Emergency Care, High Agency usage * Political climate **Effect** Resulting in * Potential breaches to the Trust's Monitor licence * Adverse impact on the Trust's ability to deliver all of its services * Impact on ability to deliver the longer term clinical strategy * Poor reputation * Impact on organisational form * Potential financial special measures	I = 5 L = 5 Extreme (25)	Clinical Workstreams in place to ensure quality of care **Control Owner:** Sally Smith	Reports to Executive Team from workstream (weekly)	Feeds into Finance and Investment Committee	Feeds into BoD	Adequate		I = 5 L = 4 Extreme (20)	Ensure that the development of the Trust's clinical strategy, "Delivering Our Future" and that of the wider Kent & Medway STP, drive financial improvement and recovery in the Trust through to 2020/21. **Person Responsible:** Nick Gerrard **To be implemented by:** 28 Feb 2017	**10 Jan 2017** **Nick Gerrard** The Case for Change is being prepared for February 2017 with a public consultation planned for Summer 2017.	I = 4 L = 3 Moderate (12)	Finance & Performance Committee
				Consultant (Mark Hackett) in place to provide support **Control Owner:** Matthew Kershaw	Reports to CEO	- Report to Executive Team and Board - Report to FPC	Report to NHSI	Adequate						
				Cost Improvement Plan targets in place with workstream in support **Control Owner:** Nick Gerrard	Monthly Executive Performance Review and Key Metric Reviews	* Executive review weekly * Turnaround report to FPC * Exception reports to BoD	- NHSI challenge at Performance Review meetings (monthly) - NHSI carrying out deep dive review around sustainability for 2016/17, 2017/18 (including Governance)	Limited			Respond appropriately to commissioner challenge of activity and cost date. Escalate concerns to NHSI. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017	**10 Jan 2017** **Nick Gerrard** Outstanding challenges have been escalated through FD and CEO and now sit with NHSI. Hoping to get an NHSI/NHSE binding arbitration on the issues but CCGs wanting external view.		
				Divisional Peer review of temporary staff savings **Control Owner:** Trish Hubbard		Monthly Finance reports to EPR, MB and FPC	- External scrutiny from NHSI every six weeks and a monthly report - NHSI carrying out deep dive review around sustainability for 2016/17, 2017/18 (including Governance)	Limited	Ensuring it's happening. No opportunity to test it yet. Will happen starting October.		Cash: ensure that NHSI and DH are fully informed of the Trust's cash requirements and that working capital is available when needed. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017	**10 Jan 2017** **Nick Gerrard** Continuing discussion with DH and NHSI on cash requirements in Q4.		
				Divisional Peer review of temporary staff savings **Control Owner:** Lesley White		Monthly finance reports to EPR, MB and FPC	- External scrutiny for NHSI every six weeks and monthly report - NHSI carrying out deep dive review around sustainability for 2016/17, 2017/18 (including Governance)	Limited	Ensuring it's happening. No opportunity to test it yet. Will happen starting October.		Ensure that the Trust Board and senior management team are fully informed of the Trust's financial position through regular updates, formal FPC papers, etc and that the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017			
				Divisional Peer review of temporary staff savings **Control Owner:** Mary Tunbridge		Monthly Finance reports to EPR, MB & FPC	- External scrutiny from NHSI every six weeks and a monthly report - NHSI carrying out deep dive review around sustainability for 2016/17, 2017/18 (including Governance)	Limited	Ensuring it's happening. No opportunity to test it yet. Will happen starting October.		Ensure that all clinical activity is being captured appropriately, coded and costed. **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017			
				Divisional Peer review of temporary staff savings **Control Owner:** Chris Hudson		Monthly Finance reports to EPR, MB and FPC	- External scrutiny from NHSI every six weeks and a monthly report - NHSI carrying out deep dive review around sustainability for 2016/17, 2017/18 (including Governance)	Limited	Ensuring it's happening. No opportunity to test it yet. Will happen starting October.					

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Financial governance in place **Control Owner:** Nick Gerrard	Director of Finance oversees the governance	* FPC receive reports on Financial Governance Action Plan as necessary	- NHS Improvement monitor progress of the action plan - NHSI carrying out deep dive review around sustainability for 2016/17, 2017/18 (including Governance)	Adequate			"Developing the Finance Team - Still Underpowered?" presented to FPC July 2016 setting out how the Leadership Development Programme would be deployed to support financial staff improvement **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017			
				Financial Recovery Plan **Control Owner:** Nick Gerrard	Divisions report progress into Financial Recovery Group on a monthly basis.	- Exceptions reported into Finance and Investment Committee (monthly) - Board has final oversight (bi-monthly)	- Monitor reviewed draft plan and discusses the financial position at Progress Review meetings (6-8 weekly) - NHSI carrying out deep dive review around sustainability for 2016/17, 2017/18 (including Governance)	Limited	Reporting shows slow improvement; Monitor still to provide feedback on 2 year plan					
				Head of PMO in post **Control Owner:** Nick Gerrard	Direct line management by Director of Finance	Monthly reports for Management Board and Finance & Performance Committee	Regular contact with NHS Improvement	Adequate						
				Payment by results infrastructure **Control Owner:** Nick Gerrard	Monthly Contracts, Finance and Internal Contracting meeting	Monthly report to the Finance & Performance Committee	External Audit External validation of clinical coding data	Limited						
SRR 11	Failure to meet the terms of the interim working capital agreement **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** Nick Gerrard **Last Updated:** 12 Oct 2016 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Nick Gerrard **Latest Review Comments:** No issues have been raised by the DH and the final tranche of funds against the existing agreement will be called down in January. A further c£10m to £15m will be required in Q4	**Cause** * Failure to abide by terms of the agreement **Effect** * Shortfall in cash to pay staff and creditors	I = 4 L = 3 Moderate (12)	Estates Strategy reviewed in light of the submission of the Sustainability and Transformation Plan **Control Owner:** Fin Murray		Signed off by the Board	NHSE approved	Substantial		I = 3 L = 2 Low (6)	Further application to DH will be made in Q4 **Person Responsible:** Nick Gerrard **To be implemented by:** 28 Feb 2017		I = 2 L = 2 Low (4)	Finance & Performance Committee
				Process in place to reduce agency spend. **Control Owner:** Sandra Le Blanc	Dedicated project resource in place through the Service Improvement Team to deliver the reduction. Off-framework agency spend reviewed weekly through the Turnaround report at Exec Team Meeting. Divisions are challenged at Executive Performance Reviews and Key Metric Reviews.	Strategic Workforce and Finance and Performance Committees review agency spend.		Adequate	Sustainable reduction needs to be seen before full assurance can be taken that this control is working.					

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 14	Inability to meet performance metrics / trajectories **Risk Owner:** Matthew Kershaw **Delegated Risk Owner:** Alison Fox **Last Updated:** 12 Oct 2016 **Latest Review Date:** 02 Dec 2016 **Latest Review By:** Alison Fox **Latest Review Comments:** Due to the Trust not meeting the STF trajectories the related funding has been withheld resulting in the financial impacts as outlined in the risk description. The risk in relation to operational performance and its effect on patient safety and experience are detailed in other risks.	**Cause** *Trust has not met its Performance trajectories * Lack of capacity - Trust is unable to meet demand with the resources and infrastructure available * Increased local demand for services **Effect** *Resulting in the Trust requiring additional working capital to support the cash position; *The need to find additional efficiencies when the current CIP programme will be a stretch; *Impact on it's ability to deliver it's long-term strategy. *Impact on relationships with Regulators	I = 5 L = 5 Extreme (25)	Annual financial plan in place including cost improvement programme. **Control Owner:** Nick Gerrard	Director of Finance manages the position routinely	Performance against plan monitored through: Turnaround Board (weekly at EMT) Executive Performance Reviews (monthly) Finance and Performance Committee (monthly) Board of Directors (bi-monthly)	Financial performance reviewed with NHSI at Progress Review Meetings	Limited	Performance against plan - to be reviewed	I = 5 L = 4 Extreme (20)	Meeting the agreed plans in respect of: Access standards **Person Responsible:** Jane Ely **To be implemented by:** 30 Sep 2016	**11 Jan 2017** **Dorothy Otite** Decline in performance targets in respect of Cancer, ED (attendance up by 6%) and RTT. Currently huge number of Consultant and middle-grade vacancies. **01 Dec 2016** **Alison Fox** STF funding is unlikely to be received due to continuing performance difficulties. Risks in relation to performance are covered fully under other risks.	I = 5 L = 3 High (15)	Board of Directors
				Emergency Care Recovery Plan in place **Control Owner:** Jane Ely	Divisional Management on a daily basis	Performance monitored through: Emergency Care Board Executive Management Team (weekly) Finance and Performance Committee (monthly) Board of Directors (bi-monthly)	Improvement Director closely monitoring performance; Discussed with NHSI at Progress review meetings (6 weekly) Surge Resilience Group reviews	Limited	Delivery of plan and trajectories met consistently.					
				Trajectory for applicable standards agreed with the CCGs and NHSI. **Control Owner:** Jane Ely	Divisional management of the standards through Governance and Business Boards	Compliance reports to Executive Performance Reviews Management Board Finance and Performance Committee Board of Directors Council of Governors	External review from: CCG's through monthly performance reviews NHSI through 6 weekly progress review meetings	Limited	Consistent performance against tracjetories		Referral management processes and re-direction of referrals to reduce pressure on RTT 18 weeks in conjunction with CCGs and NHS Elect **Person Responsible:** Jane Ely **To be implemented by:** 30 Dec 2016			
											Refresh and implement the Emergency Care Recovery Plan **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2017			
											Meeting the agreed plans in respect of: Annual financial plan **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017	**12 Jan 2017** **Dorothy Otite** Financial position remains challenging with extreme operational pressures over December and into January increasing costs and reducing income through high agency usage and cancelled operations.		

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 1	Unable to deliver a clinical strategy that can be resourced **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Rachel Jones **Last Updated:** 15 Dec 2016 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk to be reported to Board for removal from SRR as this has been subsumed into SRR 10.	**Cause** - Four CCGs having differing agendas; - Lack of stakeholder agreement; - Lack of clear commissioning intentions; - Parliamentary timings may not be conducive to timely implementation **Effect** - Patient care - Emergency transfer of services will become necessary - Reputational damage - Enforcement actions - Trust's provider licence (finance)	I = 5 L = 4 Extreme (20)	1st phase of NHS England assurance process passed **Control Owner:** Liz Shutler		Reported to Management Board and Clinical Strategy Board	Meeting with CCG and NHSE	Substantial		I = 5 L = 3 High (15)	To develop programme required to support an emergency transfer of services if required **Person Responsible:** Liz Shutler **To be implemented by:** 30 Sep 2016	**24 Nov 2016** **Dorothy Otite** Executive Team met in November 2016 with the Divisions to review options and a further meeting is planned end November to finalise a contingency plan. **13 Sep 2016** **Dorothy Otite** Programme unlikely to meet delivery date. Table top exercise planned for middle of October. Risk assessed options and trigger points agreed.	I = 5 L = 2 Moderate (10)	Finance & Performance Committee
				East Kent Strategy Board **Control Owner:** Liz Shutler	Trust Secretary hold all copies of agendas / minutes East Kent Strategy Board	In attendance are all Health economy partners	Monitor received first submission of Annual Plan 2016/17 02/2016	Adequate						
				Financial Recovery Plan **Control Owner:** Nick Gerrard	Divisional / Executive Transformation Meetings (held bi-weekly)	FIC and Board reporting from Turnaround Director	Monitor receive monthly reports on the Trusts finances as well as the quarterly returns and discussions at PRM's.	Adequate	Traction around clinical efficiencies - FIC requested an update on Theatre efficiencies / Outpatients and Workforce - scheduled for 03/2016					
				Internal clinical strategy board **Control Owner:** Matthew Kershaw	Chaired by CEO			Adequate						
				New Kent & Medway-wide Governance structure in place with overarching steering group **Control Owner:** Matthew Kershaw	*PMO established and workstreams	STPs being reviewed monthly	*External Consultancy supporting the structure *NHSE have independently reviewed the governance arrangements	Adequate			NHS England assurance process **Person Responsible:** Liz Shutler **To be implemented by:** 30 Nov 2016	**24 Nov 2016** **Dorothy Otite** Clinical Senate date now agreed for April 2017 and Investment Committee May 2017 **17 Oct 2016** **Dorothy Otite** Due to NHSE feedback the 8th November date has been delayed		
				Regular meetings with external partners / MPs / HOSC and within the Trust **Control Owner:** Liz Shutler	Engagement plan with EKSB			Adequate			Agreement of final consultation document by all partners **Person Responsible:** Liz Shutler **To be implemented by:** 30 Nov 2016	**24 Nov 2016** **Dorothy Otite** The earliest consultation date will be June 2017 **17 Oct 2016** **Dorothy Otite** Programme unlikely to meet target delivery date.		

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 3	Loss of vascular service **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Chris Hudson **Last Updated:** 15 Dec 2016 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Reviewed by Liz Shutler. This remains a low risk to the Trust. Two actions remain outstanding but are being implemented operationally. Recommended to be removed from the SRR.	**Cause** NHS England review of vascular surgery across Kent and Medway **Effect** Loss local provision of vascular surgery in east Kent and associated income, reputational damage, patient experience reduced	I = 4 L = 3 Moderate (12)	Clinical reference group chaired by EKHUFT vascular lead **Control Owner:** Chris Hudson	Noel Wilson attending	Independent clinical rep from vascular society		Adequate		I = 4 L = 1 Low (4)	Finalise clinical network solution across EKHUFT and MMFT **Person Responsible:** Liz Shutler **To be implemented by:** 31 Mar 2017	**15 Dec 2016** **Dorothy Otite** Steering Groups and Working Groups now meeting . **24 Nov 2016** **Dorothy Otite** Terms of reference agreed and membership of the Network Board and Working Groups. Meetings progressing.	I = 1 L = 1 Very Low (1)	Finance & Performance Committee
				Joint Vascular Board established between EKHUFT and MFT **Control Owner:** Liz Shutler	Monthly meetings	Reports to the Boards of both Trusts		Adequate						
				MoU signed between Medway FT and EKHUFT agreeing EKHUFT is the arterial centre, agreed with NHS England **Control Owner:** Liz Shutler	Signed by Matthew Kershaw and Lesley Dwyer			Substantial						
				NHS England led steering group for vascular service attended by Director of Strategic Development and Vascular lead surgeon **Control Owner:** Liz Shutler	Liz Shutler and Noel Wilson attend			Adequate			Development of an operational implementation plan to deliver the clinically agreed model **Person Responsible:** Liz Shutler **To be implemented by:** 29 Dec 2017	**15 Dec 2016** **Dorothy Otite** Business case agreed at the JHOSC **15 Dec 2016** **Dorothy Otite** Programme Director appointed to take this forward.		
				Successful negotiation resulted in Guys and St Thomas withdrawing their bid **Control Owner:** Liz Shutler			Withdrawal confirmed	Substantial						

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 10	Non-delivery of a timely Sustainability and Transformation Plan that can be resourced **Risk Owner:** Liz Shutler **Delegated Risk Owner:** Rachel Jones **Last Updated:** 04 Jan 2017 **Latest Review Date:** 17 Jan 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. Previous SRR 1 has been subsumed into this risk.	**Cause** - STP timescales slip due to national management of the process - Parliamentary timing may not be conducive to timely implementation **Effect** - Delay to EKHUFT clinical strategy - Poor patient care - Emergency transfer of services will become necessary - Enforcement actions - Trust's provider licence (finance)	I = 5 L = 4 Extreme (20)	East Kent Delivery Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Liz Shutler	- Trust Executive membership of the Board to influence the discussion. - Trust Secretary holds all copies of agendas/minutes	- Reported monthly to Clinical Strategy Board and Management Board - In attendance are all Health economy partners		Substantial		I = 5 L = 3 High (15)	Develop programme required to support an emergency transfer of services if required **Person Responsible:** Liz Shutler **To be implemented by:** 31 Mar 2017	**04 Jan 2017** **Dorothy Otite** Executive Team met in November 2016 to review the options and finalise a contingency plan.	I = 5 L = 2 Moderate (10)	Board of Directors
				Financial Plan in place linked to delivery of the STP **Control Owner:** Nick Gerrard	Divisional/Executive Transformation Meetings (held bi-monthly)	FIC and Board reporting (monthly)	NHSI receive regular reports on the Trusts finances and discussions at PRMs	Adequate			Submission to Clinical Senate - review of clinical standards **Person Responsible:** Liz Shutler **To be implemented by:** 28 Apr 2017	**17 Jan 2017** **Dorothy Otite** Medical Director and CCG Clinical Chair attending Clinical Senate for a stage meeting in January 2017		
				Internal Clinical Strategy Group in place **Control Owner:** Matthew Kershaw	Chaired by CEO			Adequate						
				Kent and Medway STP steering group in place **Control Owner:** Liz Shutler	*Trust CEO and Chair of East Kent Delivery Board attends to influence the programme. Liz attends in Matthew's absence *Trust CEO is on the Management Board and Chairing the Hospital work stream which Deputy CE is the Lead for *PMO established	- Various Senior Managers involved in STP work streams e.g Rachel Jones and Nick Gerrard Finance group lead for STP	PMO reviewed by NHSE and found to be adequate	Substantial			Presentation of the capital requirements to the NHSE Investment Committee **Person Responsible:** Liz Shutler **To be implemented by:** 31 May 2017			
											Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Liz Shutler **To be implemented by:** 30 Jun 2017	**24 Nov 2016** **Dorothy Otite** Public consultation delayed until June 2017 at the earliest. **17 Oct 2016** **Dorothy Otite** On track for delivery of STP for submission in October, however feedback from NHSE is East Kent will be unlikely to commence consultation in this calendar year.		
				STP submission to NHS England **Control Owner:** Liz Shutler	Submitted in time		NHSE positive feedback received in July and October 2016	Substantial						

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 13	Delay in delivery of the Pathology Transformation project **Risk Owner:** Nick Gerrard **Delegated Risk Owner:** Mary Tunbridge **Last Updated:** 23 Nov 2016 **Latest Review Date:** 10 Jan 2017 **Latest Review By:** Nick Gerrard **Latest Review Comments:** Discussions are continuing with NHSI and MTW on the best way of taking forward the project.	**Cause** * External factors such as the sustainability and transformation plan or other providers wishing to be involved. * Poor capacity and capability of local teams * Unwillingness of Partners to proceed with existing plans **Effect** * Inability to make savings * Further deterioration of equipment * Possible impact on other services that rely on Pathology for diagnostics	I = 3 L = 3 Moderate (9)	Joint Project Board in Place **Control Owner:** Nick Gerrard	Fortnightly JPB meetings	Updates to the Board as required	Approval from NHS Improvement	Adequate		I = 3 L = 3 Moderate (9)	Sign off of the SOC by NHS Improvement **Person Responsible:** Nick Gerrard **To be implemented by:** 31 Mar 2017	**10 Jan 2017** **Nick Gerrard** Discussions continue with NHSI and MTW on best way to progress the project. **14 Nov 2016** **Nick Gerrard** Project suspended pending STP review	I = 1 L = 1 Very Low (1)	Finance & Performance Committee
				Memorandum of Understanding in place - Robust governance structure in place to ensure project remains on track **Control Owner:** Nick Gerrard	DoF has been appointed as Senior Responsible Officer	Reporting from the Joint Project Board to the Board of Directors	External legal advice on the MOU has been provided	Limited						
				Regular reporting at key milestones to Finance and Performance Committee to provide additional assurance to the Board **Control Owner:** Nick Gerrard		Reports to FPC and Board as and when required		Adequate						

ANNUAL PRIORITIES: PERFORMANCE, RISK AND ASSURANCE REPORT: QUARTER 3

INTRODUCTION:

The table below gives an overview of the Trust's delivery in relation to its strategic priorities for 2016/17 as at Quarter 3 and is therefore a snapshot in time. The brackets denote the previous quarters RAG rating.

STRATEGIC OBJECTIVE	PERFORMANCE	STRATEGIC RISK	ASSURANCE
PATIENTS	**YELLOW (AMBER)**	**AMBER**	**AMBER**
PEOPLE	**YELLOW**	**AMBER**	**AMBER**
PARTNERSHIP	**AMBER**	**AMBER**	**AMBER**
PROVISION	**GREEN**	**RED**	**RED (AMBER)**

The Board Assurance Framework is available to all Board members and will provide additional information on the risks relating to the priorities along with the level of assurance provided. The performance is taken from a number of sources but wherever possible it will be from the Integrated Performance Report.

Performance against the Annual Priorities:

The following provides you with a "performance at a glance".

PATIENTS. Enable all our patients (and clients who are not ill) to take control of all aspects of their healthcare by 2021**ANNUAL PRIORITY– PERFORMANCE OVERVIEW**	**RAG Q2**	**RAG Q3**	**YEAR-END ESTIMATE**
Deliver the CQC and emergency care improvement plans to ensure Trust is removed from Special Measures at its next CQC re-inspection in 2016	**Not yet available**	**CQC Recommends**	**MET**
Deliver the agreed improvement trajectories (as submitted to and agreed with NHS Improvement) for the emergency care, RTT, cancer and diagnostic wait standards, by end of March 2017	**RED**	**RED**	**RED**
Transform care for people with learning disabilities by meeting the six criteria based on 57 recommendations in Healthcare for all (DH 2008). Measured by self-assessment against metrics by December 2016	**Not yet available**	**Not yet available**	
Deliver quality improvements by March 2017	**AMBER**	**AMBER**	**AMBER**
Agree new pathways with commissioners for patients 'medically fit' and not requiring an acute bed to reduce delays by 5% by December 2016	**Not yet available**	**MET**	**MET**

PEOPLE. Identify, recruit, educate and develop a talent pipeline of clinicians, healthcare professionals and broader teams of leaders, skilled at delivering integrated care and designing and implementing innovative solutions for performance improvement.

ANNUAL PRIORITY– PERFORMANCE OVERVIEW	**RAG Q2**	**RAG Q3**	**YEAR-END ESTIMATE**
Refresh and implement the recruitment and retention strategy to reduce the level of staff leaving by 2%, particularly in the first year of employment, by March 2017	**GREEN**	**OBJECTIVE MET**	**GREEN**
Achieve a staff turnover rate of 10%, by March 2017.	**RED**	**RED**	**RED**
Roll out the Trust wide leadership and management development programme to another 200 staff, by September 2016	**RED**	**RED**	**RED**
Continue with the implementation of the cultural change programme, incorporating divisional and corporate led plans into the programme, by June 2016	**GREEN**	**OBJECTIVE MET**	**GREEN**
Improve the overall staff engagement score as measured by the staff survey, paying particular attention to those professional groups with lower levels of engagement, by March 2017	**Not yet available**	**Not yet available**	**GREEN**

PARTNERSHIPS. To define and deliver sustainable services and patient pathways together with our health and social care partners, by 2021

ANNUAL PRIORITY– PERFORMANCE OVERVIEW	**RAG Q2**	**RAG Q3**	**YEAR-END ESTIMATE**
Submit an agreed Sustainability and Transformation Plan (STP) by 30 June 2016	**GREEN**	**GREEN**	**ACHIEVED**
To submit by June 2016, with partners, a single Local Digital Roadmap which will outline how we will use technology to provide improved patient services	**GREEN**	**GREEN**	**ACHIEVED**
Working with CCGs commence formal consultation on a sustainable clinical configuration by December 2016	**RED**	**RED**	**NOT ACHIEVED**
By working with the Vanguard, increase community provision to transfer the equivalent of 60 acute beds in patient activity, by March 2017	**RED**	**RED**	**RED**
To deliver an estates strategy that supports the Trust's clinical configurations by March 2017	**GREEN**	**GREEN**	**GREEN**
Continue to work with MTW on a joint pathology project, delivering a signed commercial agreement with external partners by June 2017	**RED**	**RED**	**RED**

PROVISION. Clearly identify 'what business we are in', 'what we want to be known for' and 'what our core services are'

ANNUAL PRIORITY– PERFORMANCE OVERVIEW	RAG Q2	RAG Q3	YEAR-END ESTIMATE
Implement a new Integrated Performance Report by May 2016.	GREEN	GREEN	ACHIEVED
Submit a financially sustainable plan for 2016 /17 and the following 4 years that meets the agreed control totals, by June 2016	GREEN	GREEN	ACHIEVED
Agree core services and a timetable to review and refresh these services, by September 2016	AMBER	GREEN	ACHIEVED
Be recognised as a provider of high quality care and as a system leader by NHS, social care and other public sector partners, as measured by 360 feedback from partners, by **December 2017**	Not yet available	ON TRACK	ON TRACK
Achieve a net positive balance on press coverage as measured by press, Trust data and social media, by **January 2017**	GREEN	GREEN	ACHIEVED
Develop and grow a number of whole system leaders, joint appointments that cross the boundaries of the whole health care economy and are designed around the patient pathway	GREEN	GREEN	
Delivery of £20m cash releasing, recurrent saving by March 2017	RED	RED	RED
Hit a year end deficit plan of £12.5m (after adjusting for any portion of STF funding not provided by Department of health), by March 2017**. New year-end deficit plan agreed with NHSI of (£19.2m)**	GREEN	GREEN	RED
Continue to progress improvements in 7 day services focussing on the implementation of priority schemes agreed following further work internally and benchmarked with other similar organisations	Not yet available		

Addendum to Risk Management Handbook (January 2017)

13. Key Performance / Key Risk Indicators (For Strategic Risks only)

13.1 When assessing likelihood and impact, the following factors need to be taken into account:

- Key Performance Indicators (KPIs) and Key Risk Indicators (KRIs) need to be identified for Strategic risks (where applicable).
- The KPIs/KRIs are used to determine/influence the risk scoring (i.e. either the likelihood of the risk occurring or its impact should it occur).

13.2 Key Performance Indicators (KPIs) are measures of actual performance against set/desired performance. They are used to measure how the Trust is performing against pre-defined performance metrics/trajectories.

13.3 Key Risk Indicators (KRIs) are measures that provide insight into potential events. They can simply be described as an early warning signal for the risk identified. They serve as an indicator that the likelihood of the risk occurring may increase and may also provide insight into the impact of the risk. In order to identify the KRI, it is important to have a clear understanding of the risk and the factors affecting it. The following process can be used to set KRIs:

- Identify Strategic Priority – e.g. People – Staff retention (Achieve a staff turnover rate of 10%)
- Identify performance measure (KPI) – Staff turnover rate
- Set the performance target – Staff turnover rate yearly target = 10%
- Set tolerance levels (thresholds) – **Above 10% - Red; 7% to <10% - Amber; Below 7% - Green**

13.4 KRIs are derived from the tolerance thresholds and are aligned to KPIs. For every KRI, there should be a KPI to measure and monitor performance against the defined tolerance level.

13.5 When the KRI for a Strategic risk reaches an Amber tolerance threshold, this should serve as a trigger/Early Warning Signal (EWS) for the Risk Owner to notify the Executive Management Team (EMT) of the imminent crystallisation of the risk including the Contingency Plan and when it will be implemented (see Section 15).

13.6 The Risk Owner should report this at the next weekly Executive Management Team (EMT) meeting following the EWS. The Chief Executive is responsible for informing the Chair of the Integrated Audit and Governance Committee (IAGC) of the EWS and the Contingency Plan (including the expected implementation date).

14. Protocols for Risk Crystallisation

14.1 A risk is said to have crystallised when the event described in the Risk Title on 4Risk occurs/happens.

14.2 Once a risk crystallises, the Risk Owner should immediately notify in writing, the relevant Risk Management Lead for their Division, Ward, Specialty, Modality or Department of the event, the reason the event occurred, the consequences and further actions planned (including the Contingency Plan – see Section 15).

14.3 The Risk Management Lead is responsible for informing the relevant Board/Committee immediately (in writing) of the event, the reason the event occurred, the consequences and further actions planned.

14.4 If the crystallised risk is a Strategic risk, the Risk Owner should report this at the next weekly Executive Management Team (EMT) meeting following crystallisation of the risk. The Chief Executive is responsible for informing the Chair of the Integrated Audit and Governance Committee (IAGC) of the crystallised risk.

14.5 If the crystallised risk is a Corporate risk, the Risk Owner should immediately notify the Deputy Director of Risk, Governance and Patient Safety in writing, who will then report this to the Management Board in writing even immediately (even if this falls outside the Management Board meeting schedule). The Chief Nurse and Director of Quality is responsible for informing the Chair of the Integrated Audit and Governance Committee (IAGC) of the crystallised risk.

15. Contingency Planning protocols (For Strategic Risks only)

15.1 A contingency plan is a plan devised as an alternative solution to existing controls or risk actions (previously identified) should a risk crystallise.

15.2 The Risk Owner is responsible for producing a Contingency Plan and uploading the Contingency Plan to the Contingency section of the Risk Record on 4Risk.

15.3 The Risk Owner should ensure the Contingency Plan is refreshed/tested regularly (as appropriate).

15.4 If there is an EWS of the risk crystallising, the Risk Owner is responsible for reporting this and determining when to implement the Contingency plan.

East Kent Hospitals University NHS
NHS Foundation Trust

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)

TERMS OF REFERENCE

1 CONSTITUTION

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

2 PURPOSE

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

2.1.1 monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them;

2.1.2 review the Trust's internal controls (clinical and financial) and risk management systems;

2.1.3 review and monitor the external auditor's independence and objectivity and the effectiveness of the external audit process, including approval of annual plans, taking into consideration relevant UK professional and regulatory requirements;

2.1.4 make recommendations to the Council of Governors regarding the appointment, re-appointment and removal of the external auditor, including tender procedures;

2.1.5 develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm;

2.1.6 monitor and review the effectiveness of the Trust's internal audit function and counter-fraud arrangements, including approval and review of related annual plans;

2.1.7 approve the appointment and/or removal of the internal auditors;

2.1.8 report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed, making recommendations as to the steps to be taken;

2.1.9 produce an annual report for the Board of Directors

2.1.10 review arrangements by which staff within the Trust may raise confidentially concerns over financial control and reporting, clinical quality and patient safety and other matters.

3 OBJECTIVES

Governance, Risk Management and Internal Control

3.1 The IAGC shall review the establishment and maintenance of an effective system of integrated governance, risk management, internal control (clinical and non-clinical) across the whole of the organisation activities that supports the achievement of the Trust's objectives.

In particular, the committee will review the adequacy of:

3.2 all risk and control related disclosure statements (in particular the Annual Governance Statement, regular reports on the activities of the Risk Management and Governance Committee, self-certification statements to the Regulator, and Care Quality Commission declarations), together with any accompanying Head of Internal Audit statement, External Auditor opinion or other appropriate independent assurances, prior to endorsement by the Board.

3.3 underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

3.4 The IAGC will undertake periodic review of progress against the Board Assurance Framework and Corporate Risk Register, with significant changes highlighted. Where these items are of such a significant nature, 4.2 refers, the Chair of the IAGC will bring them to the immediate attention of the chair of the Board of Directors. A full copy of these key documents will be made available to the IAGC in accordance with the timetable agreed by the Board and will normally be reviewed in full prior to the production of the Annual Report and Accounts and the Annual Governance Statement and as part of the Trust's mid year review process.

3.5 policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, and consider any training requirements to ensure committee members are kept up to date with emerging requirements.

3.6 policies and procedures for all work related tocounter fraud and security as required by NHS Protect.

3.7 arrangements by which staff of the Trust may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, with the aim of ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

3.8 In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.9 This will be evidenced through the committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.10 As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other committee's must not usurp the Committee's role.

External Audit

3.11 The Council of Governors will take the lead in agreeing with the IAGC the criteria for appointing, reappointing and removing auditors. The IAGC will make recommendations to the Council of Governors on these matters, and approve the remuneration and terms of engagement of the External Auditor. In accordance with its Standing Orders, the Council of Governors will appoint the external auditor following recommendation from the IAGC.

3.12 The IAGC shall develop and implement policy, in collaboration with the Finance and Performance Management Directorate, regarding the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance. All requests for the supply of non-audit services must be presented to the IAGC for noting.

3.13 The IAGC shall review and monitor the External Auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

3.14 The IAGC shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

3.14.1 consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.

3.14.2 review and agreement, before the audit commences, the nature and scope of the audit as set out in the annual external audit plan.

3.14.3 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

3.14.4 review of all audit reports that are specifically drawn to the attention of the IAGC by the auditors which will include the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

3.14.5 Ensuring that there is in place a clear policy for the engagement of external auditors to supply non audit services.

3.14.6 The Head of External Audit will have unhindered and confidential access to the Chair of the IAGC.

Internal Audit

3.15 The IAGC shall ensure that there is an effective Internal Audit function established by management that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the IAGC, Chief Executive and Board. This will be achieved by:

3.15.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

3.15.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework;

3.15.3 where there is a requirement to undertake work outside of the approved annual work plan, all such requests must be presented to the IAGC for approval;

3.15.4 consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

3.15.5 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

3.15.6 annual review of the effectiveness of internal audit in such manner as is appropriate and agreed by the IAGC, including a review of the successful operation of the contract between the Trust and Internal Audit.

3.15.7 The Head of Internal Audit will have unhindered and confidential access to the Chair of the IAGC.

Other Assurance Functions

3.16 The IAGC shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the organisation. These will include, but not be limited to, any review by Department of Health arms-length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, Monitor etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

Counter Fraud

3.17 The IAGC shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

Management

3.18 The IAGC shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.19 They may also request reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

3.20 The IAGC will monitor the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them. In doing so, the IAGC shall additionally utilise the findings of the Finance and Investment Committee, which is chaired by a Non-Executive Director of the Trust Board.

3.21 The IAGC shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

3.21.1 changes in, and compliance with, accounting policies and practices and estimation techniques;

3.21.2 major judgemental areas;

3.21.3 significant judgements in the preparation of the financial statements;

3.21.4 significant adjustments resulting from the audit;

3.21.5 the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the IAGC;

3.21.6 letters of representation;

3.21.7 explanations for significant variances;

3.21.8 unadjusted mis-statements in the financial statements.

3.21.9 Providing mandatory issues (as detailed in paragraph 1) are reserved for the attention of the full committee in session, other matters including review of the Annual Report and Summary Financial Statements may be dealt with as the IAGC deems appropriate through a process coordinated by the IAGC Chair.

3.22 The IAGC should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

4. MEMBERSHIP AND ATTENDANCE

Membership

4.1 The IAGC shall consist of not less than 4 Non Executive Director members. There will be appropriate cross-membership with other Board committees.

4.2 One member of the IAGC should have significant, recent and relevant financial experience as outlined in the Combined Code and Sarbanes-Oxley Act 2002. The Chair of the Trust shall not be a member of the IAGC.

Chair

4.3 The Chair of the committee will be a non-executive director as determined by the Nominations Committee of the Board.

Attendees

4.4 External and Internal Auditors the Head of Clinical Audit and a representative of the counter-fraud specialists are required to make themselves available when required for a private meeting with the IAGC Chair immediately prior to each IAGC meeting.

4.5 The Finance Director, Chief Nurse and Director of Quality, Trust Secretary and appropriate Internal and External Audit and counter-fraud representatives shall normally attend IAGC meetings.

4.6 The Chief Executive and other executive directors may be invited to attend, particularly when the IAGC is discussing areas of risk or operation that are the responsibility of that director.

4.7 The Chief Executive should be invited to attend, at least annually, to discuss with the IAGC the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

Quorum

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

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

Attendance by Members

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

Attendance by Officers

4.11 The Committee will be open to the Chair, Chief Executive and Trust Secretary to attend.

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

Voting

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

5 FREQUENCY OF MEETINGS

5.1 Meetings shall be held quarterly. The Board, Chief Executive, External Auditor or Head of Internal Audit may request a meeting to ensure business is conducted in a timely way.

6 AUTHORITY

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

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

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

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

7. SERVICING ARRANGEMENTS

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

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

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

7.4 The IAGC will maintain a rolling annual work plan that will inform its agendas and seek to ensure that all duties are covered over the annual cycle.

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

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

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

9 RELATIONSHIPS WITH OTHER COMMITTEES

9.1 The Committee will receive minutes for scrutiny from the following meetings:

- Information Governance Steering Group
- Information Assurance Board

9.2 Alignment with Council of Governor Audit Working Group

10 MONITORING EFFECTIVENESS AND REVIEW

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

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

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

11.3 The IAGC shall report to the Council of Governors, identifying any matters within the Council's remit in respect of which it considers that action or improvement is needed, and making recommendations as to the steps to be taken.

11. JOINT COMMITTEES

11.1 The IAGC shall meet annually in May, jointly with the Finance and Investment Committee (FIC) for the purpose of reviewing the annual report and accounts, and annual plan, prior to formal approval by the Board of Directors.

11.2 Other joint meetings with the FIC shall be held from time to time as agreed between the Chair of the FIC, the Chair of the IAGC, Trust Chairman, Trust Chief Executive and Executive Directors, for the purpose of reviewing Divisional performance and for such other matters as may be agreed by both Committees within their respective Terms of Reference.

11.3 Meetings shall be chaired jointly unless otherwise agreed by the Chairs of both committees.

11.4 All members of the IAGC and FIC shall be members of the Joint Committee. Attendance by others will be by invitation but will normally include the Deputy Finance Director and Deputy Director of Risk and Governance.

11.5 A quorum shall comprise Chairs of both the IAGC and FIC, the Director of Finance and Performance Management and the Chief Nurse/Director of Quality and Operations.

11.6 In all other regards the Joint Committee will operate and be administered in the same manner as set out in each Committee's individual Terms of Reference.

Reviewed by the Committee: DECEMBER

Approved by the Board of Directors: DECEMBER 2015

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**CARE QUALITY COMMISSION (CQC) IMPROVEMENT PLAN & UPDATE**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**QUALITY IMPROVEMENT PROGRAMME MANAGER**
PURPOSE:	**DISCUSSION**
APPENDICES	**APPENDIX 1: DECEMBER 2016 NHS CHOICES SUBMISSION**

BACKGROUND AND EXECUTIVE SUMMARY

The CQC Chief Inspector of Hospitals, Sir Mike Richards, has made the recommendation that the Trust is removed from Special Measures following the September inspection. Whilst the overall Trust status has remained as 'Requires Improvement' there was significant improvements noted within each of the domains across sites – and no inadequate ratings on any of the sites.

All sites were rated good for caring. Improvements were recognised within all of the targeted inspection areas as well as within the well-led domain and culture of the organisation. The Quality Improvement and Innovation (QII) Hubs were highlighted as being as area of outstanding practice – "an established forum to give staff the opportunity to learn about and contribute to the Trust's improvement journey".

NHS Improvement will make a decision on whether they accept the recommendation in February 2017 after further detailed work with the Trust to assess both financial performance and continuation of pace around the areas that require immediate improvement highlighted in the report. This includes 12 Must Do's and 4 Requirement Notices.

On 12 January 2017 the Quality Summit was held and the Trust formally received the report findings. The Summit was attended by representatives from the CQC, NHS Improvement, NHS England, Healthwatch, Kent County Council, Kent Community Health and the Clinical Commissioning Groups (CCGs).

In Part One, a presentation was given by Alan Thorne, Head of Hospital Inspections. This was followed by a presentation by Matthew Kershaw, David Hargroves and divisional representatives from Medicine, Emergency Care, End of Life and Maternity. External visitors were then invited to the WHH QII Hub where wider members of the team presented further evidence of work that has been completed since the Inspection.

Part Two of the Summit was chaired by NHS Improvement (NHSI) and related to partnership engagement in the next stages of the Improvement Plan.

The priority following the Summit is to refresh the interim High Level Improvement Plan and submit this to NHSI along with assurance around pace of delivery for the priority actions above. On Friday 20 January 2017 the Improvement Plan Delivery Board (IPDB) was used as a Workshop to develop the next stage of the plans. The outputs of the meeting will be shared with the divisional and corporate leads with clear deliverables and timescales agreed – and will also be used to shape the divisional improvement plans.

NHS Improvement is working with the Trust to develop an integrated plan that reflects the actions required by the whole system. This includes our CCG, community, mental health, ambulance and social care colleagues. At the time of writing, a workshop with external partners is planned for the 3 February 2017 to develop their actions against the new plan.

Performance against the plan will be managed through a new system oversight group chaired by NHSI. The first meeting is planned for 17 February 2017 where the draft plan will be presented and discussed.

SUMMARY:

Based on the December 2016 NHS Choices report (November 16 reporting period) the red schemes are as below.

- MD20 – Adult Safeguarding/Mental Capacity Act. Compliance against L2 training still below trajectory (69% against 85% target). Recovery forecast adjusted to March 2017.
- MD22 – Temporary staff induction – compliance with electronic recording very low. Manual process of audit to be agreed with divisions. A manual audit has also been undertaken for January Strategic Workforce Committee which shows also shows low compliance. Further actions to be undertaken to improve position.
- MD24 – Pain Scores – audits awaited – recovery forecast December 2016. Action led by Surgical Division.
- MD18 – Policies – manual procedures in place, requires resourcing to fully complete. This action will feature on the new plan.
- MD05 – Mental health patients in ED. Continued partnership working with KPMT and additional local input but still some significant delays experienced by some patients.

These areas will be further reviewed alongside production of the new high level plan with a decision made as to whether they are complete or need to still feature.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Identified risks include: A decision regarding whether the Trust comes out of Special Measures is still pending and awaiting a final decision by NHS Improvement in February 2017. An additional risk relates to maintaining pace around the work – in particular due to current operational pressures – but mitigation approach to this is detailed below. • Continuation of Improvement Plan Delivery Board and structure on a fixed term basis to ensure process around new plan is embedded • Improvement Plan Steering Group to continue to ensure engagement with the Hubs • Work has commenced on the revised high level improvement plans and response to the Must Do and requirements notices in the reports. This will be an integrated plan with external partners • Local Plans in development within the clinical divisions • All Must Do areas to be mapped to appropriate governance committee where detailed assurance will be given.

LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to action and deliver our regulatory requirements
RESOURCE IMPLICATIONS:	Nothing additional
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Management Board on 1st February 17

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

RECOMMENDATIONS:

The Board is invited to discuss the progress to date and seek any further assurances that may be required.

Special Measures Improvement Plan Update

East Kent Hospitals University NHS Foundation Trust

Date of Report: 13th December 2016

Date of Reporting Period: November 2016

KEY
Delivered
On Track to deliver
Some issues – narrative disclosure
Not on track to deliver

East Kent Hospitals University NHS Foundation Trust
Our improvement plan & our progress

Background & Summary

- The Trust was put into special measures on the 29th August 2014 following a CQC inspection with reports that identified two of the three main sites as "inadequate" and the Trust rated overall as "inadequate". The sites rated as inadequate were the Kent and Canterbury Hospital and the William Harvey Hospital. The Trust was also rated "inadequate" in the safety and well-led domains.
- On the 16th November 2015, the CQC presented the findings of their subsequent inspection in the Trust which took place in July 2015. The reports identified improvement since the last inspection. The overall Trust rating went from "inadequate" to "requires improvement". The trust was rated "requires improvement" for the domains of safe, responsive and well-led. The domain of caring was rated as "good". The Trust was rated as "inadequate" for effective services. The three acute sites (William Harvey Hospital, Kent & Canterbury Hospital and Queen Elizabeth Queen Mother Hospital) were all rated as "requires improvement" with the Buckland Hospital and Royal Victoria Hospital, Folkestone, rated as "good".
- The Trust has been given a variety of recommendations that can be themed below:
  - Trust leadership and governance arrangements– sustaining of changes made since the last report;
  - Staff engagement and organisational culture to address the gap between frontline staff and senior managers;
  - Safe staffing to delivery timely patient care;
  - Staff training and development, specifically around mandatory training;
  - Demand and capacity pressures on patient experience, specifically within the emergency pathway and onward flow through the hospital and maternity services;
  - Following national best practice and policy consistently, specifically in relation to end of life care – ensuring there is a suitable pathway, documentation and education in place;
  - Support services are in place to ensure 7 day services can be delivered in priority areas – including pharmacy and radiology;
  - Mental health provision and timely specialist response for our patients;
  - Caring for children and young people outside dedicated paediatric areas;
  - Estate and equipment maintenance and replacement programme concerns;
  - Key national and local audits are undertaken and action plans implemented to improve care;
  - Incident reporting processes are robustly followed and learning from incidents and complaints is shared with all teams to improve services
  - Clinical Strategy - in place and communicated with all members of staff.

- The current published CQC report can be found on the CQC website: : *http://www.cqc.org.uk/provider/RVV*
- The Trust agreed an implementation plan to deal with 30 must do actions within the High Level Improvement Plan. These can be grouped into 12 thematic work streams. Each clinical division also has a local plan containing actions surrounding all of the detailed key findings, with timeframes and corresponding key performance indicators. We recognised all of the recommendations and are addressing them to improve the quality of services.
- This document provides a summary of Trust progress against our published High Level Improvement Plan - which provides further detail. A decision was made that despite evidence of improvement, the Trust should remain in 'special measures' to ensure that required changes made are sustained. The new Improvement Plan builds on the previous plan to continue the Trust Improvement Journey and get to "good".
- Oversight and improvement arrangements have been put in place to support changes required. The Improvement Plan is overseen by a monthly Improvement Plan Delivery Board, chaired by Dr David Hargroves, Clinical Lead. The Delivery Board is accountable to the Board of Directors. Operationally progress is reviewed via a fortnightly Improvement Plan Steering Committee with accountable named leads for each site and division. A Quality Innovation and Improvement Hub is in place on each hospital site and is used as a vehicle to drive change and communicate progress. A Programme Office has ben established with Programme Management support and a Quality Improvement Facilitator working with front line divisional teams.
- The Trust was re inspected between 5-7 September 2016. The final report is expecting to be published in December.
- This report outlines on a monthly basis the progress that is being made in implementing the organisational improvement plans – our Trust Improvement Journey.

Who is responsible?

- Our actions to address the recommendations have been agreed by the Trust Board and shared with our staff.
- Our Chief Executive, Matthew Kershaw, is ultimately responsible for implementing actions in this document. Other key staff are the Chief Nurse, Director of Quality and the Medical Director, who provide the executive leadership for quality, patient safety and patient experience.
- The Improvement Director assigned to East Kent Hospitals University NHS Foundation Trust is Susan Lewis, who will be acting on behalf of Monitor and in concert with the relevant Regional Team of Monitor to oversee the implementation of the action plan overleaf and ensure delivery of the improvements. Should you require any further information on this role please contact specialmeasures@monitor.gov.uk
- If you have any questions about how we're doing, contact our Trust Secretary, Alison Fox on 01227 766877 (ext 722 2518) or by email at alison.fox4@nhs.net

East Kent Hospitals University NHS Foundation Trust - Our improvement plan & our progress

How we will communicate our progress to you

- We will update this progress report every month while we are in special measures. Our High Level Improvement Plan will also be available through the Trust internet site (link to be added when live).

Chair / Chief Executive Approval (on behalf of the Board):

Chair Name: Nikki Cole	Signature:		Date: 13 December 16
Chief Executive Name: Matthew Kershaw	Signature:		Date: 13 December 16

East Kent Hospitals University NHS Foundation Trust – Summary of progress against improvement plan

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Safe *MD07 - There are robust systems to monitor the safe management of medicines and IV fluids according to national guidelines.*	December 2015 – March 2016	The monthly audit tool has been strengthened. Average monthly performance continues to be 89-90% . An environmental audit of current IV storage facilities has been undertaken. Audit shows most areas only require minor works – aside from critical care, theatres and renal OPD. Action plan agreed at May Heads of Nursing meeting and implemented. IV storage to be added to weekly audit from June 16 and will continue as business as usual. External assurance will be required by the CCGs	Blue: Actions complete. Monitoring as part of business as usual and IPDB. **Status of previous reporting month (November 16) – Blue.**
MD30 – The Medicine Management Policy is adhered with – and there are systems in place to ensure that prescribing practices across site for critical drugs are uniform.	December 2015-February 2016	Noradrenaline standardised prescribing policy agreed and has been rolled out to all areas. Compliance monitoring in place. Audit on track for completion in June 16 according to plan.	Blue: Actions complete. **Status of previous reporting month (November 16) - Blue.**
MD08 - There are sufficient numbers of suitably qualified, skilled and experienced staff available to deliver patient care in a timely manner.	December 2015 – On-going (with monthly review)	In September 16 the Trust had an overall 10.62% vacancy factor. Workforce and recruitment and retention plans are in place. Safe staffing reports for nursing are reported every month to the Board. Targeted campaign planned for BMJ about working at EKHUFT as a Consultant. Recent overseas nursing recruitment in India in June has very successfully led to 100 offers with additional EU recruitment in November. Strategy for hard to recruit areas on track with success in pharmacy, renal and NICU. Targeted Nurse Recruitment Days held on all sites. BMJ Medical Fair has led to additional middle grade recruitment. An extended induction programme for overseas doctors has been approved and is now being implemented. A new consultant recruitment group has been set up led by a consultant to improve strategies for consultant recruitment and retention. New starter portal in development to go live early 2017. External assurance will be required by the CCGs	Green: Plans on track. Concerns remain around the ability to recruit sufficient Consultant staff in the Emergency Departments and Therapy staff due to national supply. Recruitment and Retention Plan overseen by the Strategic Workforce Committee. Ability to recruit overseas nurses a risk due to changes in ELTS (English Language qualification). **Status of previous reporting month (November 16) - Green**
MD19 - The major incident policy is up to date and staff are aware of their roles and responsibilities. Staff are confident in its application having received sufficient training and 'drills' in appropriate areas.	December 2015 - September 2016	Shared service formalised with Maidstone and Tunbridge Wells NHS Trust. Head of Service appointed and 2x Band 7 managers. A full major incident exercise took place on 30th June 16. Emergency Planning Annual Report presented to the Trust Board. External assessment undertaken by CSU on behalf of NHSE– compliant in most areas. Some deficit in CBRN training numbers but plan agreed and being implemented. EPRR self assessment undertaken in Aug 16. Awaiting report. External assurance provided South East CSU on behalf of NHSE	Blue: Actions agreed in plan complete. On going work plans to continue to be overseen by Resilience Group. **Status of previous reporting month (November 16) – Blue.**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD20 - Staff training is focused on the principles of the MCA (2005) and how to assess capacity. Trust policies relating to adult safeguarding are updated regularly and are easily accessible. There is evidence that staff consider mental capacity in the planning and delivering care. Capacity assessments are considered carefully and are proportionate to patients' needs. *Best interests decisions are timely and issue specific.*	December 2015 –June 2016	The Policy was approved in December 2015. The content of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) training has been reviewed and TNA refreshed. Agreement that refresher should be every 3 years (not 2 years) in line with UK Core Skills Training Framework. The trajectory of compliance was refreshed to take account of this. The Safeguarding intranet and internet has been refreshed with much clearer signposting for staff on accessing the correct information. Training has been delivered in the QII Hubs on MCA and DoLS and will continue across all sites on a rolling programme. An "Ask 5 questions" audit is being rolled out to assess staff understanding of both areas. and forms part of the ward peer review and quality visits. 100% of staff have now received L1 training (via a leaflet in July payslip). Current rates of L2 training have improved dramatically and are 69% against a target of 85%. An action plan has been developed with a trajectory for improvement to 85% by the end of November 2016. The CCG Contract Quality Metrics require reporting of training numbers by level. This is now in place and reported via IPR.	Red: Actions complete although improvement required in % compliance at L2. A trajectory for compliance was set as November 16 but compliance has not been fully achieved. Agreement for end of March 16. Key areas have been prioritised. This action is embedded in the interim improvement plan along with on going work with front line to support staff application of Deprivation of Liberty (DoLs) and the MCA and monitor compliance. **Status of previous reporting month (November 2016) – Red** **RECOVERY FORECAST: MARCH 17**
MD21 - There is a Trust specific Children's Safeguarding Policy (which is consistent with the Kent & Medway Multiagency policy).	December 2015 - March 2016	The Trust specific Policy was approved at the Policy Compliance Group in March and is being disseminated to staff. Board Seminar on Safeguarding to be held. The Kent & Medway Children's Safeguarding Board require assurance and receive this via the Board's work.	Blue: Compete **Status of previous reporting month (November 2016) - Blue**
MD22 - All temporary/agency staff (all disciplines) should have the appropriate competencies for the clinical environment they are placed within and receive appropriate induction.	December 2015 – August 2016	Induction checklist compliance data now widely available via IPR and targets agreed. Current rates are still low (approx. 20%) so additional communications have taken place. The bank contract retender has been finalised and the requirement for agency checklists to be stored and available for reporting is included as a key requirement. Compliance to be monitored in Oct 16. During w/c 12th December 16 a manual audit is being undertaken of the local induction records for all Nursing, Midwifery staff and ODPs that worked in the Trust in Q2. A report of compliance will be presented at the January SWC and actions agreed. External assurance is being requested by the CCGs	Red: Slippage in programme. Previous trajectory for improvement – 50% compliance by Oct 16 and 85% by Dec 16. This is not being met. Audit being undertaken in December and reported in January at SWC to provide assurance of manual process in place. **Status of previous reporting month (November 2016) – Red.** **RECOVERY FORECAST: MARCH 17**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD23 - The pharmacy department is appropriately staffed and skilled to support the timely and safe discharge of patients.	December 2015 - March 2016	Recruitment and retention plans are in place and there has been an improvement in the vacancy factor. 22 new pharmacists are due to start in post over the next four months which will improve the overall vacancy factor. There are 4 posts currently out for advert. The Department have taken part in the 'Safer Start' initiative during January and have tested out prioritising those being discharged to reduce delays. The workforce development plan has been completed and submitted to CSSD Board in March, along with the pharmacy business plan which describes in detail the strategic plan for development of pharmacy in line with the recommendations of the Carter Report. Plans now agreed. An initial assessment using the TDA Trust development tool for Medicines Optimisation has been completed. A proposal has been made about level of service by ward (with associated KPIs) and agreed at Improvement Plan Delivery Board.	Blue: all actions completed. On going work with local teams to ensure support is provided prior to new recruits coming on line. Delivery of the strategy and workforce plans to sustain improvements. **Status of previous reporting month (November 2016) – Blue**
MD28 - Fine bore naso-gastric tubes are inserted and checked in accordance with NHS England's patient safety alerts; the Trust NG Policy is in line with this guidance.	December 2015	Trust NG policy implemented. Governance procedures in place to ensure compliance against standards. There is an article in Risk Wise (Trust wide Risk publication) this month to reinforce the learning. An external review of the safety of the system for NG tube insertion was independently reviewed by a Patient Safety Consultant; there were no issues identified. NHS England undertook an external review of Trust use of the Central Alert System (CAS) on Friday 19th February 16. This does not impact on completion of this action but will provide assurance regarding Trust use of the CAS.	Blue – Completed **Status of previous reporting month (November 2016) - Blue**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Effective *MD11 - There is participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff. It is used to improve care and treatment and people's outcomes. Clear action plans developed and managed through the Trust governance framework.*	December 2015 - December 2016	Internal audit undertaken and report received. The clinical audit forward programme for 2016 / 17 was approved by the Clinical Audit and Effectiveness Committee in March and was reviewed by the Integrated Audit Governance Committee in April. The forward programme is divided into "Must do", Carried over & New audit topics with priority given to the "Must do" topics. Quarterly status reports are being provided by the clinical audit team and review meetings set up to ensure that any slippage is identified early and mitigations can be put in place. The clinical audit website was re launched in April. The Clinical Audit Strategy was revised in October 2016 ahead of date to reflect developments within the improvement journey. A review of job planned PAs for audit is in progress - as part of annual job planning. There is some slippage to date in the 1617 audit programme but this is being addressed by Divisional leads who are reviewing the agreed plans with leads and establishing recovery. All Must Do Audits on track – slippage is to local audits which are being prioritised. Audit forms part of quality indicators reported to CCG Quality Leads. .	Amber: Some slippage in delivery of 1617 Audit Programme. Plans are being reviewed by Divisional Management Teams and mitigations put in place with immediate affect. Status to be reviewed at Executive Performance Reviews feeding into the Integrated Audit and Governance Committee. Monthly exception reports to IPDB. Update to Quality Committee in January 17. **Status of previous reporting month (November 2016) – Amber**
MD12 - The environment and facilities in which patients are cared for must be safe, well maintained, fit for purpose and meet current best practice standards.	December 2015- On-going but with key milestones achieved and evidenced by June 2016	Sessions held in QII hubs promoting process and timetable for environment bids. Space mapping completed to review storage, patient and staff facilities to improve patient experience and staff facilities, a program of refurbishments is being rolled out from May 2016. Particular improvements will be undertaken at WHH Cambridge wards. Estates service now operates 7am to 10pm and are undertaking PPM and minor jobs in these hours more effectively. Productivity data is being discussed locally to ensure quick resolution of estates jobs. Web based Self reporting as been piloted with feedback being incorporated into the further deployment. Now being used in wards with great end user feedback. The first Estates store to support estates staff to be able to resolve work order quickly is 80% stocked at K&C. Work in the WHH A&E is nearing completion with only the Paediatric area needing to be completed. Work to St Augustine's at QEQM is progressing well. Finally the Trust has run two fire evacuation exercises with Kent Fire and Rescue to test the robustness of procedures and safety and a third exercise in the K&C Renal unit. HSE are working with the Trust at present to ensure compliance to essential standards.	Blue: actions complete. On-going estates improvement plan monitored as part of business as usual through PEIC. **Status of previous reporting month (November 2016) - blue**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD13 - There is sufficient equipment in place to enable the safe delivery of care and treatment, equipment is regularly maintained and fit for purpose to reduce the risk to patients and staff.	December 2015 Start February 2016 End	A programme of equipment maintenance is in place and will continue going forward. The equipment library is working effectively. The Medical Devices Group manages the equipment requirements across the Trust ensuring there is sufficient equipment in place for safe delivery of care and to manage the risk. Approval of business case at June Strategic Investment Committee for additional resources for EME team to ensure PPM levels can be sustained. Resource is being recruited too. Current performance is 83% for EME equipment and 94% for high risk equipment. New electronic system is in place where departments can review equipment and date of last service. To be communicated to all leads. Approach to training compliance agreed at June Improvement Plan Delivery Board and to be taken forward via Heads of Nursing. Reports to Improvement Plan Delivery Board to ensure sustained compliance.	Blue: Actions complete. Roll out of business case and training plan as business as usual and IPDB. Monitoring by exception. **Status of previous reporting month (November 2016) – Blue.**
		No external assurance is being sought at present.	
MD27 - Operating Theatres on all sites comply with HTM 05-01, particularly in relation to risk assessment, the environment and staff training.	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Compliant. All operating theatres are compliant with HTM 05-01 and undergo an annual verification. The General manager for surgery works closely with estates to co-ordinate a cycle of closures and repairs annually	Blue: Actions complete **Status of previous reporting month (November 2016) – Blue.**
		External assurance is provided via the Trusts external Authorised Engineer.	

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD29 - All escalation wards/clinical areas are appropriately staffed and equipped to safely care for the cohort of patients intended.	December 2015 -March 2016	Recruitment is in progress and each of the escalation areas has been risk assessed. Where possible the escalation beds are closed when not required according to the demand in the Trust. The Trust has approved funding for substantive staff in areas that are consistently opened. These posts are being recruited into currently. The model of care for St Augustine's Ward has been agreed and additional therapy posts are being recruited to. Capital works have commenced on St Augustine's ward. Confirmation has been made to recruit to unfunded beds on Cheerful Sparrows Ward.	Blue: Actions identified complete. Model of Care changes and substantive recruitment to areas to form part of on-going improvement plan. **Status of previous reporting month (November 2016) - Blue**
Caring *MD24 - Patients' pain scores should be regularly and clearly documented and there should be interventions - pharmaceutical and alternative therapies. There are clear tools for use with patients with dementia and learning disability.*	December 2015- August 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Pain scores are collected via Vital Pac and there is an audit process in place. A review of pain interventions available and access to specialist advice is underway. A tool has been developed for patients with dementia and also learning disability. Consultation and communication has been undertaken with patients and staff and the tool has been made available on PAS as a clinical form. A spot audit has taken place looking at actions taken following completion of pain scores and presented at IPDB. Patient experience related to pain is also captured through the friends and family test as well as any incidents or complaints and investigated. The Pain Group will make a proposal for all divisions for the Trust wide audit programme for 1718 to ensure this is regularly undertaken. Pain Guidelines have been updated and to be approved in Feb 17. No external assurance or support being sought.	Red: Some actions incomplete. Pain Group to advise on current pain tools and a regular audit format for the 1718 Trust Wide Audit Programme. This work is being led by the Pain Group. **Status of previous reporting month (November 2016) - Red** **RECOVERY FORECAST: FEBRUARY 17**
MD26 - Patients' complaints are responded to as per national standards. Ensure there is a clear process for learning across the Trust.	December 2015 - On-going but with key milestones achieved and evidenced by April 2016.	There has been considerable work undertaken with the complaints response team and response times are improving. A trajectory for improvement has been established with a focus on 30 day response rates. Q4 compliance of complaints responded to within 30 days is 26%. Surgical Services have a very effective 'Outcomes with Learning' newsletter for staff related to complaints. This format is being shared with the other divisions. The Terms of Reference for the Steering Group have been revised now incorporating other forms of patient feedback. Complaints training is being considered as part of the 1617 action plan for the Group. An Away Day was held with the Patient Experience Team w/c 29th March and additional investment made in the RSO role. The Deputy Chief Nurse has undertaken a review of the complaints process with recommendations for improvement. No external assurance or support being sought.	Blue: actions identified completed. Remaining improvements to be outlined in next iteration of the improvement plan with reference to continued improvement in response times. **Status of previous reporting month (November 2016) – Blue.** **.**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Responsive *MD06 - Effective processes are in place on each site (and between sites) to manage flow - senior on site leadership supported by accountable leads. Information supports escalation and decision making. Patients are cared for in the most appropriate place and care is coordinated.*	December 2015 On-going (key milestones set out in column K and detailed in interrelated Emergency Care Recovery Plan).	Clinical Site Operational Leads in place on each site and substantive model agreed for implementation. Recruitment on going. Baseline bed model agreed in May 16. The Safer Care Bundle has been launched across all sites with the next phase of roll out to commence soon. Capacity Summit held with external partners and agreed improvements to support discharge including a single point of access for 'Home First' , a therapy led ward supported by KCHFT and continuation of the H&S village beds until end of March 17. The QEQM Acute Medical Model is being evaluated. The model is being developed further at the WHH site including workforce, appropriate location , primary care triage and speciality in reach to be completed by the end of November. The Trust is working with the Acute Frailty Network on enhancing care pathways on each site. ECIP Support is in place and multi partner support via the A&E Delivery Board	Amber: Slippage against some milestones in ED Recovery Plan. Capacity Summit held in November with external partners. Improvements agreed noted in Progress section. **Status of previous reporting month (November 2016) - Amber**
MD25 - Inpatient areas are supported by 7 day services (radiology, therapies and pharmacy) to enable effective use of capacity and enable flow.	December 2015 Start On-going but with key milestones achieved and evidenced by June 2016.	Clinical Divisions have assessed which services are currently 7 days and which services may benefit from 7 day working. This forms part of workforce plans. Also ensuring that teams are aware of how to access out of hours services and is clearly documented. Discussion within contract negotiations with commissioners around short, medium and long term plan. Diagnostic audit has been undertaken and a position paper written for Executive discussion in March 2016. A 7 Day Services Working Group to be established at Trust level to carry forward work and planning for 2020. No external support or assurance requested.	Blue: Actions complete. **Status of previous reporting month (November 2016) - Blue**
Well led *MD09 - There is a positive workforce culture demonstrated by content staff who are supported and empowered to lead improvement, are aware of the Trust vision and their role within it and provide excellent patient care. Leaders at all levels have the skills to support and embed cultural change.*	December 2015 Start On-going (key milestones set out in column K and detailed in Cultural Programme Plan).	Very positive recent staff FFT results. Score for recommending EKHUFT for treatment has gone up 4% since March to 78% and up 8% to 57% as a place to work - the highest scores to date. Further workshops happening re 'Respect' campaign. Health and Wellbeing Group has been established. New appraisal process launched on 1st April with conversation around Trust Values and Behaviours. Contract awarded for leadership development. NHSI Business case underway. Divisional 'Great Place to Work' action plans agreed. The People Strategy has been agreed by the Board and implementation plans are being developed. Recent Medical Engagement Scores (received Sept 16) show improvement in many areas). Leadership Development BC with NHSI for approval	Green: Actions complete. People Strategy now approved by BoD. Approval on first stage of business case for leadership development by NHSI. **Status of previous reporting month (November 2016) – Green**

CQC Key Question	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
MD10 - The clinical strategy plan is delivered to timescale and communicated and implemented successfully led by clinical champions.	December 2015 - December 2016 (interim milestones within HLIP). Next milestone – development of models of care (April 16). STP complete end of June 16.	We continue to work closely, via the East Kent Strategy Board and aligned clinical meetings, to design of sustainable model of health and social care for east Kent. The national request for health economies to produce a 5 year Sustainability and Transformation Plan by June 2016 has also been aligned with the work on strategy. The Trust held a significant clinical engagement event on 1st to 3rd March to consider how acute care will be developed in the future and a range of meetings have taken place with staff. The output of these sessions was reviewed by the Trust Board in April and further work is being progressed for presentation back in June 16. Clinical engagement event held in July regarding next steps prior to consultation. The public facing case for change has been published and the stage 1 NHS Assurance process is underway. External collaboration is central to this item and is in place.	Green: On Track **Status of previous reporting month (November 2016) - Green**
MD16 –The Trust governance arrangements are clear and transparent	December 2015 - March 2016 (with interim measurable milestones)	GT Review received. Improvements noted since Deloitte review. Further corporate and divisional actions to embed. Significant progress in agreed actions. Additional communications complete regarding staff awareness. External support commissioned by Trust from Grant Thornton regarding board governance. Report received.	Amber: Some slippage. GT review identified good practice at board level but further work to ensure standardised divisional arrangements. Action plan in place with update to the November QC and IPDB. **Status of previous reporting month (November 2016) – Amber** **Recovery forecast – December 16.**
MD17 - The Trust incident reporting process is robustly followed by all departments - with focus on ED departments at WHH, QEQM and Maternity services. Ensure that incidents are acted on in a timely manner and that staff receive feedback	December 2015 Start September 2016	Incident reporting is high across the Trust when benchmarked against peers. Forums are in place where incidents are reviewed and action plans monitored. The next national report from the NRLS is awaited in order to confirm national benchmarking for reporting. Datix V14 testing was completed in April and fully rolled out across the Trust. External support is not required.	Green: On Track **Status of previous reporting month (November 2016) - Green**
MD18 - Trust wide policies are procedures are up to date and in line with best practice. Policies and procedures are clearly written and easily accessible by staff.	December 2015 Start June 16 (but trajectory for improvement set based on programme plan)	Policy group has been set up and meets regularly to ensure policies are up to date and are in line with best practice. There is a manual process for identification if any policy documentation which will be out of date within 2 months. A system has been purchased to provide assurance that staff have accessed and read policies relevant to role. In order for this to work effectively, the system must be configured and a member of staff nominated to work on this project. External support is not required.	Red: Slippage against milestones. Risk mitigated by manual systems and governance via Policy and Compliance Group. Meeting with 'Insight' on 14 Dec 16 and agreement of options for software. **Status of previous reporting month (November 2016) – Red** **Recovery forecast – November 16 (workforce) and January 17 (IT solution).**

East Kent Hospitals University NHS Foundation Trust – Summary of progress against improvement plan

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
End of Life *MD01 - A suitable End of Life Pathway will be in place and staff will be competent in its consistent application. Contribution to local and national audits to evidence compliance.*	December 2015 Start June 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	The End of Life Board meets bi monthly chaired by the Divisional Head of Nursing, Specialist Services with Executive level leadership. Revised documentation which is trust specific and nationally compliant is now complete and available. Multidisciplinary staff awareness of the inclusive responsibility of end of life knowledge and expertise is progressing through specific training on end of life conversations local clinical area based Link Nurses. The Link Nurse contract has been agreed and nurses identified for all areas. Link Nurses Away Day planned in July 16. The EKHUFT section of the Interagency Policy was completed for the end of March. A report following the EoL Carers Experience Questionnaire was presented to the EoL Board in April 16. The EoL Facilitator has started in June 2016. Macmillan have in addition confirmed two band 7 posts for a two year period to support the Trust's implementation programme. Draft recommendations for training were discussed on the 14th April at the EoL Board. Training has gone live for Link Nurses with 72% completion. Final Multi-Agency Policy sign off delay - CCG led. Tier 4 (EKHUFT) section complete. Now ratified in August 2016.	Blue: All actions to date complete apart from those outside Trust control. End of Life Board to develop next stage improvement plan to be overseen by working group. First meeting on 7 Nov 16. **Status of previous reporting month (November 2016) – Blue.** .
Urgent & Emergency Care *MD02 - The Trust has an effective and safe emergency and urgent care pathway. Care is delivered in the most appropriate environment, working alongside local partners, with multi-agency leadership.*	On-going (key milestones set out in column K and detailed in Emergency Care Recovery Plan).	The Emergency Pathway Improvement Plan is being implemented. ECIP are working with the Trust to make the necessary improvements in patient flow, safety and quality across the Trust. The ED Recovery Plan has been updated to reflected the HLIP and vice versa (February 2016). New UCC model in operation from July 16. A workforce model for mid grade doctors is being written. The building work in ED Minors has been completed meaning there is more space and an appropriate paediatric waiting area. The ED Escalation Policy/SOP has been approved and being rolled out. Rapid Assessment and Treatment (RAT) model established at WHH site (9-7 M-F) and being discussed at QEQM site. ED team participating in TIPS programme to measure and sustain impact. Continued risks regarding the ability to recruit to medical vacancies although 9 senior grade/consultant offers have recently been made. Revised trajectory agreed by SRG around 4 hour performance. Further work on-going to ensure privacy and dignity maintained when there is overcrowding in the department. ECIP Support is in place	Amber: Some slippage against the ED Recovery Plan impacting on 4 hour trajectory. Revised interim plan mapping on the new NHSI standards (A&E Improvement in 2016/17) for completion by March 17. **Status of previous reporting month (November 2016)- Amber**

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Children & Young People *MD15 - Ensure that appropriately trained paediatric staff are provided in all areas of the hospital where children are treated to ensure they receive a safe level of care and treatment.*	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	Recruitment and retention plans are in place . Work Programme overseen by Children's Board led by Executive Director.	Blue: Actions complete **Status of previous reporting month (November 2016 – blue)**
MD14 - There are sufficient numbers of paediatric trained staff within Emergency and Urgent Care Pathway.	December 2015 - March 2016 (with interim measurable milestones to demonstrate trajectory of improvement	Recruitment of paediatric nurses in the ED is complete to enable 24/7 cover. 24/7 cover now in place on WHH and QEQM sites. It has been recognised that there is a need to review the current model as there are times during the 24/7 period when cover is not robust and staffing does not always reflect demand. This review will form part of the interim improvement plan following re-inspection and will continue to be reported locally into the Improvement Plan Delivery Board. To be completed by November 2016.	Blue: Actions complete but review of current ways of working to take place with recommendations in liaison with the paediatric department. To be complete by November 2016. **Status of previous reporting month (November 2016 – blue).**
Maternity Services *MD04 - The Trust offers safe, effective, caring, responsive and well-led maternity services*	December 2015- September 2016	The MBRRACE-UK report has been published and shows the Trust to have a 10% lower average mortality rate for its comparator group. The RCOG final report has been received and an action plan signed off in May 2016. Maternity dashboard now updated monthly and in use. Work underway on bereavement suite at QEQM. Some delay to completion due to issue with contractor but revised timescales being agreed. Environmental constraints mean problematic to improve facilities for partners but written information to be reviewed. CTG machines received and replacement programme in place. Maternity Vision Strategy approved and 'Great Place to Work' workshops set up for staff involvement. RCOG action plan in progress overseen by Clinical Lead.	Blue: Actions complete. Work on going . Proposal to produce an interim improvement plan outlining the next steps in delivering the Maternity Vision and workforce plans. **Status of previous reporting month (November 2016 – blue).**
MD03 – The Trust has sufficient capacity for women in labour on a day to day basis	April 2016 (with interim measurable milestones to demonstrate trajectory of improvement).	The final version of Birth Rate Plus has been received. The Trust assesses staff requirements on a shift basis and addresses any shortfalls that occur with temporary staffing. A live database is in place for recruitment. A database has also been put in place to record the number of diverts and closures to the unit and a revised policy circulated for comment for sign off in July 16. An initial review of demand and capacity has been undertaken but there continues to be data quality issues. An action plan has been agreed to ensure that additional data is collected on PAS to enable more accurate modelling to occur. This will be overseen by the Information Task and Finish Group linking into the Information Assurance Board.	Blue: actions complete but additional actions identified to feed into next iteration of the improvement plan (including action plan around data quality in maternity and work to ensure maternity scorecard is embedded at all levels). **Status of previous reporting month (November 2016 – blue).**

Specific service (i.e. cutting across CQC Key Questions)	Agreed timescale for implementation	Progress (i.e. successes/outcomes) against original timescale *What has been achieved?*	Comments / Current main concerns
Mental Health *MD05 - Patients receive timely mental health assessment and have appropriate facilities whilst waiting.*	December 2015-May 2016	In December 2015, a HLIP partnership engagement session took place where the accountable officers for the local CCGs agreed to support an action plan regarding the level of psychiatric liaison support required as part of the emergency pathway. An interim solution was agreed until the end of March 2016. A&E Delivery Board have approved an options appraisal for model of care. From end of May 16, KMPT is providing 8-8pm cover on all three sites 7 days per week. A third consultant will also be employed. Changes to the physical environment in the WHH ED are complete. Internal Escalation Policy signed off and communicated with all staff – outlining practice for safe, high quality care whilst patients are awaiting assessment. Consideration to be given of additional training required by staff. Further external escalation occurring . Daily PTL established to ensure daily review and robust escalation of patients awaiting specialist placement under our care. Additional RMN cover at the QEQM site to mitigate risk in relation to local health demographic. Resolution with Commissioners and KPMT (mental health provider). Internal mitigations include regular executive escalation and operational actions to ensure departments are supported and space is dedicated in ED for patients where possible. KMPT (MH provider) and all CCG Accountable Officers . Risks around delays to specialist assessment and availability of specialist inpatient beds continue to be escalated at an Executive level. MH in ED also within scope of A&E Delivery Board.	Red: Slippage against deadline. Continued risk with resolution led by the commissioners and KPMT (mental health provider) with executive level leadership and escalation. Working closely with CCG and KMPT regarding extending provision to 7 day working. Further work to be agreed externally to mitigate risk. **Status of previous reporting month (November 2016) – Red**

Other (e.g. concerns arising after CQC re-inspection; awaiting CQC report from re-inspection etc.)

No other concerns noted.

Other comments for reporting period (November 2016):

The pace of progress has continued - as part of our organisational Improvement Journey.

The Trust were re-inspected in September 2016. The re-inspection focused on the emergency pathway, medicine, maternity and the end of life pathway. Initial feedback from the visit was positive – the CQC found evidence of improvement and our staff were described as "positive, open and enthusiastic". The CQC also provided initial feedback about our remaining challenges, which we recognise. Immediate feedback has been acted on and the High Level Improvement Plan has been refreshed since the inspection with additional targets to ensure the pace continues. The interim HLIP was approved by the October Improvement Plan Delivery Board (IPDB) and Management Board. Draft reports were received on 28th November 16 and the factual accuracy check submitted ahead of the timeframe on 5th December 16. Final reports are expected w/c 19th December 16. Our interim report will be updated on receipt of the final reports. We await the outcome but regardless of this the Trust Improvement Journey will continue.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**EMERGENCY CARE RECOVERY PLAN**
BOARD SPONSOR:	**CHIEF OPERATING OFFICER**
PAPER AUTHOR:	**DIVISIONAL DIRECTOR UC&LTC**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

The aim of the plan is to improve performance and ensure that the A&E Improvement Delivery Plan delivers sustainability across emergency care pathways. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

December performance against the 4 hour target was 74.23% against a trajectory of 89.90%. This shows a decline in performance compared to the previous month, with a lower proportion of patients seen within 4 hours.

Volume of attendances to Trust emergency departments remain above expected levels, with December activity showing a raised position above the plan (+1191, +7.3%). Volumes of attendances to Trust A&E departments continue to be higher than the previous year (+5.2% YTD), with raised volumes in particular noted at the Dover Buckland Hospital Minor Injuries Unit (+14.4% year on year), but also at the William Harvey Hospital in Ashford (+6.5%) and the Queen Elizabeth the Queen Mother in Margate (+5.9%).

The above-expected activity levels continue to contribute to high in department numbers at the sites, and with an increase in month within medical outliers (average compared to 81 in November, and a slight decrease in bed occupancy (100.5%; a high occupancy rate requiring the use of escalation beds).

The A&E Delivery plan is part of a whole system plan which has been ratified by the A&E Delivery Board. The plan will continue to be monitored internally by the Urgent Care Board and from a whole system perspective via the A&E Delivery Board. The Trust is leading on two of the 5 workstreams relating to Patient Flow and Streaming.

This report contains updates regarding the following workstreams currently underway:

- Mandated initiative 1 - Front Door – Primary and Ambulatory Care streaming
- Mandated initiative 2 - Ambulance Response Programme
- Mandated initiative 3 - NHS 111
- Mandated initiative 4 - Flow
- Mandated initiative 5 - Improving discharge from hospital

Progress updates on the following work streams are also included:

- Improving Clinical Leadership in ED
- Acute Medical Model
- Trajectory Confidence including risks and mitigating actions

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	**Continued increase in ED demand, in particular in the evenings and weekends** *Mitigation – Escalation to A&E Delivery Board. To stream, as appropriate, patients to ambulatory care and Primecare, Out of Hours GP service.* **Increasing risk of adult and paediatric patients with a mental health condition being delayed in ED for a mental health bed due to lack of bed capacity both locally and also nationally. The increased risk has been particularly noticeable at QEQMH.** *Mitigation – Daily escalation via the Chief Operating Officer (COO) or Divisional Director to senior management at KMPT. Issues are escalated by COO at the weekly EKCOO's meeting.*
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Risk to the achievement of the 4 hour Emergency Access Standard.
RESOURCE IMPLICATIONS:	Additional clinical staff in ED to meet increasing demand. Access to mental health bed capacity
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Urgent Care Board
PRIVACY IMPACT ASSESSMENT: *NO*	**EQUALITY IMPACT ASSESSMENT:** *NO*

RECOMMENDATIONS AND ACTION REQUIRED:

- To note and discuss.
- For EKCOO's to continue to monitor and escalate issues relating to delays for patients requiring access to mental health bed.
- Executive and UCLTC Divisional Director to continue to escalate the impact of increased activity to ED and develop new integrated services with primary care colleagues.

REPORT
EMERGENCY CARE RECOVERY PLAN
DECEMBER 2016

Key Performance Indicators

74.23 %

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Green
4 Hour Compliance	84.91%	80.01%	79.25%	84.06%	82.69%	85.40%	82.87%	82.24%	84.29%	79.35%	75.76%	74.23%	95%
12 Hour Trolley Waits	0	1	0	1	1	0	0	0	0	0	1	1	0
Left without being seen	2.87%	3.78%	4.20%	3.46%	4.09%	3.84%	4.59%	4.11%	3.31%	3.85%	3.96%	3.85%	<5%
Unplanned Reattenders	8.88%	8.97%	9.31%	9.10%	9.40%	9.22%	8.62%	9.01%	8.78%	8.58%	8.65%	8.95%	<5%
Time to initial assessment (15 mins)	95.4%	94.6%	92.9%	88.4%	88.7%	91.2%	85.2%	81.0%	86.9%	79.5%	74.4%	79.1%	90%
% Time to Treatment (60 Mins)	49.5%	43.5%	40.8%	46.3%	43.5%	48.3%	46.3%	48.9%	48.5%	40.9%	39.9%	40.0%	50%

Sustainability & Transformational Funding Trajectory (Submission 18th April 2016)

-15.67 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%	
Performance	84.06%	82.69%	85.40%	82.87%	82.24%	84.29%	79.35%	75.76%	74.23%				

The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard. An Emergency Care Recovery Plan (ECRP) has revised to include the five mandatory requirements of the A&E Improvement Delivery Plan. The aim of the plan is to improve performance and ensure that the A&E Improvement Delivery Plan delivers sustainability across emergency care pathways. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

December performance against the 4 hour target was 74.23% against a trajectory of 89.90%. This shows a decline in performance compared to the previous month, with a lower proportion of patients seen within 4 hours. Analysis of the breach reasons shows a similar picture compared to the previous month, with 369 additional breaches in December compared to the previous month, with the an increase in breach reasons assigned to ED-department reasons such as delays to be seen (2,105 from 1,780 in November, now 47% of the total breach reasons), delays in treatment decision (989 from 868 the previous month, 22% of all breaches). Non-ED assigned breach reasons such as Bed Management breaches fell once again in both volume and proportion of the whole, as (now only 7% of breaches in month (306 compared to 348 in November); There was a single 12 hour Trolley Wait reported in December.

Volume of attendances to Trust emergency departments remain above expected levels, with December activity showing a raised position above the plan (+1191, +7.3%). This continues the year to date trend excess volumes of attendances with a cumulative +6.0% variance to the plan since April 2016. Volumes of attendances to Trust A&E departments continue to be higher than the previous year (+5.2% YTD), with raised volumes in particular noted at the Dover Buckland Hospital Minor Injuries Unit (+14.4% year on year), but also at the William Harvey Hospital in Ashford (+6.5%) and the Queen Elizabeth the Queen Mother in Margate (+5.9%).

The above-expected activity levels continue to contribute to high in department numbers at the sites, and with an increase in month within medical outliers (average compared to 81 in November, and a slight decrease in bed occupancy (100.5%; a high occupancy rate requiring the use of escalation beds). These metrics reflect some of the difficulties in achieving flow of patients from the Emergency departments to acute wards. While the

breach analysis shows a slight reduction in the proportion of bed management breaches, occupancy figures show the potential influence of reduced patient flow out of the department to other hospital areas, with a large proportion of patients not being seen a timely manner, with an extended wait to see a senior decision maker noted through the breach reasons around the 60 minute metric.

Traditionally, for those patients who see and ED clinician and are then referred on to a specialist team for onward assessment, treatment and potential admission; the 4 hour standard has had the first two hours allocated to the Emergency Department with the next two hours allocated to the specialist team. This has meant that if the Emergency Department has not assessed and referred to a specialist within the first two hours from arrival in the breach would be allocated as a delay in being seen in ED. However, it has been raised that this is an internal metric and over the past year there have been a growing number of patients who have been referred to a specialist after two hours and then gone on to spend a greater amount of time in the ED awaiting specialist assessment or admission to a ward. In recognition of this fact, a review of how breaches are allocated will be undertaken to ensure that the impact of patients awaiting admission is recognised and specialist delays can be escalated to the appropriate Divisional teams for review and action.

ECASCARD

The Trust has introduced eCasCard into both majors departments at both the William Harvey Hospital (27th September), and into the Queen Elizabeth, the Queen Mother Hospital (25th during October). Implementation of this system is aimed to bring real-time recorded activity to the ED; to be one of the first organisations in the country to go paperless and provide up to date, real time tracking of patient journeys through the department.

Clinical staff are required to use the system in real time to fully track patients throughout their pathway and to document contemporaneous clinical notes. Additional training and support has been available within the departments in order to improve staffs compliance and offer training and encouragement to use the new system. There have remained issues with the increased time it takes to use the system and this has resulted in increased breaches, particularly in the evenings and overnight. During the implementation period all staff has been encouraged, and are able to highlight issues and propose improvements, many of which have subsequently been implemented.

A senior consultant Geriatrician from QEQMH has also completed a review of the system and proved valued feedback regarding improvements which will make the system more applicable for the speciality clinical teams.

Since the implementation there has been a decrease in performance against the 4 hour target; actions have been taken to increase management support, training and speedy resolution of issues. Executive and senior Divisional management are actively monitoring and supporting the situation to resolve issues and compliance to fully using the system to support patient care and flow through the departments.

A&E IMPROVEMENT PROGRAMME

The Urgent Care and Long Term Conditions Division have restructured the urgent care leadership team to provide a triumvirate of a General Manager, Head of Nursing and Deputy Divisional Medical Director. In December the Deputy Divisional Medical Director and Head of Nursing for Urgent Care were appointed. The General Manager interviews will be held in the New Year. The Head of Nursing and Deputy Divisional Medical Director are new posts which will provide a dedicated senior clinical focus for the Emergency Department, Acute

Medical Unit and Ambulatory Care. The A&E Delivery Plan has been critically reviewed by the new leadership team to ensure that the actions will deliver an improvement in performance and reflect the current challenges the ED's are facing with high paediatric attendances in the evenings; increased clinical acuity resulting in a higher conversion to admission.

The A&E Delivery plan is part of a whole system plan which has been ratified by the A&E Delivery Board. The plan will continue to be monitored internally by the Urgent Care Board and from a whole system perspective via the A&E Delivery Board. The Trust is leading on two of the 5 workstreams relating to Patient Flow and Streaming.

Mandated initiative 1 - Front Door – Primary and Ambulatory Care streaming
It is recommended that A&Es, particularly those with chronic staff shortages, should consider developing primary care streams to manage patients presenting with minor illnesses and/or chronic conditions during peak demand periods. The GP in the Urgent Care Centre at K&CH is now established within the minor injuries unit. Pilots for an integrated primary care service are underway; at QEQMH the Acute Response Team model went live in November 2016 and has been successful in identifying frail elderly patients who can be discharged from ED with GP and/or multi-disciplinary team support. Discussions are underway to develop an integrated streaming model for WHH with a visit to Guy's Hospital in London to review their integrated model; however, due to capacity in primary care it may not be possible to implement the model until the spring 2017.

Mandated initiative 2 - Ambulance Response Programme
EKHUFT and SECAMB have an excellent supportive working relationship, with patient safety and care being the highest priority for both organisations. During peaks in activity both organisations clinical staff prioritise the safe handover of patients. This has included a senior nurse or doctor reviewing all patients awaiting handover to ensure that clinical priority is given to the sickest patients. It is a priority to reduce handover delays and consistently improve handover times. A dedicated RAT (Rapid Assessment and Treatment) area has been identified at WHH and is opened as and when clinical staffing levels allow. This area provides a dedicated area to assess patients arriving by ambulance.

Mandated initiative 3 - NHS 111
Primecare are the providers of the out of hour's service and NHS 111. There have been some issues with consistent GP cover on the rota out of hours at weekends and overnight. It has been noted that there was an increase in paediatric attendances in the evenings and weekends. In response to this increase, the ED has booked a senior paediatric doctor to work on the middle grade rota and manage the increase in activity.

Mandated initiative 4 - Flow
It is a priority to enhance patient flow and reduce hospital bed occupancy. The SAFER programme has become embedded within the medical wards at WHH and is being implemented at QEQMH. On both sites there has been renewed focus on clinical engagement and decision making on board rounds. Senior Matron and Managers are actively involved in reviewing patient's pathways to expedite internal waits and actively progress.

Mandated initiative 5 - Improving discharge from hospital
It is a priority for health economies to develop a 'discharge to assess' model so health and social care assessments of care are carried out in patients' places of residence rather than in acute hospitals. The 'Home First' model has been launched, however there has remained issues relating to the availability of external capacity.

Progress updates on the following work streams also include:

Improving Clinical Leadership in ED

- At QEQMH there is an on-going issue in recruiting substantive middle grade doctors. There are now 13 vacant posts resulting in a high dependency on agency doctors. It is recognised that this is not a sustainable position and therefore a business case is being developed to develop advanced nurse practitioner (AHP) posts. This will be a 3 – 5 year strategy to train 8 AHP's per year. In the meantime on-going recruitment will continue, including the development of internal rotations and training programme to enhance the posts.
- An Emergency Nurse Practitioner (ENP) business case to enable a dedicated ENP service has been developed. It is proposed that this case will be funded through reinvestment of agency funding. The successful implementation of this case will also reduce the dependency on medical locums.

Acute Medical Model

- In December the Ambulatory Care service was run on a 7 day basis as and when staffing resources allowed. On the weekends that the service was open there was a notable improvement in performance against the 4 hour standard, particularly at WHH.
- Ambulatory Care clinicians have established a successful process of reviewing patients in ED every morning to identify patients who can be transferred from ED to be managed on an ambulatory pathway.
- At QEQMH Consultant Acute Physicians have been very successfully working in ED in the evenings and weekends, to provide senior consultant cover out of hours and mitigate the risk of high agency medical staff.

Trajectory Confidence

December performance against the 4 hour target was 74.23 %, against a trajectory of 89.90%. The increased activity levels seen so far this year have continued being 5% above plan YTD. The numbers attending the departments, particularly in the evenings and overnight continue to have an adverse effect on the Trusts ability to meet the 4 hour emergency access standard. The increase in children and GP expected patients' attending in the evenings has not abated.

The on-going risk to delivery of the trajectory is:

- On-going 5% increased demand to ED. These high levels of activity, particularly in the evenings make it very difficult to discharge frail elderly patients home.
- Impact of Primecare, the new out of hour's primary care provider.
- A high % of breaches of the 4 hour emergency access standard relate to implementation of the new ECASCARD system as staff become accustomed to using the system in real time.
- High numbers of patients attending ED in the evenings and weekends who could be managed by primary care, in particular paediatric attendances.
- Poor patient flow due to lack of timely bed availability.
- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.

- Impact on the ED when trying to manage high risk patients attending with a mental health condition, and who are awaiting assessment overnight by the Crisis Team.
- Delays in mental health bed availability.
- Middle grade medical staffing vacancies and unfilled gaps in rotas due to lack of agency or substantive staff. QEQMH is a particular risk due to the geographic location of the hospital.
- High number of nursing vacancies across the emergency floor at QEQMH.

Actions taken to mitigate risk and improve performance:

- Increased daily SITREP meetings with Chief Operating Officer or Divisional Director leadership at the 08:00, 13:00 and 16:00 meetings. Action focussed and structured meetings following the Trust Escalation Action Cards.
- Detained reviews of patients on the IDT working caseload and also of all admitted patients to ensure that all patients pathways are being proactively managed.
- Additional management support, at Executive and General Manager on call level has been provided at WHH and QEQMH at weekends and weekday evenings, with escalation to the CCG Executive on call to ensure all external stakeholders were aware and supporting the Acute Trust.
- Greater senior clinical engagement into the Operational Control Centres with peer review and challenge of patient flow issues.
- Additional internal and agency medical staff have been booked to provide senior clinical support in the Emergency Departments and also to enable senior medical review at the weekend.
- Continued support and close working with SECAMB to ensure that patients are handed over safely.
- ECASCARD issues are being monitored, with issues being actioned as a priority in order to make improvements to the system. Increased communication and training has been provided in real time to staff.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**PROPOSAL FOR AWARENESS TRAINING TO THE BOARD OF DIRECTORS ON HUMAN FACTORS IN HEALTHCARE AND ON MEASUREMENT FOR IMPROVEMENT FACILITATED BY EKHUFT CORPORATE PATIENT SAFETY TEAM AND NHS ELECT**
BOARD SPONSOR:	**CHAIRMAN AND CHIEF EXECUTIVE OFFICER**
PAPER AUTHOR:	**ASSOCIATE MEDICAL DIRECTOR PATIENT SAFETY** **HEAD OF PATIENT SAFETY (EDUCATION)** **TEAMS IMPROVING PATIENT SAFETY (TIPS) PROGRAMME LEAD**
PURPOSE:	**DECISION**
APPENDICES	**APPENDIX 1: PROPOSAL PAPER INCLUDED**

BACKGROUND AND EXECUTIVE SUMMARY

The attached paper presents a proposal to the Trust Board of Directors (BoD) to discuss and agree a recommendation for the BoD to receive two half day training sessions, at the March 2017 and May 2017 Board meetings, regarding Human Factors ion Healthcare Awareness and Measurement for Improvement respectively.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Lack of Human Factors awareness and Measurement for Improvement knowledge within the organisation and previous training programmes. A need to identify, understand and manage the human factors involved in developing safer systems at EKHUFT. The reliability of the organisation's safety culture, systems and processes and actions to minimise the possibility for human error. Staff beliefs, behaviours and interaction with systems can have a negative effect on the safe culture and are non-supporting of a culture of safety improvement and learning. Errors and adverse harm events by inhibiting the development of a positive safety culture. Trust wide human factors awareness and reliability design for safety assurance and improvement.
LINKS TO STRATEGIC OBJECTIVES:	**People:** SO1. Identify, recruit, educate and develop talented staff. *To prevent error and avoidable harm and to deliver a safe service.* **Provision:** SO3. Provide the services people need and do it well. *Through reliable design and safer systems.* **Partnership**: SO4. Partnership: Work with other people and other organisations to give patients the best care. *Partners with EKHUFT Human Factors Project include sponsors from NHS Elect and Health Education England*
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	**Leadership training:** SRR 12 - Insufficient capacity and capability of the leadership team (Executive and Divisional Directors) to develop and deliver key strategies and recovery plans **Culture:** SRR 8 - Inability to attract, recruit and retain high calibre staff to

	the Trust Part of Strategic objectives SO1, SO3 and SO4 as above to contribute to place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects, and rapidly implementing best practice from across the world.
RESOURCE IMPLICATIONS:	There will be no additional costs to the organisation as Training is delivered by staff: from within the organisation, from HEE funded fixed term posts and from NHS Elect.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:
The Board is asked to discuss the attached paper; review and agree the recommendations made.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

Proposal to the Board of Directors to Undertake Awareness Training in Human Factors and in Measurement for Improvement

Dr Michelle Webb Associate Medical Director Patient Safety
Sarah Coulling Head of Patient Safety (Education)
Stefa Buras-Rees Teams Improving Patient Safety (TIPS) Programme Lead

NB. This paper is presented using an SBAR framework. The Situation, Background, Assessment and Recommendation (SBAR) technique has become best practice for standardised communication in healthcare after its success in the military. Regular use of SBAR is effective because it helps individuals communicate with each other with a shared set of expectations.

1. SITUATION:

1.1 Organisations may have many policies and procedures in place but they will only be as safe as the individuals in it want it to be. Working in (and with) inadequately designed systems can have a negative effect on both individuals and organisations. Individuals because they experience symptoms such as higher levels of stress and fatigue; organisations because of consequence of these effects such as an increase in staff sickness, increased likelihood of error and poorer quality of outcomes. Thus, telling staff to be more vigilant or try harder or to deliver more training will not prevent the same event occurring again. The only thing that will is to change the system. Like many other safety critical industries healthcare settings are seeking to adopt a human factors approach to the design of our work.

1.2 The discipline of Human Factors takes a design and systems approach that looks at how people actually think and act in order to generate the best way of minimising patient safety incidents. Human Factors are often misinterpreted as purely 'factors to do with humans,' when in fact errors can happen as a result of the interaction between flaws in the working environment (the system) and humans interacting within that system. The system includes everyday work tasks, processes and procedures, equipment and technologies, organisation of work and working environments etc. Changes to the design of physical things can make a big difference as to how well people work, but it is also about the way teams work together and the culture that influences how they act.

1.3 Addressing the safety culture in the NHS, by mitigating the impact of human error, has become essential business for NHS organisations following enquires and reports that have paraphrased each other in their conclusions where incidents and deaths could have been potentially avoided. For example, the case of Sam Morrish.

<table>
<tr>
<td>
Parliamentary and Health Service Ombudsman</td>
<td>2010 Sam Morrish age 3, from Devon. His death from sepsis was deemed avoidable following errors by GPs, hospital doctors and call handlers. The PHSO Report ‘Learning from Mistakes’ identifies Human Factors and is critical of the Trust’s investigation.</td>
</tr>
<tr>
<td colspan="2">“Everyone needs to feel safe recognising and admitting mistakes in order for learning to be possible, especially when the consequences are catastrophic as they were for Sam and us. That is where safety starts. If the focus was insight, learning and improvement, rather than judgement, blame and shame, the NHS would flourish for patients and staff.”
Scott Morrish, Sam’s father</td>
</tr>
</table>

1.4 NHS Trust Boards, as a signatory to the Human Factors in Healthcare Concordat (2013), recognise the importance of addressing the reliability of their complex organisational systems, processes, equipment and controls through their leadership and influence on norms and practices. They are charged with embedding a Human Factors approach, fostering the culture and commitment required to address system issues and provide processes and tools to facilitate behaviour change and high reliability. To this end it is a commitment of Health Education England (2016) and the Trust (EKHUFT Quality Strategy 2015-2018) that all staff should have an understanding of human factors so that they can understand influences both at work and in their personal lives, which can affect the way they behave in the workplace.

1.5 The BoD’s role and understanding to embed human factors in their strategic approach is pivotal in supporting and enabling front-line staff to consistently do the right thing. Training starts with the BoD to enable their vital contribution in modelling the organisation’s safety culture from its leadership position, for example the BoD should consider:

1.5.1 A strategy for embedding human factors;
1.5.2 How to shape the safety culture;
1.5.3 Ways to ensure a just culture;
1.5.4 Accountability for human factors;
1.5.5 Visible leadership;
1.5.6 Making resources available.

2. BACKGROUND:

2.1 We “do” human factors all the time, it is part of being human. Being human, by its very nature, makes us all fallible. The additional titles we bear – doctor, nurse, midwife, pharmacist, dentist, chief executive, non-executive director (the list is endless) as a result of our education, training and technical ability – will never change the fundamental imperfections found among humans.

2.2 For these reasons there needs to be an understanding of the human within us and amongst us and put failsafe processes in place to mitigate against the human element. Human factors training is widely used in safety-critical industries, such as oil and gas, aviation, transport and nuclear power but healthcare settings are a relative latecomer to the field.

2.3 Measurement for improvement recognises that we do not need to collect large swathes of data but instead “just enough”. It challenges us to ask questions such as:

2.3.1 What does "better" look like?
2.3.2 How will we recognise better when we see it?
2.3.3 How do we know if a change is an improvement?
2.3.4 How do we know we are changing and improving?

Data collection generally falls in to one of three categories; data for judgement, research or improvement. Most data collected in the public sector is used for judgement (often external agencies have decided the data set) which may be perceived as a punitive method aiming to drive up performance of organisations. Much of the data collected has limited use in terms of improving patient safety.

2.4 Recommendations from the Institute of Healthcare Improvement (IHI), Health Foundation, NHS Elect, plus many other leading organisations suggest the need to change ways of thinking about how healthcare leaders use safety performance data if they wish to influence behaviour positively and accelerate safety improvements.

“Just because things can be measured, does not mean that they should be “
(W. Edwards Deming).

3. ASSESSMENT:

3.1 The development of our staff knowledge and skills in Human Factors forms part of the Trust's Patient Safety Plan 2015-2018. This year within EKHUFT the Human Factors Project Group was formed with an ultimate aim "to ensure all clinical and non-clinical staff will contribute to the reduction in patient harm (as measured through the reduction in the severity of harms of incidents reported) through the use of Human Factors Trustwide". A key action required to achieve this is an organisation that understands human factors with easily identifiable measures to illustrate what makes a positive difference.

3.2 Currently in EKHUFT we have a handful of Human Factors trainers who have delivered Human Factors awareness training to a number of multidisciplinary groups via the Teams Improving Patient Safety (TIPS) Programme, the consultant development programme, the clinical leadership programme and a few bespoke departmental sessions. Whilst the numbers are relatively significant (approximately 200 in 18 months) it will be a bigger task and require more resources to reach the 8,000 workforce that need to understand how their human factors impact on safety. A critical mass with an aware leadership team needs to be built within the organisation to ensure a change. A recurrent cry from frontline staff is that their ability to translate the learning in to practice is hampered by a lack of understanding of the importance of human factors in the higher echelons of the organisation.

3.3 Although there have been real improvements the staff surveys show that some staff still feel there is a blame culture and, whilst as an organisation we do well in the quality of our investigations to determine causal factors, we could strengthen the impact of learning by focusing more on system changes rather that the behaviours of the individuals involved. This needs to change if we are to become truly transparent, safe and a great place to work.

3.4 If we are to improve safety then we need to identify true, realistic measurements for improvement. A recent, national audit demonstrated poor compliance with standards relating to observations on paediatric patients in emergency departments. The identified actions were to make a change then wait for the next years' audit to see if improvement had been made. Neither yearly nor monthly audits are sufficient methods of measurement to support a robust improvement culture. Quick, easy, relevant measurement for improvement is what is required with consideration of how

we can use a knowledge of Human Factors to improve our ways of working.

3.5 Whilst there is a groundswell of activity to raise awareness of human factors with frontline staff, this will not be enough without leadership buy in. Leaders such as the BoD and senior managers need to talk the same language and challenge with the right questions.

4. RECOMMENDATIONS:

4.1 The proposal is for the BoD to agree to receive two half days on Human Factors and Measurement for Improvement awareness training at their March 2017 and May 2017 meetings respectively.

4.2 At the March meeting the proposal is for a small EKHUFT team to deliver a session to:

4.2.1 Raise the awareness and stimulate discussion about human factors and reliable design;
4.2.2 Understand how human factors impacts on quality, safety and productivity;
4.2.3 'Encourage' the Board to support (time and resources) the embedding of human factors;
4.2.4 Identify the contributions of the Board and that which its individual members can make in this area.

At the May meeting Matt Tite, an expert analyst from NHS Elect, will deliver a session titled Measurement for Improvement and cover topics such as: standardisation, reliable design, capability analysis, variation, Plan – Do – Study – Act cycle (PDSA) linked to measurement, making measures meaningful, run and Statistical Process Control (SPC) charts.

RESOURCES AND USEFUL LINKS:

Clinical Human Factors Website http://chfg.org/ Last accessed 24/01/2017

Clinical Human Factors Group (2013) Getting to Grips With the Human Factor. Strategic Actions for Safer Care. A learning resource for Boards. http://chfg.org/wp-content/uploads/2013/10/Learning-resource-for-Boards-FINAL-for-web-2013_10_01-1.pdf

Kohn LT, Corrigan JM, Donaldson MS, (1999). To Err is Human – Building a Safer Healthcare System. Washington DC: Committee on Quality of Healthcare in America, Institute of Medicine, National Academy Press.

The Health Foundation, (2014). A framework for measuring and monitoring safety: a practical guide to using a new framework for measuring and monitoring safety in the NHS. London

Hospital Improvement Innovation Network (2015) IHI Whiteboard videos. https://www.youtube.com/playlist?list=PLwpWmQpRN38NDtFr0Hl22zqnteusAtZKC Last accessed 24/01/2017

NHS England. Health Education England (2015) Improving Safety Through Education and Training. Report by the Commission on Education and Training for Patient Safety.

NHS National Quality Board (2013) human Factors in Healthcare Concordat Available at: https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf Last accessed 24/01/2017

Patient Safety 2030 (2016). NIHR Patient Safety Translational Research Centre at Imperial College London and Imperial College Healthcare NHS Trust Forward by Ara Darzi, Professor, Lord Darzi of Denham http://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/centre-for-health-policy/Patient-Safety-2030-Report-VFinal.pdf Last accessed 24/01/2017

East Kent Hospitals University NHS
NHS Foundation Trust

DECEMBER 2016

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
NHS Foundation Trust

Chief Executive's Summary

As reported previously, the Trust was re-inspected by the CQC in September 2016 and reports were published in December 2016. The CQC held a Quality Summit on 12 January. This was attended by the Chair of Health Overview Scrutiny Committee, NHS Improvement (NHSI), NHS England, Healthwatch, Kent county Council, Kent Community Health Trust and East Kent Hospitals Trust. The CQC presented its findings, the Trust gave an update on further improvements it had made since the re inspection and NHSI led a discussion about the next steps, which focussed on partnership working.

The Trust now has no "red" inadequate scores and Sir Mike Richards, England's Chief Inspector of Hospitals, has recommended that the Trust be taken out of special measures as a result of "further significant improvements" for local patients.

NHS Improvement will make the final decision about whether the Trust will come out of special measures. The regulator's decision is expected at the end of February.

The Trust has seen continued improvement in the 62 day GP cancer referral target since August, although still under target. There has also been a marginal increase in Cancer 31 day (diagnosis to treatment) which is now reporting nearly at target.

The 4 hour target continues to be an area of significant challenge for the Trust, with performance reducing further in December to 74.23% compared to 75.76% in November 2016.

As reported previously, this performance has been driven by continued pressure on the whole system and reduced patient flow and increased attendances especially of elderly patients with complex needs. Internal and external focus continues to improve processes to ensure rapid support to patients and support to staff.

Referral to treatment (18 weeks) performance has reduced further to 83.83% in December from 85.79% in November 2016. This is due to reduced elective activity as a result of emergency pressures. Work is underway to address these issues.

The Trust continues to deliver well on the safety metrics: an increase in the compliments to complaints ratio compared to the previous month; further improvement in complaint response times; improved inpatient satisfaction across every metric; and a reported improvement in harm free care.

With regard to infection control, there was one (unassigned and not reported) case of MRSA bacteraemia reported in December and five (unrelated) cases of post 72 hours C.difficle. Although, the latter is at the top end of our trajectory and remains a cause for concern and therefore real focus.

The outbreak of carbepenmase-resistant Klebsiella pneumonia reported last month continues to be managed and all contacts who responded were found to be negative. Contract tracing also continues following the late diagnosis of pulmonary TB in a patient on ITU at William Harvey Hospital. Patient risk is considered to be minimal.

The Trust?'s monthly I&E deficit reported at £2.5m in December 2016 compared to £ 1.3m in November 2016. This is in line with forecast trajectory through to year end driven by income being £2.8m lower in month linked to the reduced working days in December.

The year to date I&E deficit stands at £16.5m with STF income of £4m relating to Q1 having been received. No further STF is expected.

Pay costs in the month of £28.2m included agency and locum costs of £2.2m which now stand at £20.4m for the year to date against the ceiling trajectory of £18.8m. Spend reduced by £0.4m in December through staff taking leave and fewer working days. Of the December agency spend, 70% related to medical staff. The agency spend is forecast to rise again in Q4.

Total income was £46.9m in month 9. Use of the independent sector increased for the fourth consecutive month to £1.2m driven by Ophthalmology, Endoscopy and Orthopaedics. Against the initial £20m CIPS target, including income, for the year to date £11.7m has been delivered against a target of £13.6m.

The Trust has put in place a set of measures following the board meeting designed to secure the year end forecast but has been experiencing, in common with the majority of acute trusts,

extreme operational demand-led pressures, with high levels of occupancy, poor flow and an increase in cancelled operations. A more likely year end position is a deficit of £23m rather than the stretch target of £19m although work will continue to ensure the best possible financial position is delivered.

The Q4 position must be a substantial improvement on the year to date performance if forecast position is to be achieved.

NHSI continues to provide intensive support and challenge to the Trust to deliver our 2016/17 financial plan and to develop and implement a financial plan which delivers the 2017/18 and 208/19 control totals and takes the trust to a sustainable financial operating model. This work will continue and remains a top priority for the organisation linked to our work on the improvement journey and special measures.

East Kent Hospitals University NHS
NHS Foundation Trust

Understanding the IPR

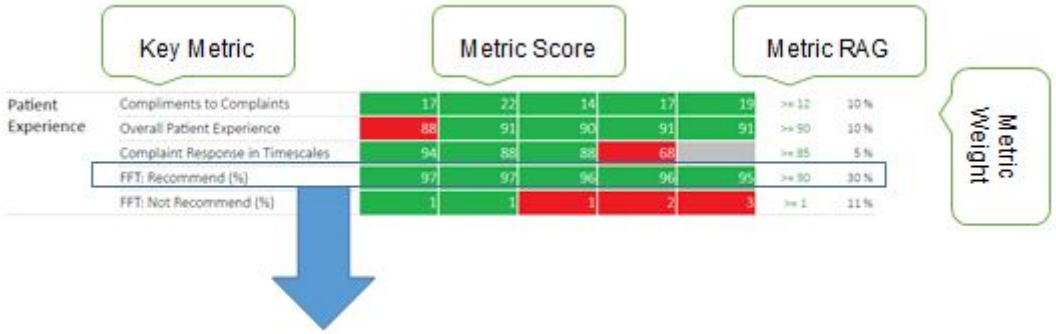
1 **Headlines**: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that the CQC organises its inspection into specific areas.

2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall domain score. The second page illustrates key (but not all) metrics measured within that sub-domain.
This is important as it explains why the sum of each metric doesn't total 100%. A list of all metrics used in the calculation is summarised in the Glossary pages.

East Kent Hospitals University NHS
NHS Foundation Trust

Understanding the IPR

3 **Key Metrics:** This section provides the actual data that builds up into the domain, the actual performance in percentage or volume terms for any given metric. These metrics are explored in more detail in the next section, Strategic Themes.



4 **Strategic Themes**: The Strategic Theme pages house key metrics with additional analysis, showing trend over the last 12 months. They show the latest month RAG together with the last 12 months position status (ie improved or worsened % from the previous 12 months plus average metric score). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.

All RAGs are banded as Green, Amber and Red. A grey cell indicates that data is not yet available. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Priorities

East Kent Hospitals University NHS
NHS Foundation Trust

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East Kent Hospitals University NHS
NHS Foundation Trust

Headlines

	Positives	Challenges	
Caring	• Increase in compliment to complaint ratio compared to last month • December has returned an improved overall inpatient satisfaction with care across every metric, in particular with respect and dignity • We are reporting this month a further improvement in complaint response times	• The number of mixed sex breaches has increased this month. This is a reflection of the operational winter pressures experienced in December • Although the percentage of patients who would not recommend the Trust remains better than this time last year, December did show an increase in this domain	A S O N Dec Sally Smith
Effective	• Elective and non-elective readmissions have not changed significantly which is encouraging when there is so much pressure on the whole system. • Did not attend rates over the Christmas period have increased slightly for first appointments and reduced slightly for follow up appointments. • On time starts in theatre have improved slightly.	• Bed occupancy remains well above 100% in December which shows the significant pressure our acute hospitals have been under. A great deal of hard work resulted in a fall in bed occupancy immediately prior to Christmas yet this was short lived. • Discharges before midday and delayed transfers of care have not improved again highlighting the pressure in the whole system and our patients staying longer than they should in an acute bed once they are ready for discharge.	A S O N Dec Jane Ely
Responsive	• There has been further improvement in performance of Cancer 62 day (GP Ref) since August at 76.15 % although still under target. there has been a marginal increase in performance for Cancer 31 day(diagnosis – treat) from 94.93 to 95.25%, nearly at target of >96 There has also been a marginal increase for Cancer 31 day (2nd treat – surgical) from 89.09 to 91.18% • Patients waiting more than 52 weeks on an elective pathway have reduced further to 12 in total. • We continue to meet the diagnostic standard with 99.72% of patients receiving their test within 6 weeks of referral.	• The emergency A&E 4 hour standard has deteriorated further to 74.23% and reflects the pressure on the department with increased attendances especially of elderly patients that have complex needs. Maintaining safety in the department and across the whole hospital sites is our main focus. Patients are delayed when we are unable to move them to a bed in the hospital. This requires on going commitment internally and externally to improve our processes so that there is rapid support for patients to return to their own home or to a safe bed in the community • Cancer 2ww (Breast) performance dropped by nearly 10% reflective of patients delaying their appointments over the festive period. • RTT - 18 weeks performance has reduced further to 83.83%, due to reduced elective activity as a result on emergency pressures.	A S O N Dec Jane Ely

Safe	• December has reported an improvement in harm free care • This month we have seen a reduction in the falls rate compared to this time last year, and although above target, our falls rate has improved across all three sites and is better than the national average	• December reported an increase in category 2 pressure ulcers and one category three ulcer • On the heatmap the medical wards at William Harvey Hospital are flagging with regard to harm free care	A S O N Dec	 Paul Stevens
Well Led	• Reduction in agency spend in month by £0.4m to £2.2m • Vacancy levels flat (10.1%) • Reducing sickness rates (3.5%)	• Increase in I&E position in month to £2.5m • Income lower by £2.8m (as forecast) • Cash balance at lowest level this year (£2.5m) • Financial position through to year end • Increase in RIDDOR reports (3) • Small reduction in nursing shifts filled (97% day, 106% night)	A S O N Dec	 Matthew Kershaw

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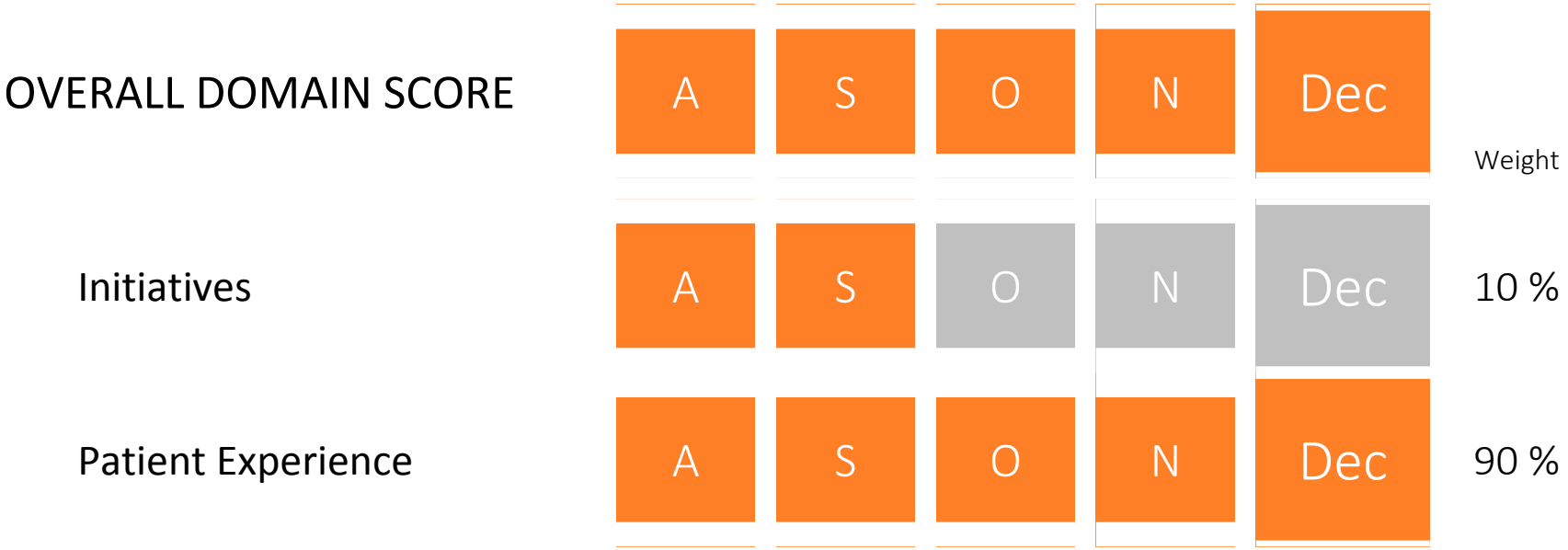
Caring



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Caring

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Initiatives	Staff Health & Wellbeing CQUIN	100	100				>= 100	20 %
	Sepsis CQUIN Delivered %	90	90				>= 100	20 %
	Antimicrobial Resistance &	100	100				>= 100	20 %
	End of Life Pathway CQUIN Delivered	90	90				>= 100	20 %
	Patient Flow CQUIN Delivered %	100	90				>= 100	20 %
Patient Experience	Compliments to Complaints (#/1)	15	20	21	16	46	>= 12	10 %
	Mixed Sex Breaches	45	70	51	10	87	1	10 %
	Overall Patient Experience %	92	91	90	92	94	>= 90	10 %
	Complaint Response in Timescales %	97	92	94	94	97	>= 85	5 %
	FFT: Recommend (%)	97	97	97	97	95	>= 90	30 %
	FFT: Not Recommend (%)	1.1	1.5	1.3	1.3	2.1	>= 1	10 %

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Effective

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Effective

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Beds	Bed Occupancy (%)	99	101	101	102	101	<= 90	60 %
	IP - Discharges Before Midday (%)	15	14	15	15	14	>= 35	10 %
	DToCs (Average per Day)	58	53	61	57	50	< 28	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3	3	3	3	3	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	16	17	17	16	16	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	97	97	95	94	93	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	8.0	7.6	7.4	7.1	7.8	< 7	
	DNA Rate: Fup %	7.1	6.9	6.6	6.3	7.5	< 7	
	New:FUp Ratio (1:#)	0.7	0.7	0.7	0.7	0.6		
Productivity	LoS: Elective (Days)	3.1	3.0	3.0	2.8	3.1		
	LoS: Non-Elective (Days)	6.0	6.1	6.1	6.5	6.2		
	Theatres: Session Utilisation (%)	83	80	82	81	80	>= 85	25 %
	Theatres: On Time Start (% 30min)	78	75	77	78	80	>= 90	10 %
	Non-Clinical Cancellations (%)	1.1	1.2	1.7	1.5	1.1	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	17	10	7	6	5	< 5	10 %
	EME PPE Compliance %	83	82	82	79	76	>= 90	20 %

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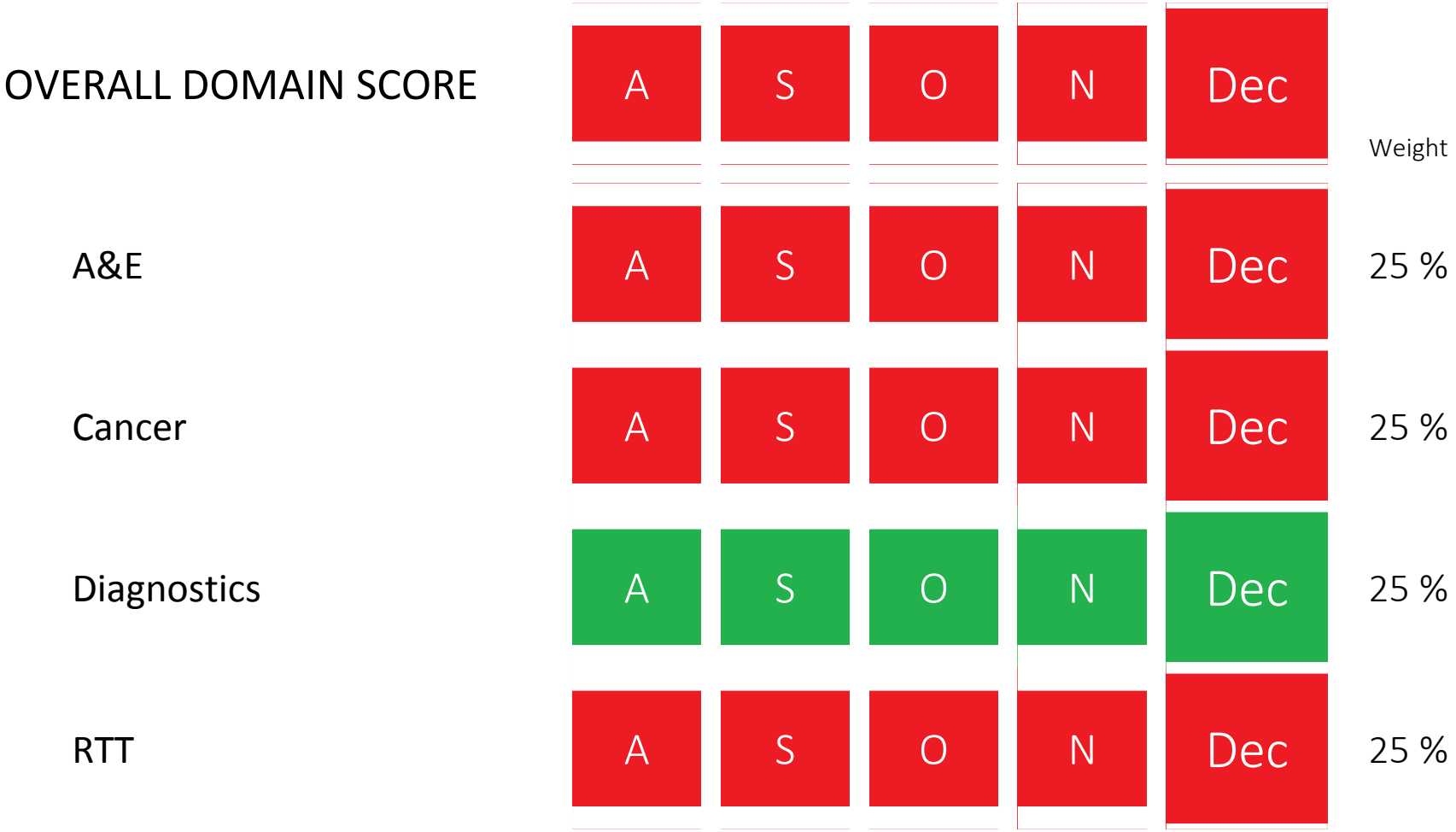
Responsive



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Responsive

		Aug	Sep	Oct	Nov	Dec	Green	Weight
A&E	ED - 4hr Compliance (%)	82.24	84.29	79.35	75.76	74.23	>= 95	100 %
Cancer	Cancer: 2ww (All) %	94.77	94.81	97.21	97.45	96.30	>= 93	10 %
	Cancer: 2ww (Breast) %	93.22	95.31	94.59	96.43	86.61	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	93.64	93.39	96.10	94.93	95.25	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	90.38	92.59	89.23	89.09	91.18	>= 94	5 %
	Cancer: 31d (Drug) %	98.88	100.00	100.00	99.12	100.00	>= 98	5 %
	Cancer: 62d (GP Ref) %	74.58	71.50	70.00	72.77	76.15	>= 85	50 %
	Cancer: 62d (Screening Ref) %	87.50	93.94	89.55	96.23	91.43	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	85.71	100.00	80.00	83.33	74.36	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.56	99.74	99.91	99.88	99.72	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	99.66	100.00	100.00	100.00	>= 99	
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	99.65	100.00	100.00	>= 99	
RTT	RTT: Incompletes (%)	85.52	85.11	86.03	85.79	83.83	>= 92	100 %
	RTT: 52 Week Waits (Number)	20	27	21	13	12	< 1	

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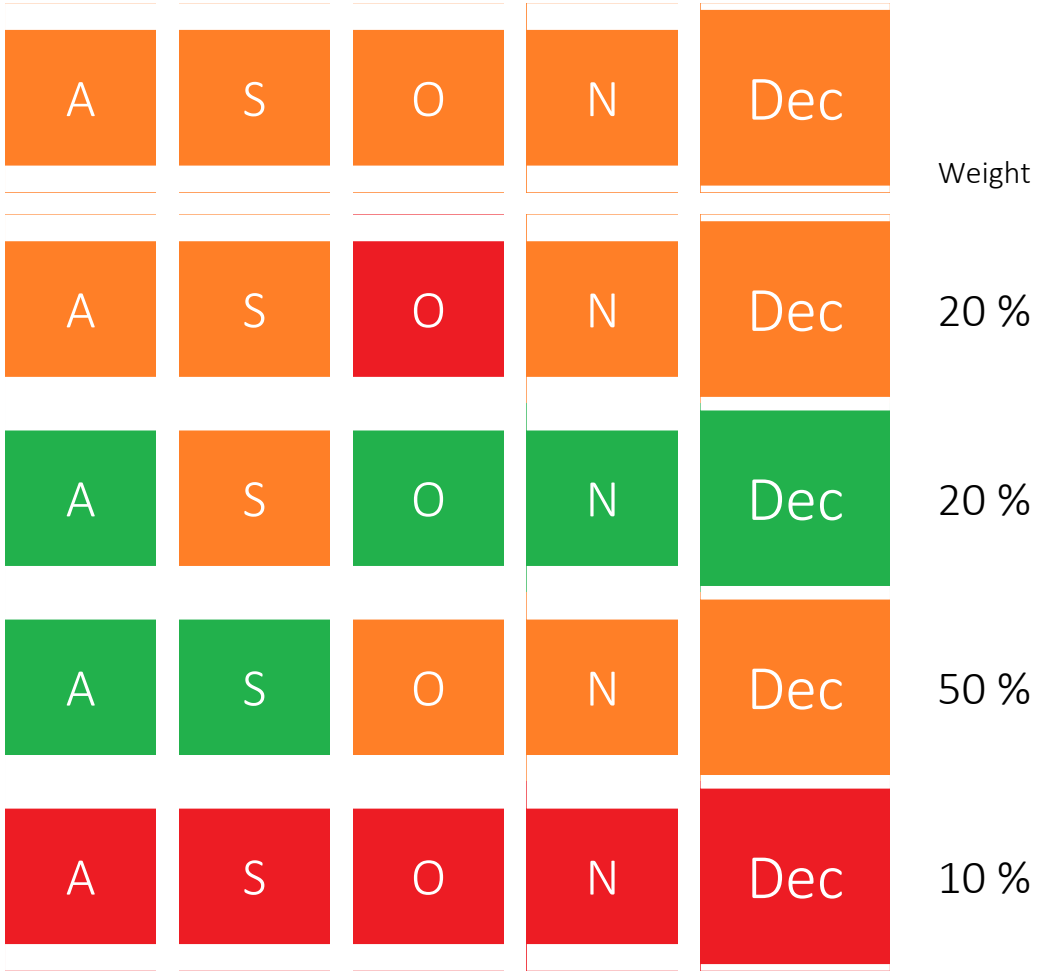
Safe



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Safe

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Incidents	Serious Incidents (STEIS)	5	8	6	4	6		
	Harm Free Care: New Harms (%)	98.0	97.7	97.9	98.1	98.4	>= 98	20 %
	Falls (per 1,000 bed days)	5.50	5.52	5.76	6.62	6.27	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.25	0.31	0.24	0.24	0.39	<= 0.15	10 %
	Clinical Incidents: Total (#)	1,307	1,392	1,375	1,391	1,237		
Infection	Cases of C.Diff (Cumulative)	19	21	27	30	35	<= Traj	40 %
	Cases of MRSA (per month)	0	1	0	0	0	< 1	40 %
Mortality	HSMR (Index)	82	82				< 90	35 %
	Crude Mortality EL (per 1,000)	0.4	0.3	0.3	0.0	0.4	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	30	27	32	31	37	< 27.1	10 %
	RAMI (Index)	82	83				< 87.45	30 %
Observations	VTE: Risk Assessment %	88	91	90	91	89	>= 95	20 %

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Well Led

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Well Led

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Culture	Staff FFT - Work (%)	58	58	58	58	58	>= 60	50 %
	Staff FFT - Treatment (%)	79	79	79	79	79	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	1	1	1	1	1	< 4	25 %
	Valid NHS Number %	99	99	99	100	100	>= 99.5	40 %
	Uncoded Spells %	0	0	0	0	0	< 0.25	25 %
Finance	I&E £m	-3.5	-1.6	-1.7	-1.2	-2.5	>= Plan	30 %
	Cash Balance £m	17.5	9.8	11.7	10.0	2.4	>= Plan	20 %
	Total Cost £m	-49.4	-50.1	-49.1	-51.0	-49.4	>= Plan	20 %
	Forecast I&E £m	-24.6	-19.6	-19.6	-19.6	-19.6	>= Plan	20 %
	Normalised Forecast £m	-27.6	-23.6	-23.6	-23.6	-23.6	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	1	1	3	0	3	<= 3	20 %
	Formal Notices	0	0	0	0	0	1	15 %
Staffing	Sickness (%)	3.8	3.8	3.9	3.9	3.5	< 3.6	10 %
	Staff Turnover (%)	12.0	12.6	12.7	12.6	12.7	<= 10	15 %
	Vacancy (%)	10.5	10.8	10.7	10.1	10.1	<= 7	15 %
	Shifts Filled - Day (%)	91	93	93	99	97	>= 80	15 %
	Shifts Filled - Night (%)	102	100	102	110	106	>= 80	15 %
	Agency %	21.7	21.1	22.0	21.3		<= 10	
	NHSP Use % of Agency	100.0	100.0	100.0	100.0	100.0	> 90	
Training	Appraisal Rate (%)	79.5	81.2	83.2	82.2	82.5	>= 90	50 %
	Mandatory Training (%)	88	89	88	88	87	>= 85	50 %

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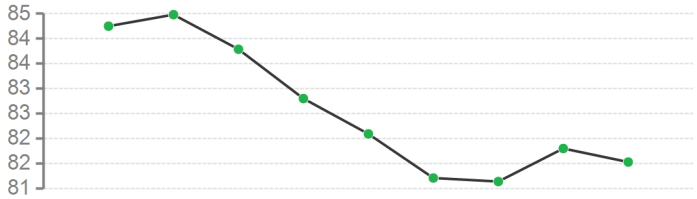
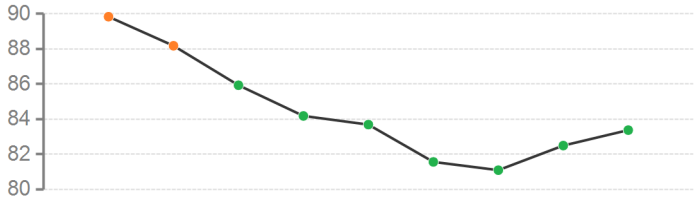
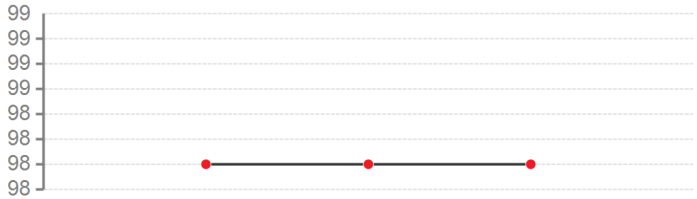
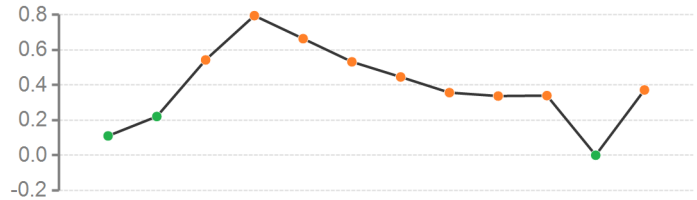
Strategic Theme: Patient Safety

Mortality

Dec	HSMR (Index)	83 (-9.0%)		Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.
Dec	RAMI (Index)	84 (-10.8%)		Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Dec	SHMI	98 (-4.6%)		Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data.
Dec	Crude Mortality EL (per 1,000)	0.4 (26.0%)		The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

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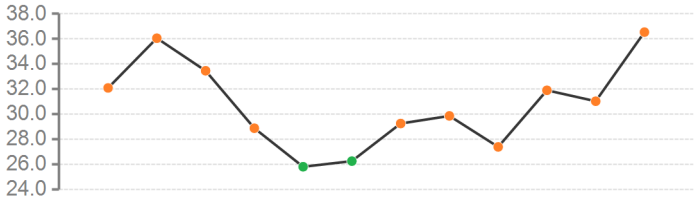
Strategic Theme: Patient Safety

Dec

Crude Mortality NEL (per 1,000)

31
(1.4%)



The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

Crude mortality for December has risen as expected at this time of year but adjusted mortality continues to be positive and our HSMR was again 83 demonstrating a favourable position in comparison to other Trusts. Our national SHMI is 0.97 for the period July 2015 - June 2016 and this
has shown a consistent fall from 1.03 in the period July 2014 - June 2015. There are some areas of concern lying below that overall indicator and these continue to include cardiac related
diagnostic groups (acute myocardial infarction, cardiac arrests/ventricular fibrillation, heart failure), carcinoma of the lung and colon, chronic obstructive pulmonary disease and septicaemia.
Although the above areas are the areas where observed mortality is higher than expected there are no worrying trends apart from septicaemia and we clearly have work to do here. During this past month we have received the national standardised mortality review tool and we will use this to critically examine a sample of 30 deaths due to septicaemia to extract the learning.

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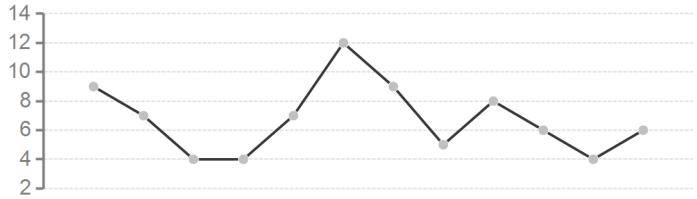
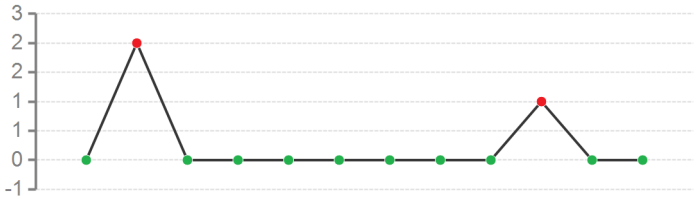
Strategic Theme: Patient Safety

Serious Incidents

Dec	Serious Incidents (STEIS)	81 (-9.0%)		Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Dec	Never Events (STEIS)	3 (-50.0%)		Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

Total open SIs on STEIS December 2016: 78 (including 6 new)
SIs under investigation: 32
Breaches: 15
Non-breaches: 17

SIs awaiting closure: 46
Waiting CCG response: 39
Waiting EKHUFT non-closure response: 7

Supporting Narrative:
The number of breached cases have fallen from 21 to 15. Breaches are mainly due to the quality of analysis. This is being managed by the Root Cause Analysis Group and at the Executive Performance Reviews each month.

Work continues on clearing the longest breached cases and there has been progress on this and further progress is predicted. There are no longer breaches over four months old (compared to eight months last month). The Clinical Incident Manager has been working with the division to progress these cases.

There were six new SIs relating to:
- one Never Event – wrong site surgery (wrong tooth removed)
- one infection control relating to CPO (Carbapenemase-Producing Organism);
- one fall following a delayed angiogram leading to the death of a patient;
- one treatment delay relating to a head and neck tumour
- one delayed treatment relating to Clexane
- one maternity incident (affecting baby only) – five pulls of ventouse leading to hypoxia

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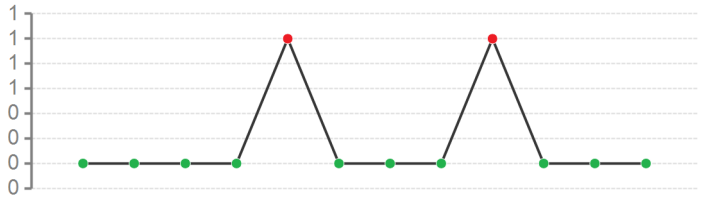
Strategic Theme: Patient Safety

Infection Control

Dec	Cases of MRSA (per month)	2 (0.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Dec	Cases of C.Diff (Cumulative)	35 (16.7%)		Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month.
Dec	E. Coli	87 (40.3%)		The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

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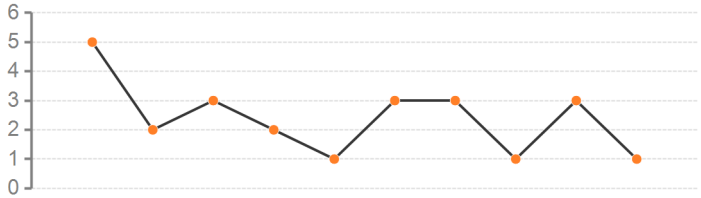
Strategic Theme: Patient Safety

Dec

MSSA

24
(14.3%)



The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

There was one (unassigned and not yet reported) case of MRSA bacteremia in December 2016. This case has been correctly assigned to the Trust due to the patient acquiring MRSA colonisation during a recent hospital stay.

There were 5 cases of post 72 Hours C.difficile and the total number of cases to-date is 35 which although in line with trajectory is at the top of our trajectory and remains a cause for concern. None of the cases in December are related (2 in K&CH, 2 in QEQMH and 1 in WHH, all different wards).

Investigation of possible contacts following the outbreak of Carbepenemase resistant Klebsiella infection has to date found all contacts who have responded (17/23) to be negative on stool testing. The remaining patients will be requested to send stool sample to rule out CPO acquisition.

TB exposure incident - 26 ITU staff contacts are being followed up with Tspot testing to assess if they have acquired TB infection. Risk to other patients was considered minimal due to the nature of clinical environment (WHH ITU). Staff who managed the source patient's airways were those at risk of exposure. Results are not yet available.

Parvovirus incident. A pregnant staff member (Midwife) developed a rash on the 15th January and subsequent serology testing of current and antenatal booking blood samples confirmed a Parvovirus infection. The serum sample has been sent to the Reference laboratory for confirmation. The relevance of this for most people is low, parvovirus infection is mild and treatment is not required. However, in pregnant women who are not immune, infection in the first 20 weeks of pregnancy can lead to serious adverse outcomes in the foetus: hydrops foetalis and intrauterine death. These consequences usually occur some 3 to 5 weeks after the onset of maternal infection, but can be later.
The period of infectivity is 5-10 days prior to onset of rash which means that the member of staff will have had contact with other pregnant women. We have identified 16 pregnant patients who may have been exposed to the infected staff member between 5-15th January. Two of these patients are known to be immune based on past antenatal serology results. We are currently testing antenatal serum samples for remaining 14 patients and results will shortly be available.
A incident meeting will be convened to agree actions and patients will be contacted for follow-up serology testing.

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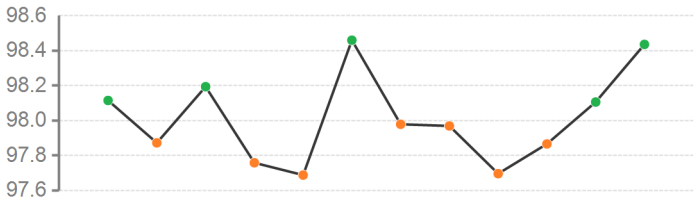
Strategic Theme: Patient Safety

Harm Free Care

Dec	Harm Free Care: New Harms (%)	98.0 (-0.2%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.

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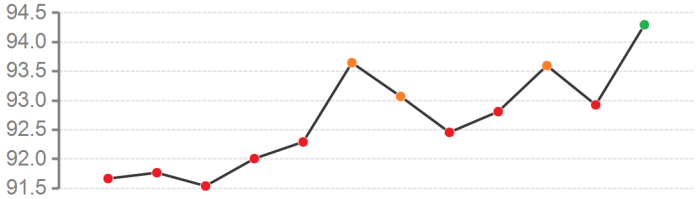
Strategic Theme: Patient Safety

Dec

Harm Free Care: All Harms (%)

92.7
(-0.3%)



Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.

Comments:

Overall Harm Free Care (HFC) relates to the Harms patients are admitted with as well as those they acquire in our care. HFC in December was 94.02% compared to 92.50% in November and is slightly below both the overall national average of 94.28% and the acute hospitals only national average of 94.06%. A wide variation, as expected, is seen across the divisions with specialist achieving 96.97%, surgical 93.97% and UCLTC 93.18%. All harms were 5.70% compared to national average of 5.72% which indicates that our patients are admitted with a slightly lower level of harm than the national average.

However, Harm Free Care experienced in our care (New Harms only) at 98.44% in December is higher than national average which means that our patients are receiving care that causes less harm than is reported nationally. New Harms only were 1.56% compared to 2.19% national average for acute hospitals; this means that our patients acquire reduced levels of new harms than the national average for acute hospitals. This is particularly relevant when looked at in the context of our bed occupancy (which is unsustainably high).

WHH New Harms Only HFC improved to 98.05% in December compared to 96.70% in November.
QEQM New Harms Only HFC improved to 99.22% in December compared to 99.13% in November.
K&C New Harms Only HFC fell slightly to 97.94% in December from 98.62% in November.

HFC (new harms only) for individual harms are lower than or close to the national average for acute hospitals for 3 out of the 4 harms measured. The Safety Thermometer for December demonstrates:

- Lower levels of New Pressure Ulcers (0.46%) compared to the acute hospitals average (0.86%)
- Lower levels of catheters & New UTI's (0.09%) compared to the acute hospital average (0.35%)
- Higher prevalence of falls with harm (0.64%) than the acute hospital average (0.45%)
- Lower prevalence of new VTEs (0.37%) compared to the acute hospital national average (0.58%)

Rigorous work will continue to ensure validation is carried out correctly and focus work continues to be carried out to reduce the number of falls to ensure patient safety.

Notably, HFC (all harms) shows a lower than national level of patients being admitted who have already started treatment for UTI or a UTI was already present on admission – 0.92% compared to the national average of 0.95% for acute hospitals. This has improved as a result of the collaborative work undertaken with community partners.

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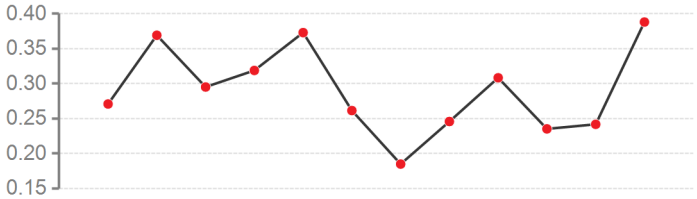
Strategic Theme: Patient Safety

Pressure Damage

Dec	Pressure Ulcers Cat 2 (per 1,000)	0.29 (14.3%)		Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Pressure Ulcers Cat 3/4 (per 1,000)	0.01 (-76.6%)		Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

In December 2016 a total of 40 category two pressure ulcers were reported and 13 were confirmed as avoidable. This has increased by five avoidable ulcers from last month. Five of these affected the sacrum/buttocks occurring on RSW x 2 (both related to equipment, one malfunction and one delay); CSF due to lack of repositioning and KC1 x 2 (both relating to length of time sitting in the chair and one also delayed equipment). Three avoidable ulcers affected the heels, on CDU/WHH, CM2 and Seabathing, all due to lack of heel offloading. All the others related to medical devices i.e. AES stockings, NG tubes and catheter tubing, where lack of evidence of regular skin care was identified as learning.

There were two confirmed category three pressure ulcers acquired in December 2016 of which one was avoidable. This occurred on Deal Ward and affected the sacrum with long periods laying supine and inappropriate moving and handling techniques using the bed sheet were identified. There were 12 potential deep tissue ulcers/unstageable of which three were avoidable. One affecting the sacrum on Kings B with delay in active mattress and repositioning issues identified; two affected the heel (Kingston/Cambridge L), both due to heel offloading insufficiencies and one also had a malfunctioning active mattress.

During December 2016, there was a learning event for Tissue Viability link nurses which consisted of workshops including moving and handling demonstrations. Each ward was visited and presented with an award for the highest number of avoidable pressure ulcer free days they had achieved since April 2015. The Tissue Viability team have been highly visible in the clinical areas supporting with patient care and raising awareness of pressure ulcer prevention strategies.

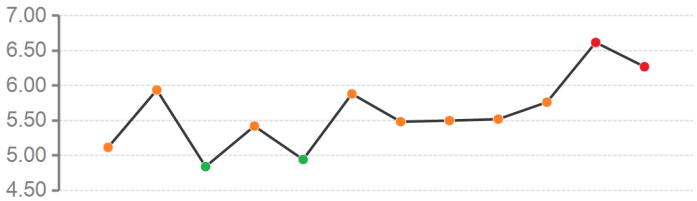
Strategic Theme: Patient Safety

Falls

Dec

Falls (per 1,000 bed days)

5.61
(-24.0%)



Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded.
Data source - Datix.
Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

The number of falls decreased slightly in December (210) compared to November (219). 97 were at WHH (increase) with a rate of 6.98 (6.25 in Nov), 64 at QEQMH (decrease)with a rate of 5.63 (8.73 in Nov) and 48 at K&CH (same) with a rate of 6.61 (6.44 in Nov). Wards with the most reported falls were Cambridge L (17), CDU WHH (13), Kings D male (12), Treble (11), Minster (10) and Kings B, Richard Stevens and Cambridge M1 (8). 1 fall at QEQMH resulted in an avoidable hip fracture and is being investigated. 1 fall at QEQMH resulted in a head injury where the patient subsequently died. This is being investigated with a RCA. 1 fall at K&CH resulted in a fractured hip but was unavoidable. 1 fall at K&CH resulted in a head injury but was unavoidable and a further head injury at K&CH following a fall was potentially avoidable. Falls at WHH resulted in a nasal fracture and humeral fracture but were both unavoidable. Further falls resulted in 1 avoidable and 1 unavoidable head injury.

Very high bed occupancy and increasing frailty have been significant contributory factors. Overall the Trust still has a lower than the national average falls rate for the year to date and a lower rate than was seen in the previous year. Open training dates have been planned to enable wards to participate in a self directed way in the Fallstop programme.

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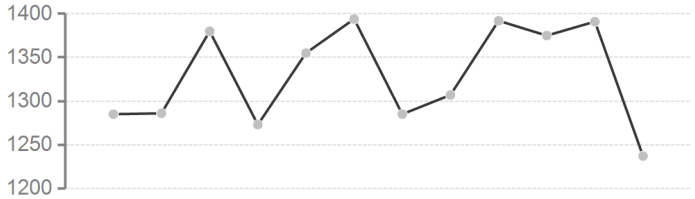
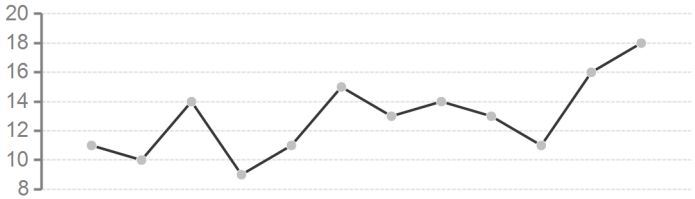
Strategic Theme: Patient Safety

Incidents

Dec	Clinical Incidents: Total (#)	15,960 (11.4%)		Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.
Dec	Blood Transfusion Errors	155 (-5.5%)		The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

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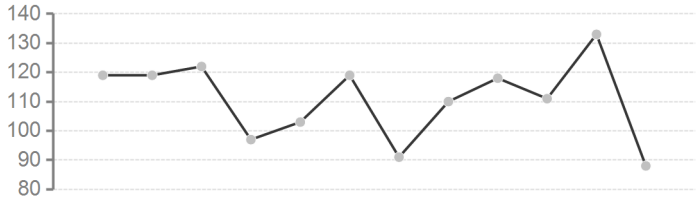
Strategic Theme: Patient Safety

Dec

Medicines Mgmt. Incidents

1,330
(11.0%)



The number of medicine management issues sourced from Datix.
Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Comments:

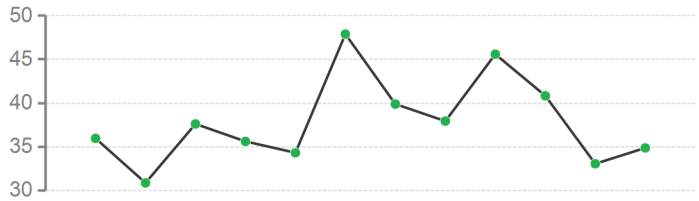
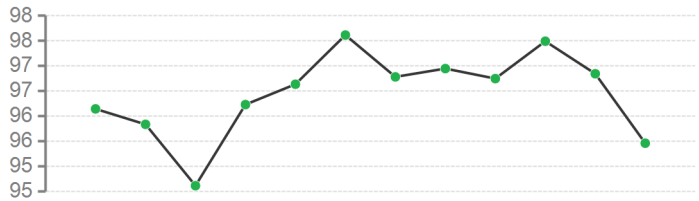
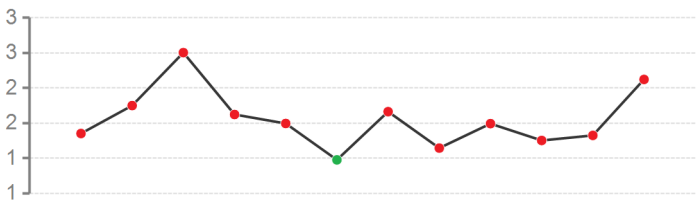
A total of 1214 clinical incidents have been logged as occurring in Dec-16 compared with 1388 recorded for Nov-16 and 1215 in Dec-15. In Dec-16, four incidents have been graded as death and one as severe harm. In addition, 20 incidents have been escalated as a serious near miss, of which 18 are still under investigation. The number of moderate harm incidents reported during Dec-16 is on a par with previous months [Dec-16: 40 compared with Nov-16: 58 and Dec-15: 32].
Six serious incidents were required to be reported on STEIS in December. Three cases have been closed and one case downgraded; there remains 78 serious incidents open at the end of December.
Over the last 12 months incident reporting has increased at WHH, remained level at QEQMH, and has decreased at K&CH.
Blood transfusion
In December, there were 18 blood transfusion errors reported (16 in Nov-16 and 14 in Dec-15). There was one theme in December: there were five incidents of allergic reaction to transfusion, 2 delays in provision of component/product and 2 incidents of wastage. Thirteen incidents were graded no harm and five low harm. Reporting by site: four at K&CH, ten at QEH and four at WHH.
Medicines management
There were 87 medication incidents reported as occurring in December (133 in Nov-16 and 109 in Dec-15). On average, over the last 12 months, the numbers of medication incidents reported at K&CH and QEQMH have risen, but have declined at WHH.
Of the 87 reported, 53 were graded as no harm (including two serious near misses) and 34 as low harm. No incidents resulted in moderate harm, severe harm or death. Top reporting areas were: Cheerful Sparrows male ward (QEQMH) with six incidents; A&E (QEQMH), CDU (QEQMH) and ITU (K&CH) with four incidents each; ECC / Pharmacy (K&CH), Minster ward / Rainbow ward / Seabathing unit / Viking Day unit (QEQMH), Cambridge L / Folkestone ward (WHH) with three incidents each; other areas reported 2 incidents or fewer. Twenty-six incidents occurred at K&CH, 40 at QEQMH and 21 at WHH.
*Missing Drugs are broken down as follows: four incidents relating to stock control/documentation errors, one incident of medication being delivered to the wrong department and one where medication was omitted as was unlicensed (prescribed in the community).

Total
Drug error - prescribing 13
Drug error - dispensing 18
Drug error - administering 44
Drug shortage (not available or in stock) 1
Drug missing* (stock discrepancy or lost between wards/pharmacy) 6
Adverse drug reaction 2
Infusion injury - extravasation 1
Infusion problems - medication related 2
Totals: 87

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Patient Safety

Friends & Family Test

Dec	FFT: Response Rate (%)	38 (10.5%)		The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	FFT: Recommend (%)	96 (1.0%)		Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	FFT: Not Recommend (%)	1.6 (-22.9%)		Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During December we received 7513 responses in total. Overall 32% eligible patients responded and 90% would recommend us to their friends and family and 7% would not. The total number of inpatients, including pediatrics who would recommend our services was 95% (97% November-16). For A&E it was 76% (76% November-16), maternity 99% (99% November-16), outpatients 92% (91% November-16) and day cases 96% (94% November-16). The Trust star rating in December is 4.52 (4.50 November-16).

Response rates for December have reduced in some departments and work will continue to make improvements. The response rate for inpatients was 35% (33% in November-16), A&E 15% (17% November-16), maternity 30% (21% November-16). (Please note as per DH guidelines only the Birth experience is given a response rate, FFT questions at other stages in the patient's pathway are not calculated or required nationally). The response rate for day cases was 19% (23% November-16) but for outpatients was not available due to a national reporting error.

All areas receive their individual reports to display each month, containing the feedback left by our patients which will assist staff in identifying areas for further improvement. This is monitored and actioned by the Divisional Governance teams.

FFT - Top 5 Positive & Negative Themes

ED
Positive Themes – Care, Staff attitude, Implementation of care, Competence, Communication
Negative Themes – Care, Waiting times, Staff attitude, Environment, Communication

Inpatients

Strategic Theme: Patient Safety

Positive Themes – Staff attitude, Care, Competence, Compassion, Communication
Negative Themes – Care, Staff attitude, Competence, Environment, Implementation of care

Out patients
Positives Themes – Staff attitude, Care, Competence, Compassion, Implementation of care
Negative Themes – Care, Waiting time, Communication, Staff attitude, Environment

Maternity
Antenatal
Positive Themes – Staff attitude, Care, Communication, Patient mood/feeling, Competence
Negative Themes – None

Birth
Positive Themes – Staff attitude, Care, Competence, Compassion, Implementation of care
Negative Themes – None

Postnatal ward
Positive Themes – Staff attitude, Care, Competence, Compassion, Commitment
Negative Themes – None

Postnatal community
Positive Themes – Staff attitude, Care, Compassion, Implementation of care, Commitment
Negative Themes - None

Day Case
Positive Themes – Staff attitude, Care, Competence, Implementation of care, Compassion
Negative Themes – Care, Staff attitude, Waiting time, Communication, Clinical treatment

The trust needs to improve on staff attitude, Care, the environment and waiting times for patients within the ED, Outpatients, Inpatients and Day Case care. Maternity received no negative themes for December, which is a outstanding achievement. It should be highlighted that there are considerably more positive themes/comments regarding Staff attitude, care and competence, which staff must be congratulated on.

East Kent Hospitals University NHS
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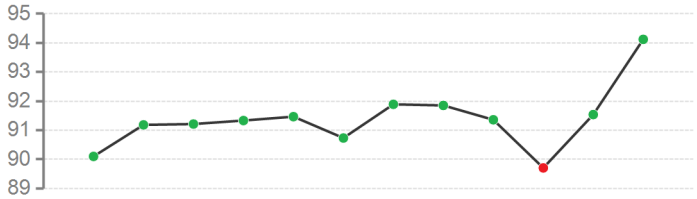
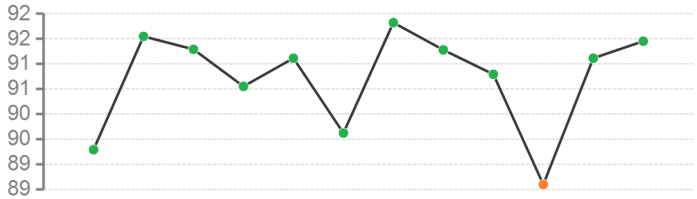
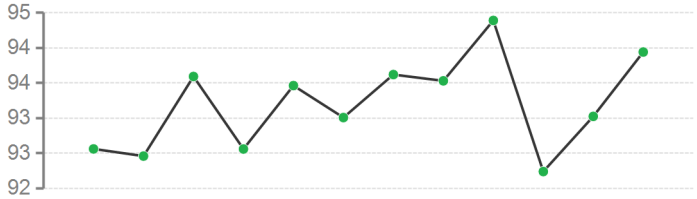
Strategic Theme: Patient Safety

Patient Experience 1

Dec	Overall Patient Experience %	91 (2.3%)		Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Dec	Care Explained? %	91 (15.7%)		Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Dec	Care that matters to you? %	93 (0.9%)		Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).

Comments:

This month patient experience as recorded in real-time by the patients has remained the same as last month with 3 out of the 6 criteria being rated as green.

There has been an improvement in the reporting for the experience of patients in relation to both overall patient experience and overall performance has improved over the last 12 months. Feedback on whether patients received the care that matters to them, the explanation of care or treatment in an understandable way and whether they were treated with respect and dignity has remained the same for this month.

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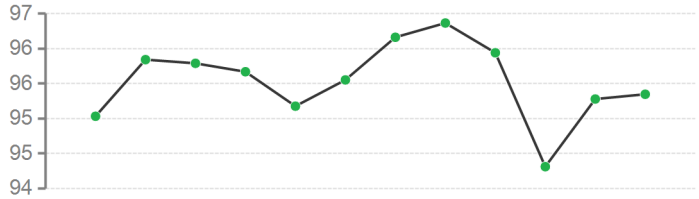
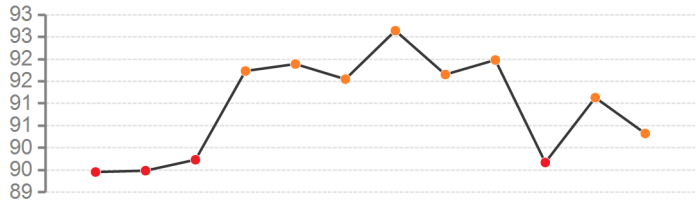
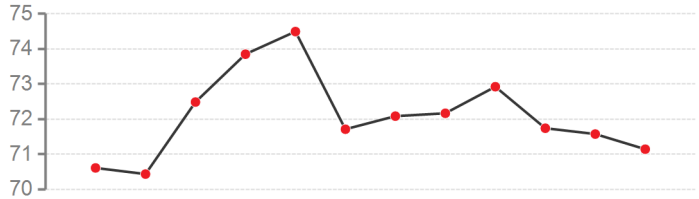
Strategic Theme: Patient Safety

Patient Experience 2

Dec	Respect & Dignity? %	96 (-0.2%)		Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Dec	Cleanliness? %	91 (-1.5%)		Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Hospital Food? %	72 (1.6%)		Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

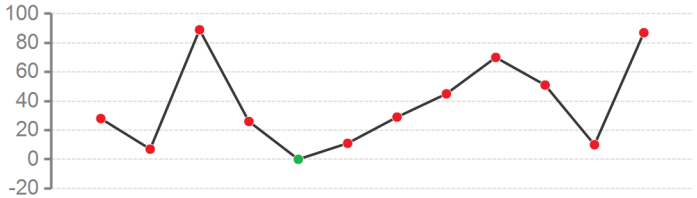
Comments:

December 16 - Evaluation of the Patient Safety Heatmap demonstrates that the majority of wards are now compliant with capturing patient experience in December. Escalation to Divisional heads of nursing and matrons has taken place to enable focused local improvements.

Cleaning and food remain relative to normal ranges with both showing slight positive movements. Cleaning audits are recording cleaning this month at 98.3%. Discussions have been had with SERCO to ensure consistent standards are maintained during this busy period.

Strategic Theme: Patient Safety

Mixed Sex

Dec	Mixed Sex Breaches	453 (52.5%)		Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

During December, 11 non-justifiable incidents of a mixed sex accommodation breach occurred at WHH CDU due to capacity issues. This information has been reported to NHS England via the Unify2 system.

There were 20 mixed sex accommodation occurrences in total, affecting 119 patients. This number has increased since last month when there were a total of 4 occurrences affecting 22 patients. The remaining incidents occurred at QEQM on the QEQM CCU (1), Fordwich (4), WHH Richard Stevens Unit (1), K&C Kingston stroke unit (2), Ambulatory care (1), which are justifiable mixes based on clinical need.

During December, daily reporting of mixed sex occurrences has improved at the three acute sites. WHH CDU had a significant increased number of mixed sex breaches during December due to a more robust recording of mixed sex occurrences and to minimise the risk of mix sex occurrences the nursing team are:

- Each side of CDU is separated one side for males and the other for females
- Nursing staff move patients continuously to stop mixed sex breaches
- Transfer patients to the ward quickly and efficiently
- Discharge patients home as soon as possible
- Use the discharge lounge, whilst patients await transport etc.
- Observation bay is used for patients when possible to stop any mixed sex breaches
- Side rooms are used (if mixing has to occur on the male/female side)

East Kent Hospitals University NHS
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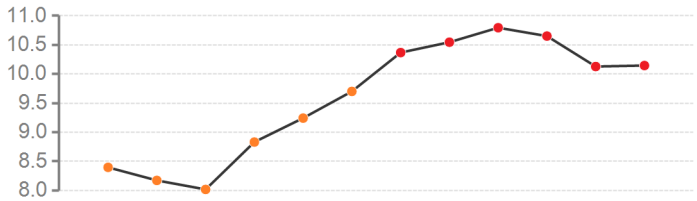
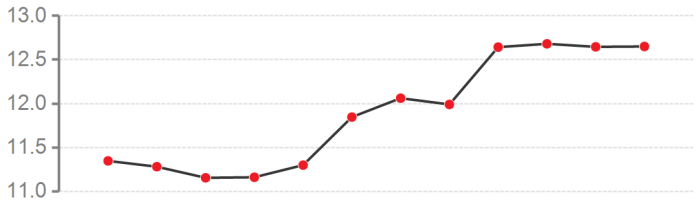
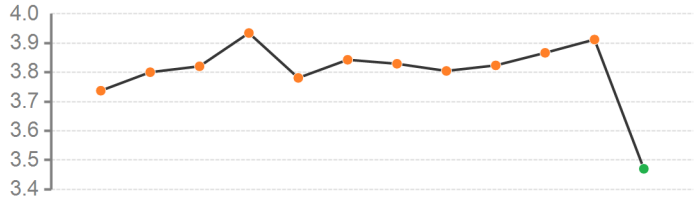
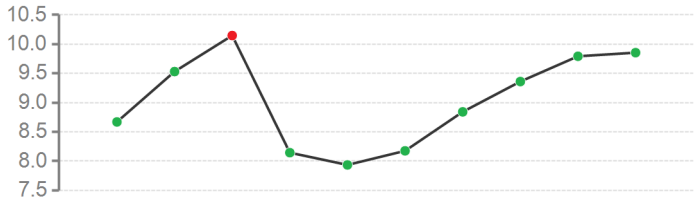
Strategic Theme: Human Resources

Gaps & Overtime

Dec	Vacancy (%)	9.6 (8.3%)		% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Staff Turnover (%)	11.9 (-2.6%)		% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Sickness (%)	3.8 (1.5%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the
Dec	Overtime %	9.0 (20.0%)		% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).

Comments:

Gaps and Overtime

The Turnover rate remained above 12.5%, and the vacancy rate remained at 10.2%. The average Turnover rate for the past 12 months remains marginally lower than the previous 12 months. The vacancy and turnover rates by Division are examined in detail at Executive Performance Reviews (EPR), and Divisions have actions in place to address their recruitment hotspots and retention challenges. Vacancy Rates within Specialist and Surgical Divisions continue to remain lower than the Trust average as vacancies held by the Vacancy Control Panel are removed.

Sickness absence predicted rate for December is 4.25%, which would be an increase from November. The 12 month average sickness rate is 3.8%, which is much higher than the previous 12 months. Divisions have submitted a monthly trajectory for sickness absence, which are examined at EPRs and monthly Agency Pay Control meetings. Divisions are running behind their trajectories, and a deep dive of sickness absence by Division has been requested for thee EPRs in January.

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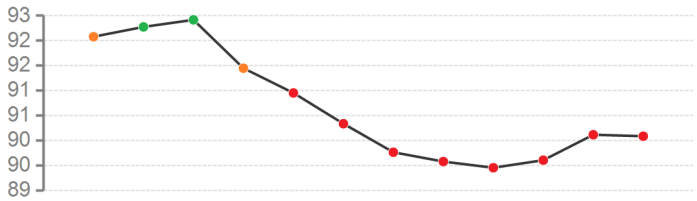
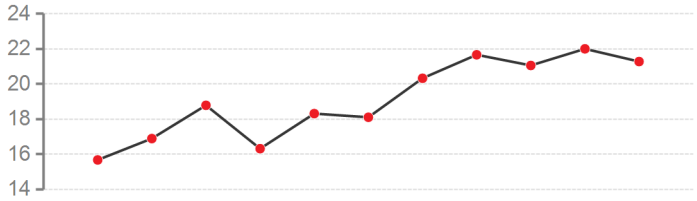
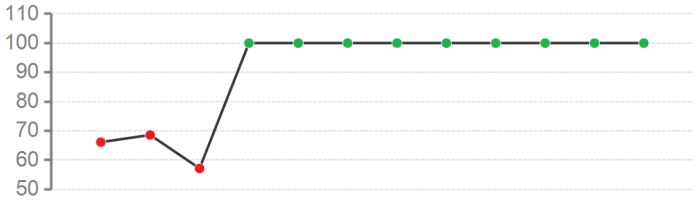
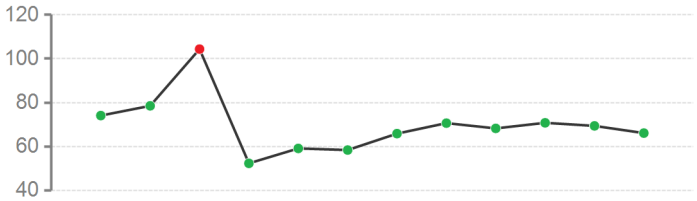
Strategic Theme: Human Resources

Temporary Staff

Dec	Employed vs Temporary Staff (%)	90.7 (-1.2%)		Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Agency %	19.1 (42.3%)		% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).
Dec	NHSP Use % of Agency	88.6 (29.8%)		% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).
Dec	Agency Orders Placed	70 (0.9%)		Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).

Comments:

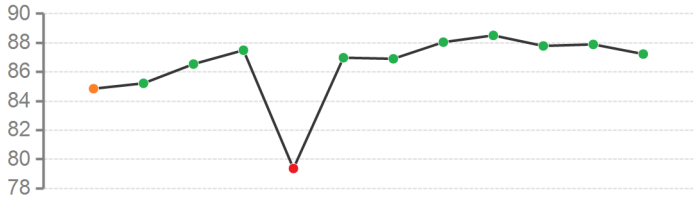
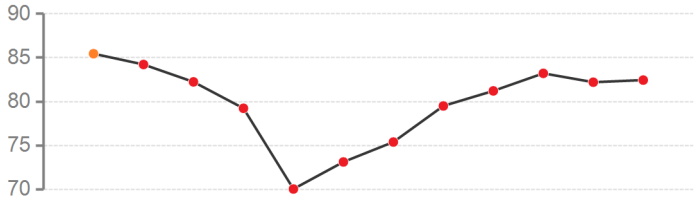
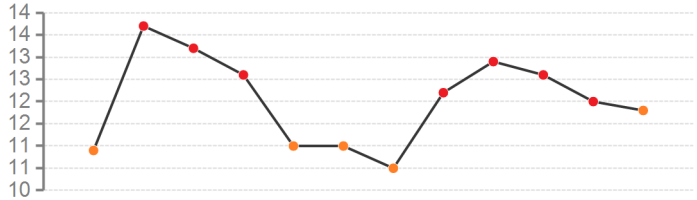
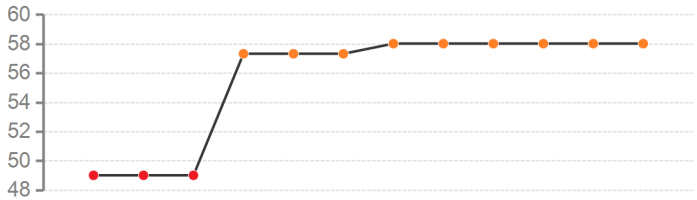
Reduction in agency spend is a key component of our cost improvement programme and continues to be an area of focus. There is an Agency Pay Control programme, led by the Head of Human Resources and supported by the Improvement Delivery Team and Programme Management Office. The Trust monitors and reports on a weekly basis, all agency shifts that breach the agency framework and NHSI pay caps by occupational group and division. Additionally, any shifts that breach the agency framework and pay caps now require approval at an executive level. The percentage of employees deployed through an agency that are NHSP remains at 100%. The percentage of staffing which is agency is at 21.3% (predicted) in December, with the 12 month average increasing to 19.1%.

Divisions are held to account for their Agency CIPs at EPR meetings, and against Divisional Agency Spend Trajectories, that are updated monthly by Divisional Finance Leads and HR Business Partners. Action Plans to remove the use of the Pulse agency are being presented by Divisions to the Agency Pay Control Group during January.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Dec	Mandatory Training (%)	86 (4.6%)		The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Appraisal Rate (%)	79.9 (1.7%)		Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Time to Recruit	12 (11.6%)		Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Staff FFT - Work (%)	56 (9.0%)		Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

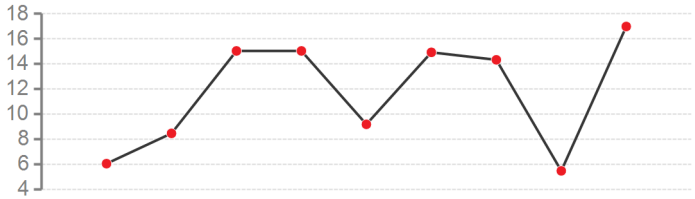
East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Dec

Local Induction Compliance %

11.7



Local Induction Compliance rates (%) for temporary employee's to the Trust.
Number indicates average of last 12 months data (as shown in graph).

Comments:

Statutory training was at 86% for December. This remains above the target of 85%, with the Clinical Support Services Division at 91% compliance. Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements. There remains an on-going with the recording of Information Governance, so this is being sent manually in some cases.

The Trust staff appraisal rate in December was 82%, and remains below the 90% target. The Surgical Division remains above the target at 91%. Divisions have been focussed on improving appraisal compliance whilst also ensuring appraisal quality using the new 'We Care' Behaviours appraisal paperwork. Work continues to implement less manual ways of reporting the information.

The 12 month average for both Mandatory Training and Appraisal Compliance remains higher than the previous 12 month average.

Weekly Recruitment Updates are sent out by the Resourcing Team to Divisions to provide information on workload within the team, and plans to reduce time the time taken to recruit. Two days of process mapping took place during November/December to review current systems and develop new streamlined ways of working.

Local Induction Compliance increased to 16.99%, which is the highest it has been to date. However, the Divisions are working with their teams to improve this level significantly over the next couple of months.

Activity vs. Internal Business Plan

Key Performance Indicators

Dec

	Dec-16				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	12,469	12,145	324	3%	129,582	124,728	4,854	4%	129,582	128,570	1,012	1%	<=0%
Referral Non-Primary Care	12,333	13,179	(-846)	-6%	125,670	128,621	(-2,951)	-2%	125,670	130,966	(-5,296)	-4%	<=0%
OP New	17,571	18,747	(-1,176)	-6%	183,341	182,317	1,024	1%	183,341	183,542	(-201)	0%	>=0%
OP Follow Up	35,006	38,956	(-3,950)	-10%	368,965	375,041	(-6,076)	-2%	368,965	377,751	(-8,786)	-2%	>=0%
Elective Daycase	6,014	7,079	(-1,065)	-15%	59,571	66,733	(-7,162)	-11%	59,571	61,408	(-1,837)	-3%	>=0%
Elective Inpatient	1,230	1,199	31	3%	11,984	12,060	(-76)	-1%	11,984	11,793	191	2%	>=0%
A&E	17,513	16,322	1,191	7%	160,090	151,013	9,077	6%	160,090	152,230	7,860	5%	>=0 & <5%
Urgent Care Assessment	1,026	1,272	(-246)	-19%	9,649	10,544	(-895)	-8%	9,649	10,777	(-1,128)	-10%	>=0 & <5%
Non-Elective Inpatient	6,091	6,062	29	0%	52,925	52,745	180	0%	52,925	52,777	148	0%	>=0 & <5%
Chemotherapy	1,160	1,130	30	3%	11,669	9,666	2,003	21%	11,669	10,227	1,442	14%	>=0%
Critical Care	1,983	1,753	230	13%	16,269	15,539	730	5%	16,269	15,493	776	5%	>=0%
Dialysis	7,250	7,426	(-176)	-2%	62,261	64,878	(-2,617)	-4%	62,261	64,704	(-2,443)	-4%	>=0%
Maternity Pathway	1,044	1,175	(-131)	-11%	10,453	10,756	(-303)	-3%	10,453	10,613	(-160)	-2%	>=0%
Pre-Op Assessments	2,457	2,868	(-411)	-14%	25,426	25,824	(-398)	-2%	25,426	25,648	(-222)	-1%	>=0%
Diagnostic	358,061	367,066	(-9,005)	-2%	3,875,185	4,053,610	(-178,425)	-4%	3,875,185	3,877,187	(-2,002)	0%	<=0%
Other	4,474	4,079	395	10%	42,476	35,778	6,698	19%	42,476	36,424	6,052	17%	>=0%

The 2016/17 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2015/16 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals, activity required to achieve sustainable elective services is included and further adjustments for patient safety/best practice issues such as reductions or increases in new to follow up rates have been applied. Finally EKHUFT have taken a view on the viability of CCG QIPP schemes achieving a reduction in demand in 2016/17. It should be noted that this does not reflect demand levels agreed within the 2016/17 contract. All trajectories to support attainment of the Sustainability and Transformation Funding have been based on this activity plan.

The capacity levels within the plans should be considered achievable although in many instances will stretch our services beyond their internal substantive capacity, efficiency programmes, workforce recruitments plans and it is anticipated therefore that substantial elements of the plan will continue to be delivered though additional waiting list payments. Within Orthopaedics and Dermatology projected demand exceeded our ability to deliver the operative demand and as such agreements have been made with our local CCGs for services to be directly commissioned with alternative providers.

December 2016

Elective Care

Elective care is pre-arranged, non-emergency care, including scheduled operations. It is provided by medical specialists in a hospital or another care setting; Patents will usually be referred by their GP, and covers the period from referral through to discharge.

The Primary Care demand received by the Trust was 3% above planned levels in December and the Trust level over performance remains +4% above contract, this equates to over 4,854 additional referrals. Encouragingly the Trust has not observed the historic exponential growth that has occurred in both Gastroenterology and Breast Referrals, although referrals into key specialties Orthopaedics, Dermatology Maxillo Facial, Gynaecology, and Paediatrics have significantly exceeded planned levels. The Trusts Internal Business Plan stretches most services to maximum capacity and as such we have not been able to flex our capacity further to deal with this unplanned demand. The Trust does not have the operative capacity to deal with the current demand, a key element of our business plan requires Orthopaedic referrals to be directed to the independent sector at point of referral.

The Trust failed to deliver the new outpatient Plan in December 2016. The observed variance of -6% (-1,176) reduced the year to date position to just 1% of planned performance. New Outpatient activity was at its lowest level since 2011. The biggest under performances were observed in the following specialties, Orthopaedics, Ophthalmology, Dermatology, HCOOP and Gastroenterology. Orthopaedics identified higher than expected annual leave in month, it is expected that this is purely a change of delivery profile and will not affect achievement of the full year business plan. The specialty is still over performing their YTD business plans although the waiting list for first outpatient appointments grew significantly during December. Ophthalmology & Dermatology services are currently reliant on external providers providing insourcing services to deliver their Outpatient plans, this activity could not be delivered during the festive period. The postponing of some outpatient clinics was required within HCOOP to release clinician time for inpatient work.

Anti-coagulation follow up appointments continue to decrease at higher than anticipated levels. More patients are taking up long-acting drugs, and being seen in the community, rather than in the acute settings. The service has already reduced the workforce through natural turnover and reallocation of resources, and continues to monitor the demand vs capacity requirements.

November hit plan across outpatient news, but in December this has ‘fallen back’ to the year to date position. This is due to annual leave (lower than expected amounts in November); and contribution towards rotas over the Christmas period requiring cancellation of outpatient activity of a consultant to support this. Additional Endoscopy capacity continues to allow the Trust to meet its plan over December, allowing the service to cope with the current demand levels and begin to reduce the waiting list size.

Primary care referrals into Gynaecology remain high (13% increase compared to last year) and consequently first outpatients continue to over perform against the plan (9% year to date). However, follow ups are under plan (7% year to date) as the service prioritises seeing new patients, especially those referred under rapid access. The numbers

of follow ups seen in December was lower than normal, as a change in Colposcopy management has started to occur which sees more patients discharged after their first appointment. The impact of this was not anticipated in the business planning assumptions.

Furthermore, a potential data recording issue has been identified within the Early Pregnancy service at WHH, which is being investigated by the service. Gynaecology has seen another month of high elective activity by utilising as much capacity as possible within the existing workforce and two additional locum consultants. Currently, the service is back to delivering the majority of activity needed to sustain the demand, however, there is still insufficient capacity to reduce the backlog to the required level. Work continues to identify additional capacity both internally and with external providers.

The General Surgery department (including Colorectal and Breast) has continued to achieve near to planned levels since July 2016, this has been achieved by maximising the use of empty theatre lists in the weekdays, funded through a combination of flexible job plans & additional sessions. The service has now identified additional capacity required to recover the YTD day case underperformance. The recovery plans for Orthopaedics and General Surgery will be reliant on access to the day surgery departments at weekends, as such pressure from sustained increased Non-Elective demand may render the recovery plan unachievable.

The Ophthalmology service implemented a contractually mandated cost neutral change in activity recording within the AMD Injection service. The service is now recording and reporting approximately 600-800 injections per month as outpatient procedures as opposed to elective admitted daycase activity. The change is reflective of the PbR tariff the trust receives for this activity. As a result of the change we are now expecting daycase activity to underperform the plan for the remainder of the year.

Non Elective Care

The Trust accepts non elective admissions to all of its 3 sites. These are typically some of the patients who attend the Trust Accident & Emergency departments, or are admitted directly through to the wards upon agreement with General Practitioners. These patients have an urgent clinical need that cannot wait for an elective pathway or outpatient appointment to be given, and so are monitored within the hospital site as diagnosis and treatment for their clinical condition is conducted.

Over Quarter 1 of 2016-17, the Trust saw a rise in medical non elective admissions that was significantly above the planned levels for the year (+10%). This has reduced slightly over Q2 and the forecast position for year end is that the Trust will be 2% above plan for medical non elective admissions (+883 patients). December showed a month position of -2% against the plan (-95), as the number of medical patients was below the expected levels in the month.

Despite the reduced medical admissions against the December plan, the continuing increase in Length of Stay of patients over the year compared to the previous year continues to put pressure on the Trust's bed base, as Bed Occupancy levels remain high and in excess of 100%, above a recommended level of 85%. A high number of beds continue to be occupied by Delayed Transfers of Care patients (DToC), patients who are safe for discharge or transfer and do not require the use of an acute hospital bed.

Monitoring metrics shown below demonstrate that though the month's activity was within the levels planned, the Trust sites continued to see high bed occupancy throughout the month (patients present in beds at midnight against the core bed base). There was some variation across all of the Trust sites, with William Harvey Hospital Ashford showing high bed occupancy in December (100% on average), despite a fall in occupancy in the weeks around Christmas. Occupancy at Kent & Canterbury Hospital increased notably to 104.3% on average over December. This contrasts with both the William Harvey & Queen Elizabeth the Queen Mother Hospital in Margate (97.9%) –

both sites saw a reduction in bed occupancy in December compared to November, whereas Kent & Canterbury Hospital saw an increase, and did not see a characteristic reduction in the weeks around Christmas.

	Last 8 Weeks Weekly Trend - Daily Average								Monthly Totals	
	13.11.16	20.11.16	27.11.16	04.12.16	11.12.16	18.12.16	25.12.16	01.01.17	Nov 2016	Dec 2016
ED - Total Attendances	3,939	4,104	4,069	4,058	4,208	4,016	3,579	4,048	17,075	17,512
IP - Stranded Patient Metric (> 7 Days LoS)	507	531	525	516	513	512	438	529	500	499
IP - LoS - Medical - exc. 0 day (Avg)	9.1	9.1	9.2	8.3	8.9	8.9	8.3	8.2	9.3	8.5
IP - Discharges before Midday (%)	16.9%	15.2%	14.7%	16.1%	15.6%	16.9%	14.9%	16.%	16.2%	15.7%
IP - Discharges before 3pm (%)	39.%	38.7%	37.5%	39.5%	38.9%	38.4%	39.9%	41.3%	39.1%	39.2%
IDT - DToC - Total Patients (Avg)	51	57	62	59	51	53	41	39	56	49
IP - NEL Medical Discharges < 24h (%)	41.8%	45.7%	44.5%	47.%	43.5%	43.9%	43.3%	41.%	44.7%	43.5%
IP - NEL Medical Discharges < 72h (%)	61.5%	62.5%	62.6%	63.8%	61.7%	62.2%	61.2%	61.5%	62.2%	62.%
IP - Occupancy @ Midnight (%)	100.9%	101.9%	102.3%	100.7%	101.9%	101.6%	98.1%	101.1%	101.3%	100.5%
IP - Escalation Beds @ Midnight (Avg)	49	53	53	49	57	59	53	62	51	56
IP - Medical Outliers (Avg)	87	74	73	74	88	88	74	122	81	89

The Medical Outliers metric shows the daily average number of medical patients which were bedded in non-medical wards. This can happen for a variety of reasons; such as care being recently transferred to a medical specialty consultant, or as a result of the ward in question having free beds available for patients at the time of clinical need. Patients remain under the medical consultant responsible for their care for the purpose of treatment and clinical review. During December the number of Medical Outliers increased from a daily average of 81 patients across the Trust to 89.

The number of escalation beds open at midnight also increased in month, with an average of 56 open daily during December compared to 51 in November.

Length of Stay is a measure of how long patients stay in Hospital Treatment. The Length of Stay for Medical patients reduced slightly in month to 8.5 days on average from 9.3 days in November. These Figures exclude patients discharged on the same day as their admission. Length of Stay for medical patients has grown year on year across all Trust Sites, indicating that though the month of December showed a reduction in Length of Stay overall, the number of occupied beds remained high.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	6,537	7,393	-12%	-856
103 - Breast Surgery	5,111	5,688	-10%	-577
300 - General Medicine	1,479	1,787	-17%	-308
101 - Urology	6,034	5,742	5%	292
130 - Ophthalmology	14,228	13,827	3%	401
140 - Maxillo Facial	5,920	5,500	8%	420
330 - Dermatology	10,787	10,087	7%	700
110 - Trauma & Orthopaedics	7,957	7,220	10%	737
420 - Paediatrics	3,988	3,203	25%	785
502 - Gynaecology	7,828	6,828	15%	1000
Total	**112,565**	**109,178**	**3%**	**3,387**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	15,403	16,096	-4%	-693
502 - Gynaecology	5,360	5,853	-8%	-493
140 - Maxillo Facial	1,337	1,792	-25%	-455
430 - HCOOP	3,216	3,512	-8%	-296
303 - Clinical Haematology	772	1,034	-25%	-262
100 - General Surgery	2,532	2,249	13%	283
420 - Paediatrics	2,409	2,045	18%	364
340 - Respiratory Medicine	2,001	1,529	31%	472
101 - Urology	5,363	4,838	11%	525
130 - Ophthalmology	8,660	7,183	21%	1477
Total	**80,969**	**79,842**	**1%**	**1,127**

OP New

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	4,941	6,207	-20%	-1266
100 - General Surgery	3,954	5,143	-23%	-1189
430 - HCOOP	3,582	4,253	-16%	-671
420 - Paediatrics	6,017	5,559	8%	458
104 - Colorectal Surgery	5,917	5,250	13%	667
300 - General Medicine	1,671	970	72%	701
110 - Trauma & Orthopaedics	16,848	16,019	5%	829
502 - Gynaecology	12,072	11,110	9%	962
130 - Ophthalmology	17,958	16,769	7%	1189
330 - Dermatology	10,810	9,544	13%	1266
Total	**142,868**	**140,965**	**1%**	**1,903**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
301 - Gastroenterology	8,807	13,796	-36%	-4989
324 - Anticoagulation Service	10,440	12,842	-19%	-2402
100 - General Surgery	2,097	3,801	-45%	-1704
430 - HCOOP	2,893	4,178	-31%	-1285
302 - Endocrinology	5,824	6,996	-17%	-1172
502 - Gynaecology	11,077	12,053	-8%	-976
103 - Breast Surgery	5,106	4,151	23%	955
800 - Clinical Oncology	31,072	29,099	7%	1973
110 - Trauma & Orthopaedics	28,633	25,619	12%	3014
130 - Ophthalmology	50,393	45,583	11%	4810
Total	**288,403**	**290,592**	**-1%**	**-2,189**

*Payment by Results Only

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	7,973	11,282	-29%	-3309
300 - General Medicine	13,913	16,865	-18%	-2952
110 - Trauma & Orthopaedics	4,607	5,080	-9%	-473
330 - Dermatology	3,494	3,883	-10%	-389
410 - Rheumatology	1,121	1,399	-20%	-278
800 - Clinical Oncology	2,553	2,746	-7%	-193
340 - Respiratory Medicine	705	897	-21%	-192
180 - Accident & Emergency	164	10	1521%	154
303 - Clinical Haematology	2,435	2,244	9%	191
140 - Maxillo Facial	1,794	1,524	18%	270
Total	**59,562**	**66,733**	**-11%**	**-7,171**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
502 - Gynaecology	1,155	1,454	-21%	-299
100 - General Surgery	957	1,181	-19%	-224
320 - Cardiology	534	689	-22%	-155
401 - Neurophysiology	1	54	-98%	-53
120 - Ear, Nose & Throat	551	495	11%	56
300 - General Medicine	834	771	8%	63
103 - Breast Surgery	382	306	25%	76
503 - Gynaecology Oncology	98	21	358%	77
400 - Neurology	245	167	47%	78
101 - Urology	2,230	2,013	11%	217
Total	**11,980**	**12,060**	**-1%**	**-80**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
420 - Paediatrics	4,599	5,266	-13%	-667
502 - Gynaecology	1,351	1,974	-32%	-623
100 - General Surgery	4,562	5,092	-10%	-530
501 - Obstetrics	3,429	3,828	-10%	-399
320 - Cardiology	1,502	1,701	-12%	-199
410 - Rheumatology	44	223	-80%	-179
180 - Accident & Emergency	3,942	4,051	-3%	-109
560 - Midwifery	2,054	1,836	12%	218
430 - HCOOP	8,143	7,411	10%	732
300 - General Medicine	15,626	13,708	14%	1918
Total	**52,906**	**52,745**	**0%**	**161**

*Payment by Results Only

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

4 Hour Emergency Access Standard

Key Performance Indicators

74.23 %

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Green
4 Hour Compliance	84.91%	80.01%	79.25%	84.06%	82.69%	85.40%	82.87%	82.24%	84.29%	79.35%	75.76%	74.23%	95%
12 Hour Trolley Waits	0	1	0	1	1	0	0	0	0	0	1	1	0
Left without being seen	2.87%	3.78%	4.20%	3.46%	4.09%	3.84%	4.59%	4.11%	3.31%	3.85%	3.96%	3.85%	<5%
Unplanned Reattenders	8.88%	8.97%	9.31%	9.10%	9.40%	9.22%	8.62%	9.01%	8.78%	8.58%	8.65%	8.95%	<5%
Time to initial assessment (15 mins)	95.4%	94.6%	92.9%	88.4%	88.7%	91.2%	85.2%	81.0%	86.9%	79.5%	74.4%	79.1%	90%
% Time to Treatment (60 Mins)	49.5%	43.5%	40.8%	46.3%	43.5%	48.3%	46.3%	48.9%	48.5%	40.9%	39.9%	40.0%	50%

Sustainability & Transformational Funding Trajectory (Submission 18th April 2016)

-15.67 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	85.22%	90.02%	90.17%	89.68%	90.80%	90.80%	91.20%	91.50%	89.90%	89.83%	90.48%	91.40%	
Performance	84.06%	82.69%	85.40%	82.87%	82.24%	84.29%	79.35%	75.76%	74.23%				

Summary Performance

The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated, and then admitted or discharged in under 4 hours. This target was last revised by the Department of Health in 2010. When a decision to admit a patient from the emergency department is made, there is zero tolerance for waits of over 12 hours for admission to a ward.

The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard. An Emergency Care Recovery Plan (ECRP) has revised to include the five mandatory requirements of the A&E Improvement Delivery Plan. The aim of the plan is to improve performance and ensure that the A&E Improvement Delivery Plan delivers sustainability across emergency care pathways. It has been mandated through the Sustainability & Transformational Plans that the Trust will achieve performance levels which demonstrate consistent improvement over the course of 2016-17, with overall compliance in excess of 90%.

December performance against the 4 hour target was 74.21% against a trajectory of 89.90%. This shows a decline in performance compared to the previous month, with a lower proportion of patients seen within 4 hours. Analysis of the breach reasons shows a similar picture compared to the previous month, with 369 additional breaches in December compared to the previous month, with the an increase in breach reasons assigned to ED-department reasons such as delays to be seen (2,105 from 1,780 in November, now 47% of the total breach reasons), delays in treatment decision (989 from 868 the previous month, 22% of all breaches). Non-ED assigned breach reasons such as Bed Management breaches fell once again in both volume and proportion of the whole, as (now only 7% of breaches in month (306 compared to 348 in November); There was a single 12 hour Trolley Wait reported in December.

Volume of attendances to Trust emergency departments remain above expected levels, with December activity showing a raised position above the plan (+1191, +7.3%). This continues the year to date trend excess volumes of attendances with a cumulative +6.0% variance to the plan since April 2016. Volumes of attendances to Trust A&E departments continue to be higher than the previous year (+5.2% YTD), with raised volumes in particular noted at the Dover Buckland Hospital Minor Injuries Unit (+14.4% year on year), but also at the William Harvey Hospital in Ashford (+6.5%) and the Queen Elizabeth the Queen Mother in Margate (+5.9%).

The above-expected activity levels continue to contribute to high in department numbers at the sites, and with an increase in month within medical outliers (average compared to 81 in November, and a slight decrease in bed occupancy (100.5%; a high occupancy rate requiring the use of escalation beds). These metrics reflect some of the difficulties in achieving flow of patients from the Emergency departments to acute wards. While the breach analysis shows a slight reduction in the proportion of bed management breaches, occupancy figures show the potential influence of reduced patient flow out of the department to other hospital areas, with a large proportion of patients not being seen a timely manner, with an extended wait to see a senior decision maker noted through the breach reasons around the 60 minute metric.

Traditionally, for those patients who see and ED clinician and are then referred on to a specialist team for onward assessment, treatment and potential admission; the 4 hour standard has had the first two hours allocated to the Emergency Department with the next two hours allocated to the specialist team. This has meant that if the Emergency Department has not assessed and referred to a specialist within the first two hours from arrival in the breach would be allocated as a delay in being seen in ED. However, it has been raised that this is an internal metric and over the past year there have been a growing number of patients who have been referred to a specialist after two hours and then gone on to spend a greater amount of time in the ED awaiting specialist assessment or admission to a ward. In recognition of this fact, a review of how breaches are allocated will be undertaken to ensure that the impact of patients awaiting admission is recognised and specialist delays can be escalated to the appropriate Divisional teams for review and action.

ECASCARD

The Trust has now introduced ecascard into both majors departments at both the William Harvey Hospital (27th September), and into the Queen Elizabeth, the Queen Mother Hospital (from 25th during October). Implementation of this system is aimed to bring real-time recorded activity to the A&E department, and being one of the first organisations in the country to go paperless, and provide up to date, real time tracking of patient journeys through the department.

The implementation plan has highlighted the requirement for clinical staff to use the system in real time and ensure that staffs always fully track patients throughout their pathway. Although 24/7 training and support has been available within the departments there have been issues with staff adapting to using the new system; which have slowed down processes and caused increased breaches, particularly in the evenings and overnight. During the implementation period all staff have been encouraged, and are able to highlight issues and propose improvements, many of which have subsequently been implemented.

Since the implementation there has been a decrease in performance against the 4 hour target; actions have been taken to increase management support, training and speedy resolution of issues. Executive and senior Divisional management are actively monitoring and supporting the situation to resolve issues and compliance to fully using the system to support patient care and flow through the departments.

A&E IMPROVEMENT PROGRAMME

The Urgent Care and Long Term Conditions Division have restructured the urgent care leadership team to provide a triumvirate of a General Manager, Head of Nursing and Deputy Divisional Medical Director. In December the Deputy Divisional Medical Director and Head of Nursing for Urgent Care were appointed. The General Manager interviews will be held in January. The Head of Nursing and Deputy Divisonal Medical Director are new posts which will provide a dedicated senior clinical focus for the Emergency Department, Acute Medical Unit and Ambulatory Care. The A&E Delivery Plan has been critically reviewed by the new leadership team to ensure that the actions will deliver an improvement in performance and reflect the current challenges the ED's are facing with high paediatric attendances in the evenings; increased clinical acuity resulting in a higher conversion to admission.

The A&E Delivery plan is part of an whole system plan which has been ratified by the A&E Delivery Board. The plan will continue to be monitored internally by the Urgent Care Board and from an whole system perspective via the A&E Delivery Board. The Trust is leading on two of the 5 workstreams relating to Patient Flow and Streaming.

Mandated initiative 1 - Front Door – Primary and Ambulatory Care streaming

It is recommended that A&Es, particularly those with chronic staff shortages, should consider developing primary care streams to manage patients presenting with minor illnesses and/or chronic conditions during peak demand periods. The GP in the Urgent Care Centre at K&CH is now established within the minor injuries unit. Pilots for an integrated primary care service are underway; at QEQMH the Acute Response Team model went live in November 2016 and has been successful in identifying frail elderly patients who can be discharged from ED with GP and/or multi-disciplinary team support. Discussions are underway to develop an integrated streaming model for WHH with a visit to Guy's Hospital in London to review their integrated model; however, due to capacity in primary care it may not be possible to implement the model until the spring 2017.

Mandated initiative 2 - Ambulance Response Programme

EKHUFT and SECAMB have an excellent supportive working relationship, with patient safety and care being the highest priority for both organisations. During peaks in activity both organisations clinical staff prioritise the safe handover of patients. This has included a senior nurse or doctor reviewing all patients awaiting handover to ensure that clinical priority is given to the sickest patients. It is a priority to reduce handover delays and consistently improve handover times. A dedicated RAT (Rapid Assessment and Treatment) area has been identified at WHH and is opened as and when clinical staffing levels allow. This area provides a dedicated area to assess patients arriving by ambulance.

Mandated initiative 3 - NHS 111

Primecare are the providers of the out of hours service and NHS 111. There have been some issues with consistent GP cover on the rota out of hours at weekends and overnight. It has been noted that there was an increase in paediatric attendances in the evenings and weekends. In response to this increase, the ED has booked a senior paediatric doctor to work on the middle grade rota and manage the increase in activity.

Mandated initiative 4 - Flow

It is a priority to enhance patient flow and reduce hospital bed occupancy. The SAFER programme has become embedded within the medical wards at WHH and is being implemented at QEQMH. On both sites there has been renewed focus on clinical engagement and decision making on board rounds. Senior Matron and Managers are actively involved in reviewing patient's pathways to expedite internal waits and actively progress.

Mandated initiative 5 - Improving discharge from hospital

It is a priority for health economies to develop a 'discharge to assess' model so health and social care assessments of care are carried out in patients' places of residence rather than in acute hospitals. The 'Home First' model has been launched, however there has remained issues relating to the availability of external capacity.

Progress updates on the following work streams also include:

Improving Clinical Leadership in ED

- At QEQMH there is an on-going issue in recruiting substantive middle grade doctors. There are now 13 vacant posts resulting in a high dependency on agency doctors. It is recognised that this is not a sustainable position and therefore a business case is being developed to develop advanced nurse practitioner (AHP) posts. This will be a 3 – 5 year strategy to train 8 AHP's per year. In the meantime on-going recruitment will continue, including the development of internal rotations and training programme to enhance the posts.
- An Emergency Nurse Practitioner (ENP) business case to enable a dedicated ENP service has been developed. It is proposed that this case will be funded through reinvestment of agency funding. The successful implementation of this case will also reduce the dependency on medical locums.

Acute Medical Model

- In December the Ambulatory Care service was run on a 7 day basis as and when staffing resources allowed. On the weekends that the service was open there was a notable improvement in performance against the 4 hour standard, particularly at WHH.
- Ambulatory Care clinicians have established a successful process of reviewing patients in ED every morning to identify patients who can be transferred from ED to be managed on an ambulatory pathway.

- At QEQMH Consultant Acute Physicians have been very successfully working in ED in the evenings and weekends, to provide senior consultant cover out of hours and mitigate the risk of high agency medical staff.

Trajectory Confidence

December performance against the 4 hour target was 74.21 %, against a trajectory of 89.90%. The increased activity levels seen so far this year have continued being 5% above plan YTD. The numbers attending the departments, particularly in the evenings and overnight continue to have an adverse effect on the Trusts ability to meet the 4 hour emergency access standard. The increase in children and GP expected patients' attending in the evenings has not abated.

The on-going risk to delivery of the trajectory is:

- On-going 5% increased demand to ED. These high levels of activity, particularly in the evenings make it very difficult to discharge frail elderly patients home.
- Impact of Primecare, the new out of hour's primary care provider.
- A high % of breaches of the 4 hour emergency access standard relate to implementation of the new ECASCARD system as staff become accustomed to using the system in real time.
- High numbers of patients attending ED in the evenings and weekends who could be managed by primary care, in particular paediatric attendances.
- Poor patient flow due to lack of timely bed availability.
- The number of DTOC's (delayed transfers of care) and access to short term external capacity in the community continues to be a high risk. There have been issues with a lack of external capacity across all geographic areas.
- Impact on the ED when trying to manage high risk patients attending with a mental health condition, and who are awaiting assessment overnight by the Crisis Team.
- Delays in mental health bed availability.
- Middle grade medical staffing vacancies and unfilled gaps in rotas due to lack of agency or substantive staff. QEQMH is a particular risk due to the geographic location of the hospital.
- High number of nursing vacancies across the emergency floor at QEQMH.

Actions taken to mitigate risk and improve performance:

- Increased daily SITREP meetings with Chief Operating Officer or Divisional Director leadership at the 08:00, 13:00 and 16:00 meetings. Action focussed and structured meetings following the Trust Escalation Action Cards.
- Detained reviews of patients on the IDT working caseload and also of all admitted patients to ensure that all patients pathways are being proactively managed.

- Additional management support, at Executive and General Manager on call level has been provided at WHH and QEQMH at weekends and weekday evenings, with escalation to the CCG Executive on call to ensure all external stakeholders were aware and supporting the Acute Trust.
- Greater senior clinical engagement into the Operational Control Centres with peer review and challenge of patient flow issues.
- Additional internal and agency medical staff have been booked to provide senior clinical support in the Emergency Departments and also to enable senior medical review at the weekend.
- Continued support and close working with SECAMB to ensure that patients are handed over safely.
- ECASCARD issues are being monitored, with issues being actioned as a priority in order to make improvements to the system. Increased communication and training has been provided in real time to staff.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

Cancer Compliance

Key Performance Indicators

76.15 %

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Green
62 day Treatments	71.68%	79.86%	73.57%	71.04%	79.20%	75.42%	70.94%	74.58%	71.50%	70.00%	72.77%	76.15%	>=85%
>104 day breaches	75	57	64	65	61	42	56	57	45	53	44	31	<0
Demand: 2ww Refs	2,553	2,733	2,812	2,950	3,085	2,964	2,999	2,905	2,869	3,036	2,763	3,042	2628 - 2905
2ww Compliance	93.28%	94.10%	93.58%	89.25%	88.48%	94.61%	96.44%	94.77%	94.81%	97.21%	97.45%	96.30%	>=93%
Symptomatic Breast	94.06%	88.03%	92.98%	85.00%	83.73%	93.71%	93.10%	93.22%	95.31%	94.59%	96.43%	86.61%	>=93%
31 Day First Treatment	94.82%	97.07%	98.10%	96.11%	96.31%	94.55%	94.31%	93.64%	93.39%	96.10%	94.93%	95.25%	>=96%
31 Day Subsequent Surgery	94.59%	97.50%	96.72%	91.49%	88.24%	86.96%	96.61%	90.38%	92.59%	89.23%	89.09%	91.18%	>=94%
31 Day Subsequent Drug	86.17%	100.00%	100.00%	98.25%	98.95%	100.00%	97.33%	98.88%	100.00%	100.00%	99.12%	100.00%	>=98%
62 Day Screening	93.75%	95.65%	92.31%	92.86%	93.10%	100.00%	83.33%	87.50%	93.94%	89.55%	96.23%	91.43%	>=90%
62 Day Upgrades	50.00%	86.67%	70.37%	100.00%	57.14%	100.00%	82.35%	85.71%	100.00%	80.00%	83.33%	74.36%	>=85%

Sustainability & Transformational Funding Trajectory

- 12.73

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	74.10%	76.40%	77.60%	77.40%	82.70%	85.40%	85.00%	85.50%	85.20%	85.10%	85.40%	85.20%	Sept
Performance	71.04%	79.20%	75.42%	70.94%	74.58%	71.50%	70.00%	72.77%					Sept

Summary Performance

The NHS Constitution states that patients with suspected cancer have the right to:

- Access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible.
- To be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

In addition there are a set of performance standards set out by NHS England on which NHS providers are held to account. The standards for treatment of patients with suspected cancer are:

- A maximum two-week wait to see a specialist for all patients referred with suspected cancer symptoms (**standard 93%**).
- A maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms; even if cancer is not initially suspected (**standard 93%**).
- A maximum of 31 day wait from the date a decision to treat (DTT) is made to the first definitive treatment for all cancers (**standard 96%**).
- Maximum 31 day wait for subsequent treatments where treatment is surgery (**standard 94%**).
- Maximum 31 day wait for subsequent treatments where the treatment is a course of radiotherapy (no standard – aim for 98%).
- Maximum 31 day wait for subsequent treatments where the treatment is an anti-cancer drug regimen (chemotherapy) (**standard 98%**).
- Maximum 62 day wait from urgent referral for suspected cancer to the first definitive treatment for all cancers (**standard 85%**).
- Maximum 62 day wait from an NHS cancer screening service to the first definitive treatment for cancer (**standard 90%**).
- Maximum 62 day wait for the first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) (no standard – aim 85%).

These standards are all measured across a number of defined tumour sites:

- Breast
- Skin
- Urology
- Upper Gastro-intestinal
- Lower Gastro-intestinal
- Lung
- Gynaecology
- Head and neck
- Haematology
- Other (includes brain, thyroid, children)

The Trust's performance is weighted as 5% of the sustainability and transformation fund (STF) with the most emphasis on the 62 day treatment:

- 50% for the 62 day treatment (includes screening)
- 15 % each 2 week wait and 31 day surgery (30%)
- The remaining standards 5% each (5% x 4)

The Trust has been non-compliant against the 62 day standard since December 2014. A trajectory to recover this target was agreed in April 2016, which predicted compliance by September 2016, due to a drop in Urology performance and the agreed recovery this trajectory has been revised to January 2017. Performance in Urology has dipped significantly over the summer period lack of DaVinci Robotic surgery capacity, MRI breakdown at Canterbury and the failure of the booking process, following the first outpatient appointment. Radiology and Urology teams are meeting to align the MRI appointments and reporting with the TRUS biopsy to prevent delays in the pathway and reports have been designed to support this.

December performance is currently 76.15% against the improvement trajectory of 85.20%, validation continues to the 6th Feb 2017

- The total number of patients currently on an active Cancer Pathway is 2,686
- Number of patients over the 62 day standard is 226 (7.4% of total PTL) of which;
    - 65 have a diagnosis
    - 34 of these have a decision to treat
- The total number of patients waiting 104 days is 31 (1.2% of Total PTL) of which;
    - 10 have a diagnosis
    - 5 have a decision to treat.

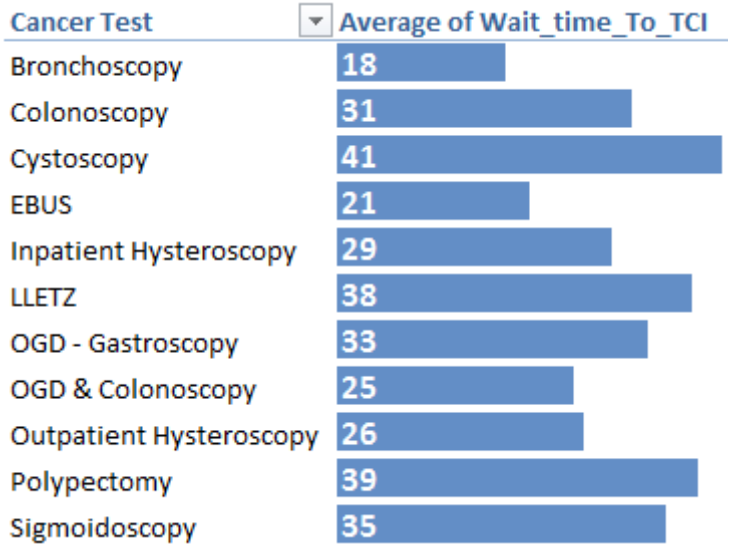
During December there has been significant emphasis on clearing the backlog of patients waiting beyond 62 days on a cancer pathway. The cancer compliance team are focussing on escalation which has resulted in a reduction in the number of patients waiting above 62 days. The number of patients over 104 days has fluctuated through December between just below and just above 30.

A summary of the PTL is shared with Divisional Directors each week to support escalation and resolution of pathways of patients on the cancer PTL.

Diagnostics

Key areas of concern for the Trust are Endoscopy, Colorectal, Urology, Gynae-oncology and Radiology (both appointment and reporting capacity). Monitoring tools for the delivery of waiting times of diagnostic that are timely along the Cancer Pathway are being developed by the Information team (ie. 10 days turnaround time from referral for cancer test to patient having that test). Reduction of waiting times for key diagnostic tests undertaken along the cancer pathway will deliver sustainable compliance against the 62 day target.

Summary of current waiting times for key cancer tests within the Trust.



Tumour site risks

Urology remains a risk to the trajectory of 85% compliance in January. Monthly meetings between the Cancer Compliance Team and Urology are scheduled to monitor compliance to the action plan and recovery trajectory.

Lower GI and Gynae are also areas of concern. Delivery of waiting times of key diagnostic has been recognised as bottle necks for these pathways. Plans for extra Endoscopy capacity and Gynae Hysteroscopy capacity are underway.

104 day patients

The number of patients waiting past 104 days has reduced and is currently 31. It is expected that will continue to reduce through January when it is expected to fall below 30. This will represent around 1.1% (2.15% Nov 15) of the overall PTL. DATIX reporting and clinical investigation continues for these patients, if harm to a patient is considered an RCA will be completed. This process was recently praised by NHSI on review of the Trusts reports from August 2016.

The escalation processes that have been introduced will ensure that patients with long waits are moved more quickly through their pathway. The aim of the Trust is to have zero tolerance to non-clinical waits over 104 days, recognising there will always be clinical exceptions, but these will be small in numbers. A trajectory is being worked on to improve 104 days with the aim to get down to zero.

A report of patients waiting over 104 days is presented to Patient Safety Board each month and discussed at each Cancer Board.

A meeting with the CCG has reviewed the process for monitoring patients over 104 days and reported serious incidents where there has been a delay in diagnosis or missed cancer. This will continue to be an agenda item through the CCH Performance and Quality Meeting.

18 Week Referral to Treatment Standard

Key Performance Indicators

83.83 %

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Green
Performance	90.10%	89.17%	89.27%	88.56%	87.89%	86.81%	86.65%	85.52%	85.11%	86.03%	85.79%	83.83%	>=92%
52w+	3	5	5	6	9	17	25	20	27	21	13	12	0
Waiting list Size	42,239	42,791	43,000	44,620	45,663	44,213	45,487	45,352	45,531	44,822	46,191	46,398	<38,938
Backlog Size	4,181	4,634	4,614	5,105	5,531	5,831	6,072	6,568	6,781	6,262	6,563	7,502	<2,178
Demand: PC Referrals	15,057	15,907	16,431	16,760	16,103	16,254	16,174	15,596	15,489	14,854	16,522	13,403	<15,484
Demand: Additions to IP WL	3,201	3,346	3,325	3,145	3,233	3,560	3,266	3,357	3,432	3,487	4,054	3,138	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

Sustainability & Transformational Funding Trajectory

-8.74 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
STF Trajectory	89.03%	89.86%	90.45%	90.96%	91.67%	92.10%	92.66%	92.94%	92.57%	92.93%	93.42%	94.41%	Sept
Performance	88.56%	87.89%	86.81%	86.65%	85.52%	85.11%	86.03%	85.79%	83.83%				Sept

Summary Performance

The NHS Constitution gives all patients the legal right to start their non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral; unless they choose to wait longer or it is clinically appropriate that they wait longer. To measure compliance against this constitutional right EKHUFT is monitored against the Percentage of Patients on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral, the Threshold for national compliance has been set at 92%. There is a zero tolerance for any patient waiting over 52 weeks for treatment to commence. All breaches undergo a full root cause analysis, the results are shared with our Clinical Commissioning Groups and themes and lessons learnt are cascaded through our divisional governance structure.

The Trust failed to deliver compliance against the national standard by the agreed trajectory timelines of September 2016. This was due to;

- Primary care referrals higher than planned particularly in Orthopaedics which have continued all year, this results in long waiting times for first outpatient appointments i.e. Gastroenterology, Ophthalmology and Gynaecology
- Increase in Orthopaedic & General Surgery waiting list additions
- Higher than planned demand within business plan resulting in no flexibility within capacity in key specialities such as Orthopaedics, Dermatology, Maxillo Facial and Gynaecology
- Gastroenterology & Endoscopy capacity due to high demand
- Workforce vacancies in Otology resulting in referring to London Hospital which has seen an increase in waiting times, particularly 52 weeks waits
- General Surgery capacity for patients presenting with high BMI for benign disease (single handed surgeon) creating 52 week waits

Despite being unable to deliver the performance against the aggregate target, the Trust has maintained performance in;

- Health care of older people
- General medicine and respiratory medicine.

The new Interactive Patient Tracking Technology has been implemented which allows real time recording of patient pathways and supports the operational teams in delivery

Recovery Trajectory

The Trust, working in partnership with the four local clinical commissioning groups and NHS Elect, has developed a recovery Trajectory intended to achieve compliance by March 2017. The challenging recovery Trajectory will require significant investment from both the Trust and the CCGs to reduce waiting list sizes to sustainable levels.

The Recovery profile is detailed below;

Recovery Trajectory

-4.57 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Green
Recovery Trajectory						85.60%	85.96%	87.00%	88.40%	89.84%	90.97%	92.20%	Sept
Performance						85.11%	86.03%	85.79%	83.83%				Sept

Key Elements to the recovery plan

Scheme	Specialty	Provider	Backlog Reduction Required (as at 8/11/2016)	Nov	Dec	Jan	Feb	Mar	Total	Status
Additional theatre lists to achieve plan	General Surgery	EKHUFT	319	60	60	60	60	60	**300**	On plan to deliver
Demand redirection for >35 BMI	General Surgery	KIMS		30	30	30	30	30	**150**	CCG to advise on timescale
Outsourcing of current admitted waiting list	General Surgery	Ash 1, SW		50	50	50	50		**200**	Approved
Outsourcing of current admitted waiting list	Orthopaedics	One Health Ashford	941	100	100	140	140	140	**620**	Recovery plan in place
Outsourcing of current admitted waiting list	Orthopaedics	Spencer Wing		45	45	45	45	45	**225**	On plan to deliver
Demand redirection: Choice at point of Referral	Orthopaedics	IS Providers						250	**250**	CCG to advise on timescale
Intensive Validation	ENT	EKHUFT	211	75					**75**	On plan to deliver
Recruitment of two Otologists	ENT	EKHUFT		8	8	16	16	16	**64**	Recovery plan in place
Resolution of sleep studies	ENT	EKHUFT		10	10	10	10	10	**50**	CCG to advise on timescale
Appointment of Locum Consultant	Maxillo Facial	EKHUFT	201	56	56	56	56	56	**280**	On plan to deliver
Insourcing additional capacity for Cataracts	Ophthalmology	18 Week Insourcing	470	96	96	96	96	96	**480**	Recovery plan in place
Insourcing additional capacity for Endoscopy	Gastroenterology	18 Week Insourcing	362	75	75	75	75	75	**375**	Recovery plan in place

Further work is continuing in other specialities such as Urology, cardiology and Gynaecology with the CCG

In December performance against the standard fell to 83.83%. This significant reduction in performance was driven by a combination of factors. Throughout the month the Trust planned to reduce clinical outpatient and surgical activity due to the festive period. A surge in an unprecedented number in non-elective demand, led to beds and emergency services coming under extreme pressure. This led to the postponing of some outpatient clinics to release clinician time for inpatient work, and an increased cancellation rate for elective surgery, primarily driven by a reduction in surgical bed availability. The Medical Director, Chief Nurse and the Chief Operating Officer are working closely together to make sure all these decisions take into account clinical need, quality of care and patient safety.

In addition to the loss of capacity, as operational focus was directed to unblocking delays and improving patient flow to ensure business continuity, resource was taken away from validation of RTT pathways throughout December. Further challenges were also observed in all specialties, with high vacancy and sickness rates, combined with an inability to recruit short term clinical cover for Gastroenterology services has led to a significant increase in patients waiting over 18 weeks for a first outpatient appointment.

Encouragingly the number of patients who were waiting for treatment for more than 52 weeks as at the end of the month reduced to 12 by the end of December.

Priority 1 - Improve Pathway Management

- Due to operational issues with the unprecedented demand focus has been on the emergency pathways and flow. Through January and February there will be a focus on validation and the use of newly developed information tools

Priority 2 - Achieve the Outpatient Milestones

Demand Management – The health system acknowledges the Trust does not have the operational capacity to deal with the current demand, as such our local Clinical Commissioning Groups (CCGs) committed to reducing referrals to East Kent in 2016/17.

- The CCGs are continuing to identify alternative providers to deliver pathways in Gynaecology, Orthopaedics and General Surgery in 2016/17.
- The CCG's have implemented choice navigators into referral management centres for Orthopaedics and are exploring other avenues to aid other specialities, such as gastroenterology and Gynaecology, although the benefit of this is yet to be seen in the trust.
- The CCG are in the process of awarding the contracts for outpatient procedure management of wet macular oedema (Ophthalmology). This will mean patients will receive treatment closer to home in a primary care setting and will no longer have to attend hospital. Time frame yet to be established.
- The trust is working with the CCG to explore the development of in-house sleep studies in ENT to enable a one stop service to avoid transfer to the community for diagnostic testing.

The Trust is addressing current shortfalls in capacity with increased demand by:

- Additional outpatient internal capacity is being established for Orthopaedics, ENT, General Surgery, Maxillo Facial and gynaecology
- Seven new consultant posts have been recruited in Ophthalmology to commence in February and March 2017
- Validation process in ENT being reviewed with individual consultants with training being provided on the RTT pathway
- Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste has commenced.
- Bring forward the Decision to Treat Date – Identifying patients who have passed the optimal point in patient pathway and securing decision or treatment capacity

Priority 3 - Deliver the Efficiency Programme

6-4-2 Programme – The Trust has established a programme of work to reduce the number of Theatre sessions that are cancelled and not re-established.

- The Trust has developed future focused reports and established meetings to review underutilised and empty theatre sessions.
- Profile of unused theatre lists are addressed at weekly theatre site meetings and weekly Trust theatre efficiency meetings.

Priority 4 – Deliver recurrent demand substantively

Live view of current demand – Monitoring referrals on a weekly basis to identify outpatient and admitted capacity required to respond

Real time response – Developing a process to empower staff to address changes in demand, this will reduce delays in responding to unplanned or unexpected changes to patient flow.

- Agreed waiting list initiative authorisation process, to include weekly demand monitoring and risk management within in the established PTL meetings.

Closing the loop on business planning and accountability – Developing operational procedures and monitoring tools to ensure delivery of the Business Plan

- Develop, train and embed consultant session tracker models to ensure we achieve our substantive internal activity.
- Deliver business planning action plans at speciality level to be monitored weekly at the RTT meeting.
- Clear objective setting, monitoring and accountability at monthly 1-2-1 meetings.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: KPIs

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.72 %

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Performance	99.81%	99.65%	99.65%	99.78%	99.87%	99.86%	99.77%	99.56%	99.74%	99.91%	99.88%	99.72%
Waiting list Size	12,496	12,993	13,358	13,449	14,812	13,533	13,321	10,269	14,728	14,011	15,457	15,023
Waiting > 6 Week Breaches	24	45	47	29	19	19	31	45	39	12	19	42
Average Wait												

Sustainability & Transformational Funding Trajectory

0.62 %

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
STF Trajectory	99.08%	99.09%	99.15%	99.15%	99.13%	99.14%	99.13%	99.05%	99.10%	99.02%	99.03%	99.13%
Performance	99.78%	99.87%	99.86%	99.77%	99.56%	99.74%	99.91%	99.88%	99.72%			

Summary Performance

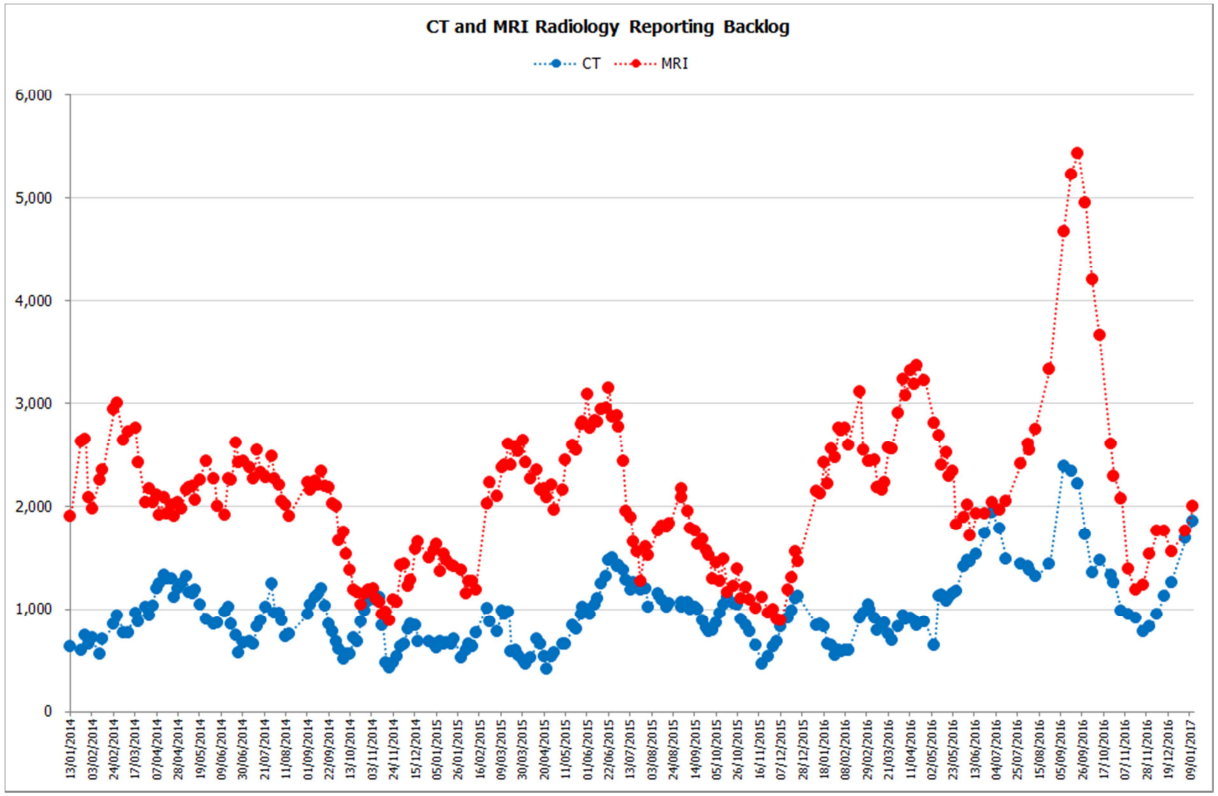
The DM01 is a national monthly report of performance against the 6 week standard for 15 key diagnostic tests. These include Radiology (MRI, CT and Ultrasound), Audiology, Echocardiography, Neurophysiology and Cystoscopy. Around 13/14 thousand tests per month are measured against the 6 week standard. The Division support the pathways for all patients on an 18 week and Cancer pathway. As well as monitoring the % of patients waiting 6 weeks or less for a diagnostic, the waiting list size and number of breaches over 6 weeks are also monitored, as these are key indicators that result in achievement of the DM01 standard.

42 patients waited over the 6 weeks standards in December 16 – breakdown below

Computed Tomography – 13
Magnetic Resonance Imaging – 8
Cardiology – echocardiography - 7
Non-obstetric ultrasound – 5
Urodynamics - pressures & flows - 4
Other - 5

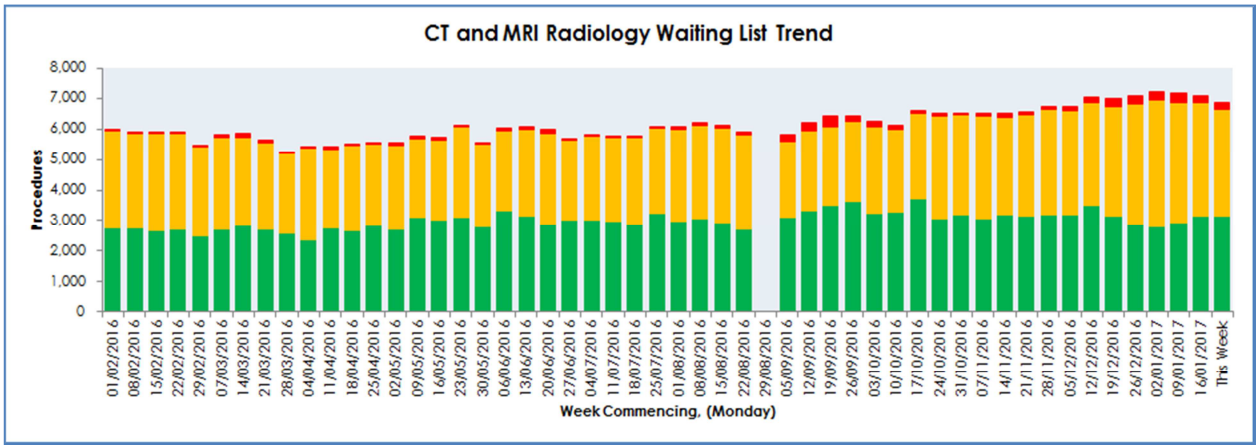
Risks; Issues and action's to mitigate a sustainable performance

The DM01 position remains compliant above the 99% standard, however, at the cost of putting on additional capacity to meet increasing Emergency activity over and above plan. This is coupled with additional reporting costs in order to get results back to clinicians in a timely manner.



The Reporting Backlog in Radiology is beginning to increase again. Significant efforts and investment had been put into reducing the backlog after the GE RIS downtime. However we were trying to manage the demand and locum use –this is not proving easy or sustainable

If the Reporting Backlog continues to grow at the current rate, the DMO1 position and sustainability is not achievable without significant additional resources.



CT and MRI Waiting lists remain high. Currently CT and MRI average waits are close to 5 weeks.

Therefore, if these waiting lists were to increase over the coming weeks/months, it is likely that the 6 week DM01 standard would become at risk.

Mitigating Actions Taken

The team continue to outsource and use locums with a reduction planned over next few weeks. We have undertaken benchmark and deep dive exercises to understand our productivity and efficiency in supporting the above. This has proved useful and serves to prove an overall productive department.

We continue to manage variations in demand in all modalities with limited capacity to deliver more. All equipment working to maximise opportunity – **Mitigating Action** We continue to vet requests, provide information to Trust Divisional clinical teams; CCG's at Consultant/Practice and GP level to enable a greater level of understanding and assessment of need and challenge as to requesting. Additional lists being undertaken to include both extended days during the week and Saturday lists.

Recruitment of Consultants Radiologists remains a huge risk to delivery concern. **Mitigating Action** On-going substantive recruitment. External advert open and reviewing opportunities in Europe for recruitment. We are also developing a marketing strategy to sit alongside our normal recruitment

The Trust ageing equipment continues to be monitored closely and serviced as required. **Mitigating Actions,** The Division are replacing 2 MRIs at KCH. Works have commenced however there is slippage to original timelines due to a requirement of more detailed evaluation of the original Siemen supplied estimates for required building works, into the turnkey solution. Although this resulted in delaying the project, it required Siemens to quantify the actual likely costs associated with the supplied provisional sums, thereby limiting future cost risk to the Trust. This is being picked up by SIG and Management Board. Work will progress at pace.

Daily oversight, monitoring and escalation to DD as required.

East Kent Hospitals University NHS
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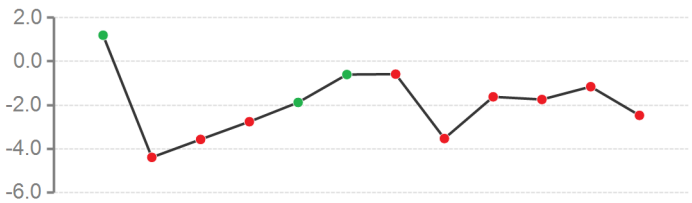
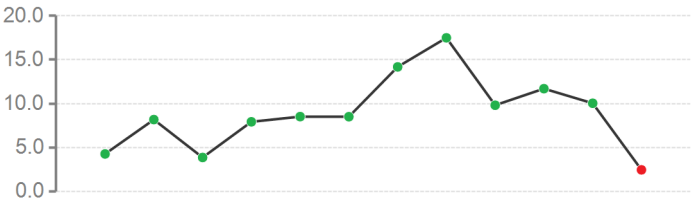
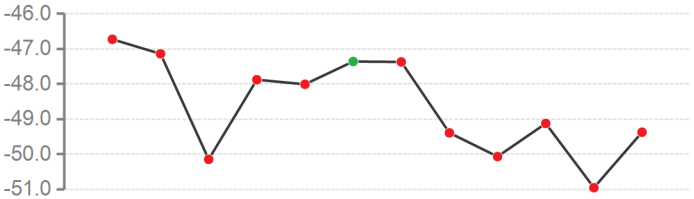
Strategic Theme: Finance

Finance

Dec	I&E £m	-16.3 (113.8%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £5.2m deficit adjusted for "extra" CIPS
Dec	Cash Balance £m	2.4 (-75.6%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
Dec	Total Cost £m	-49.4 (-3.1%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.
Dec	Forecast I&E £m	-19.6 (0.0%)		This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Dec

Normalised Forecast £m

-23.6
(0.0%)

This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments:

The Trust's monthly I&E deficit in December (month 9) was £2.5m compared to £1.3m in November and £1.7m in October. This was roughly in line with the forecast trajectory through to year end driven by income being £2.8m lower in month. The year to date I&E deficit stands at £16.5 with STF income of £4m relating to Q1 having been received. No further STF is expected. If the Trust had received STF in Q2 and Q3, the year to date deficit would be £8.5m.

Pay costs in the month of £28.2m included agency and locum costs of £2.2m which now stand at £20.4m for the year to date against the ceiling trajectory of £18.8m. Spend reduced by £0.4m in December through staff taking leave and fewer working days. Of the December agency spend, 70% related to medical staff. The agency spend is forecast to rise again in Q4.

Total income was £46.9m in month 9. Use of the independent sector increased for the fourth consecutive month to £1.2m driven by Ophthalmology, Endoscopy and Orthopaedics. Against the initial £20m CIPS target, including income, for the year to date £11.7m has been delivered against a target of £13.6m.

The Trust is continuing to discuss its cash requirements with NHSI and to the end of M9 had accessed £12.8 of its approved interim credit facility of £14.6m. The latest forecast submitted to NHSI indicates a requirement for c£28.5m.

The Trust's year end forecast is £19m as agreed at the Trust Board on 7 October 2016 and communicated to NHSI, a £5m stretch on the previous forecast, comprising a £7m operational deficit and £12m of lost STF income. The Trust has put in place a set of measures following the board meeting designed to secure the year end forecast but has been experiencing, in common with the majority of acute trusts, extreme operational demand-led pressures, with high levels of occupancy, poor flow and an increase in cancelled operations. A more likely year end position is a deficit of £22m

The Q4 position must be a substantial improvement on the year to date performance if forecast position is to be achieved.

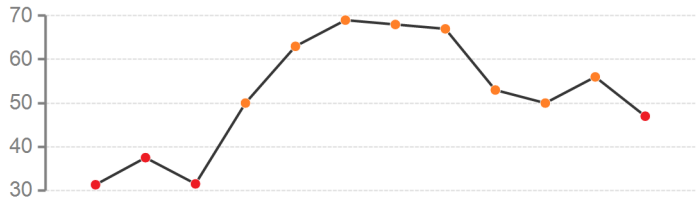
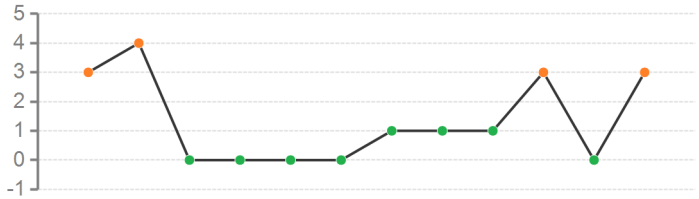
The forecast is rated as high risk as a result of:

- Workforce pressures increasing in Q4
- Potential activity and income reductions in Q4
- Continuing and significant demand and activity pressures in emergency care
- High levels of cancelled operations, occupancy rates and delayed transfers of care
- High level of commissioner challenge continues (£6m)
- Oncology SLA with MTW £0.5m+ risk
- Minimal reserve against fines, penalties and challenges and the crystallisation of those risks

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

Dec	Representation at H&S	623 (23.1%)		% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	RIDDOR Reports (Number)	16 (-23.8%)		RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Formal Notices	1		Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).

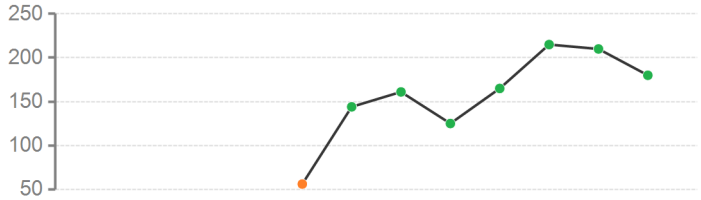
East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Dec

Health & Safety Training

1256



H&S Training includes all H&S and risk avoidance training including manual handling

Comments:

Divisional Representation at H&S meetings decreased in December to a low of 47%. As all sites were in BC during December we did expect attendance to be low.

We have had 3 RIDDOR reports in December as follows:
A staff member slipped on water in a procedure room (following hand washing at the sink)
A back injury from retrieving patient notes from a filing room
A member of staff sprained their finger whilst washing a patient.

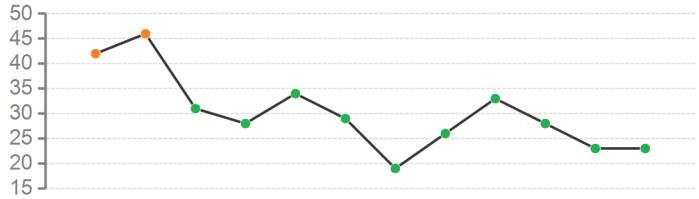
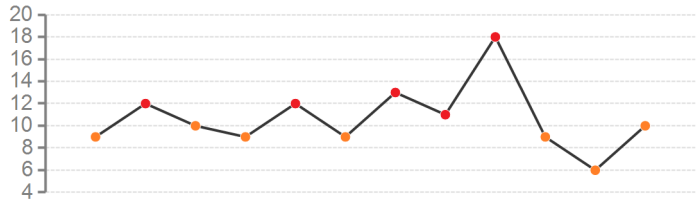
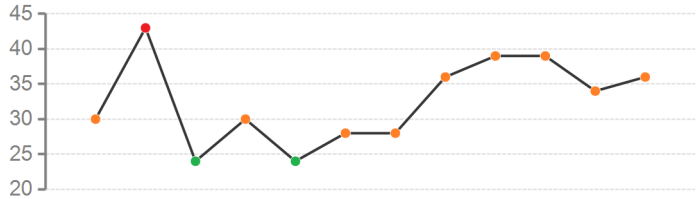
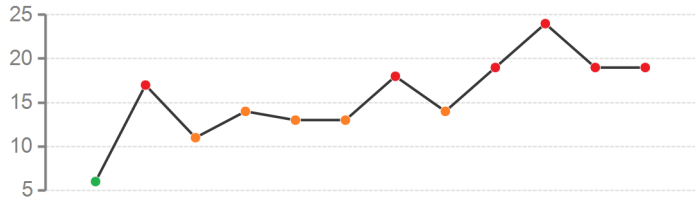
In the last 12 months we have had no Improvement Notices or Fee for Intervention notices from the HSE. We have proactively supplied the HSE with a written Quarterly update and follow up meeting in December. The HSE have thanked us for the update.

We continue to evaluate the RIDDOR data in relation to near misses. The relative small data source is making this difficult at this time. One issue that is being reviewed is the time taken by staff to report RIDDORS to managers and the time being taken by managers to relate RIDDOR to episodes to sickness which at the time may not appear as RIDDOR reportable. We are undertaking a review of the data with the support of the HSE.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

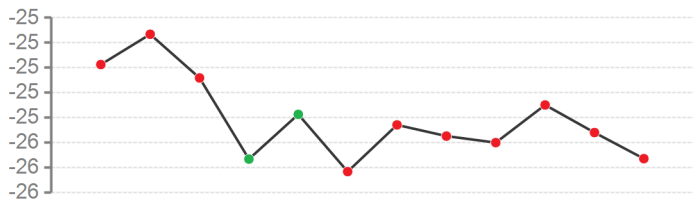
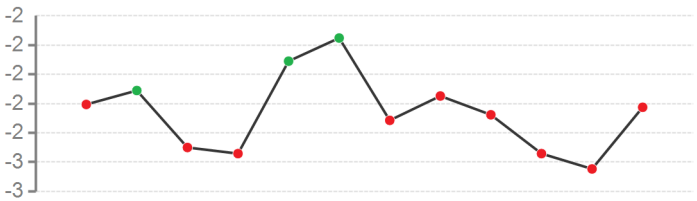
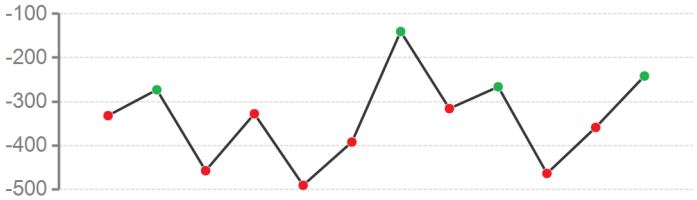
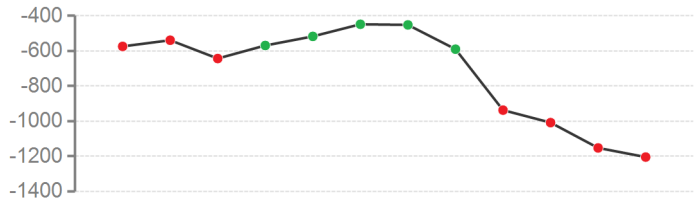
Dec	Accidents	362 (-33.1%)		Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Fire Incidents	128 (-1.5%)		Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Violence & Aggression	391 (-16.3%)		Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Sharps	187 (83.3%)		Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments: Both Accidents and Sharps instances remained static in December. However Violence & Aggression and Fire instances increased slightly on last month.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

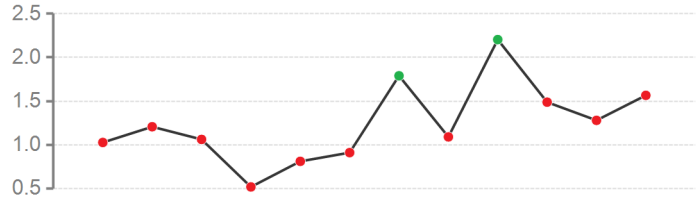
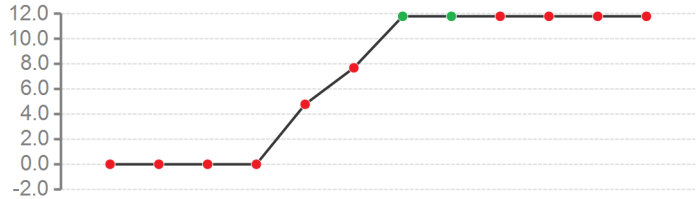
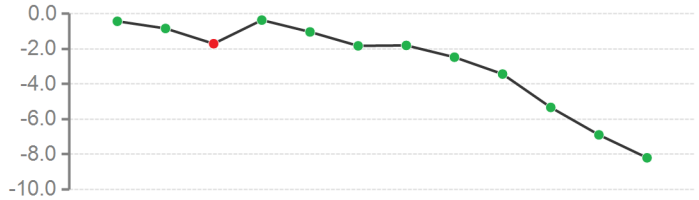
Dec	Payroll Pay £m	-25.7 (0.8%)		Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Dec	Agency Spend £m	-2.2 (-15.9%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Dec	Additional sessions £k	-242 (-32.6%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Dec	Independent Sector £k	-1,205 (4.5%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments: Pay costs in month were £28.2m as against an average of £28.2m per month up to month 8. Agency and locum costs reduced by £0.4m in the month to £2.2m, and now stand at £20.4m for the year to date against the ceiling trajectory of £18.8m. This is an 11% reduction year on year. Of the December agency spend, 70% related to medical staff. Year to date 66% of agency spend is medical staff compared with 34% across the region. 66% of agency and locum costs are in Urgent Care and Long Term Conditions. Measures continue to be strengthened to reduce the agency bill, but are challenged from the high number of vacant medical staff posts, particularly in medicine. Although spend reduced in December, it is expected to increase in Q4 and resents the most serious risk to the Trust's financial position.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Balance Sheet

Dec	CIPS £m	11.7 (22.4%)		Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.
Dec	Cash borrowings £m			Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Dec	Capital position £m	-31.3 (18.9%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.

Comments:

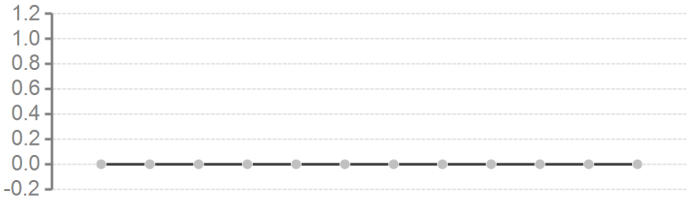
CIPS of £11.7m have been reported ytd, including £2.4m of income schemes, which is £1.9m below plan mainly due to the shortfall in theatres efficiency savings, and some slippage on outpatients and workforce. The CIPS target for the year is £20m with a further £5m stretch of run rate and cost avoidance measures. As at the end of October, schemes valued at £17.5m had been identified. This reduces to £16.7m when risk adjusted. New CIPs Ideas sufficient to close the gap continue to be developed and in recent weeks agreement has been reached to move to a single supplier for hip prostheses (£170k fye), review blue badge parking charges (£250k fye), and pilot Australian CT reporting (£100k)

At the end of December the cash balance stood at £2.5m. The cash forecast for 2016/17 continues to be extremely challenging with only a further £3.3m to be drawn down in January 2017. In August the Trust received the first quarter STF payment £4m but no further STF is expected. The Trust is continuing to work with NHSI to secure additional working capital financing. The latest cash forecast submitted to NHSi highlighted a working capital financing requirement of £28.5m (plan submission £20.8m). The main driver for the increased requirement is the removal of the STF funding relating to future periods and the reforecast to reflect the I&E Trust deficit.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Productivity

Dec	Clinical Productivity: Theatres	0.0		Clinical Productivity graph: theatre sessions v plan.
Dec	Clinical Productivity: Outpatient	0.0		Clinical Productivity graph: outpatient sessions v plan

Comments: The programme of improvement put in place supported by Four Eyes is being rolled out and further efficiency improvements are planned for Q4 to maximise income. This will be dependent on operational pressures reducing. Clinical coding has now coded 100% of activity within the required periods in each of the last three months.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Improvement Journey

		Aug	Sep	Oct	Nov	Dec
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	82.24	84.29	79.35	75.76	74.23
MD03 - Maternity Capacity	Midwife:Birth Ratio (%)	29	30	30	27	28
MD06 - Pathway Flow	IP - Discharges Before Midday (%)	15	14	15	15	14
	DToCs (Average per Day)	58	53	61	57	50
MD07 - Medicines Management	Pharm: Fridges Locked (%)	92	93	91	89	88
	Pharm: Fridge Temps (%)	81	83	84	87	79
	Pharm: Drug Trolleys Locked (%)	99	98	98	98	98
	Pharm: Resus. Trolley Check (%)	90	89	87	87	83
	Pharm: Drug Cupboards Locked (%)	92	90	91	86	87
MD08 - Staffing Levels	Vacancy (%)	10.5	10.8	10.7	10.1	10.1
	Shifts Filled - Day (%)	91	93	93	99	97
	Shifts Filled - Night (%)	102	100	102	110	106
MD09 - Workforce Culture	Sickness (%)	3.8	3.8	3.9	3.9	3.5
	Appraisal Rate (%)	79.5	81.2	83.2	82.2	82.5
	Staff Turnover (%)	12.0	12.6	12.7	12.6	12.7
	Corporate Induction (%)	100	100	100	100	100
	Staff FFT - Work (%)	58	58	58	58	58
	Staff FFT - Treatment (%)	79	79	79	79	79
MD11 - Clinical Audit	Clinical Audit Prog. Audit	3	3	3	3	3
	Clinical Audit Review	3	3	3	3	3

MD12 - Environment	Cleanliness Audits (%)	98.0	97.7	98.3	98.1	98.3
MD17 - Incident Reporting	Clinical Incidents: Total (#)	1,307	1,391	1,375	1,390	1,218
MD19 - Major Incident Planning	Major Incident Training (%)	31	33	34	35	36
MD22 - Agency Staffing	Unplanned Agency Expense	100	115	109	103	95
	Clinical Time Worked (%)	71	70	74	74	72
	Temp Staff (WTE)	226	229	233	227	202
	Employed vs Temporary Staff (%)	89.6	89.5	89.6	90.1	90.1
	Local Induction Compliance %	9.2	14.9	14.3	5.5	17.0
MD26 - Complaints Process	Complaint Response in Timescales %	97	92	94	94	97
MD30 - Medicines Management	Medicines Mgmt. Incidents	110	118	111	133	88

East Kent Hospitals University NHS
NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 4hr Compliance (%)	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge.	>= 95	100 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	<= 90	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 28	30 %
	Extra Beds	Number of extra 'unfunded' beds available		
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Outliers	Number of Bed Outliers in the Trust, where the intended use of the bed is used for another service		
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %
Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	Cleanliness Audits (%)	Cleaning Schedule Audits	>= 98	5 %
	Clinical Audit Prog. Audit	Agreed Clinical Audit programme meets national programme requirements	>= 3	5 %
	Clinical Audit Review	Review of the Clinical Audit Programme	>= 3	5 %

Clinical Outcomes	FNoF (36h) (%)	% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database. Reporting one month in arrears to ensure upload completeness to the National Hip Fracture Database.	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90	5 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>=95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	PROMs EQ-5D Index: Groin Hernia	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		
	PROMs EQ-5D Index: Hip Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		
	PROMs EQ-5D Index: Knee Replacement	PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.		
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Policies in Date (%)	All documents that are marked as policies are in date on the SharePoint system	>= 95	10 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 60	50 %

Data Quality & Assurance	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings.	< 4	25 %
	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	< 0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code %	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	< 7	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £5.2m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %

Health & Safety	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %
	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	Representation at H&S	% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 76	20 %
	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 25	10 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.	< 1	
	Blood Transfusion Errors	The number of blood transfusion errors sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Falls (per 1,000 bed days)	Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 94	10 %
	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.	>= 98	20 %

Incidents	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.	< 1	30 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls	>= 1	0 %
	Pressure Ulcers Cat 2 (per 1,000)	Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 0.15	10 %
	Pressure Ulcers Cat 3/4 (per 1,000)	Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	C. Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	< 1	
	Cases of C.Diff (Cumulative)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month.	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	E. Coli	The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 44	10 %
	E. Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	

Infection	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	< 1	
	MSSA	The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	
Initiatives	Antimicrobial Resistance & Stewardship CQUIN Delivered %	CQUIN made up of two parts – reducing antibiotic consumption in named antibiotics and review of patients on antibiotics after 48/72 hours	>= 100	20 %
	End of Life Pathway CQUIN Delivered %	CQUIN linked to current improvement work and multi-agency policy	>= 100	20 %
	Patient Flow CQUIN Delivered %	CQUIN linked to SAFER project	>= 100	20 %
	Sepsis CQUIN Delivered %	CQUIN including acute wards and with antibiotic review at 72 hours	>= 100	20 %
	Staff Health & Wellbeing CQUIN Delivered %	CQUIN made up of three parts – staff access to healthy activities, health food options on site and flu vaccine uptake	>= 100	20 %
Mortality	Crude Mortality EL (per 1,000)	The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.	< 90	35 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	< 87.45	30 %
	SHMI	Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data.	< 0.95	15 %

Observations	Cannula: Daily Check (%)	The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-9pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 9pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant.	>= 95	20 %
Patient Experience	Care Explained? %	Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 89	4 %
	Care that matters to you? %	Based on a question asked within the Trust's Inpatient Survey, did you get the care that matters to you? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data (as shown in graph).	>= 89	4 %
	Cleanliness? %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaint Response in Timescales %	Audit due to commence in January - Percentage of controlled drugs signed off by two nurses	>= 85	5 %
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	FFT: Not Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 1	10 %
	FFT: Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	30 %

Patient Experience	FFT: Response Rate (%)	The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 15	1 %
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	Mixed Sex Breaches	Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	1	10 %
	Number of Complaints	The number of complaints recorded per ward. Data source - Datix.	< 1	0 %
	Number of Compliments	The number of compliments recorded overall Data source - Patient Experience Team (Kayleigh McIntyre).	>= 1	0 %
	Overall Patient Experience %	Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 90	10 %
	Respect & Dignity? %	Based on a question asked within the Trust's Inpatient Survey, overall, did you feel you were treated with respect and dignity while you were in hospital by the nursing staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 89	2 %
Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use – allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 90	20 %
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	< 5	10 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	< 1	

RTT	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency %	% of Staff working employed through an agency. Number indicates average of last 12 months data (as shown in graph).	<= 10	
	Agency & Locum Spend	Total agency spend including NHSP spend		
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	Ratio showing mix of permanent vs temporary staff in post. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
	Local Induction Compliance %	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	
	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	< 28	2 %
	NHSP Use % of Agency	% of Employee's deployed through an agency that are NHSP. Number indicates average of last 12 months data (as shown in graph).	> 90	
	Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	
	Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
	Roster Effectiveness (%)	The time ward staff attribute to clinical duties as a % of the ward duty roster. Data source - eRoster.		15 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA)	>= 80	15 %
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 80	15 %
	Sickness (%)	% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 3.6	10 %
	Stability Index (excl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		
	Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		

Staffing	Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	15 %
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Temp Staff (WTE)	Count of Temporary Staff in post	< 182	1 %
	Time to Recruit	Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Total Staff In Post (SiP)	Count of total staff in post		1 %
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %
	Vacancy (%)	% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	15 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	
	Mandatory Training (%)	The percentage of staff that have completed mandatory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0	
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	0	
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.	0	
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	0	
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	0	

Use of Resources	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan	
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.	
	Independent Sector £k	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	0

Data Assurance Stars

★☆☆ Not captured on an electronic system, no assurance process, data is not robust

★★☆ Data is either not captured on an electronic system or via a manual feeder sheet, does not follow an assured process, or not validated/reconciled

★★★ Data captured on electronic system with direct feed, data has an assured process, data is validated/reconciled

East Kent Hospitals University NHS
NHS Foundation Trust

Patient Safety Heatmap

KEY

	data not yet available
NULL	null return, data not received
N/A	metric is not applicable

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Care that matters to you? %	Care Explained? %	Respect & Dignity? %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)
KCH - Kent & Canterbury																
Specialist																
KBRA - BRABOURNE (KCH)	100.0	0	0	0	0	0	47	100	100	88	72	100	0.0	90.4	83	107
MARL - MARLOWE WARD	96.4	3	6	0	0	0	158	NULL	NULL	NULL	47	98	0.0	87.4	98	100
Surgical																
CLKE - CLARKE WARD	96.3	1	3	1	0	1	1	100	100	100	25	98	0.0	83.5	92	111
KENT - KENT WARD	100.0	6	1	0	0	1	1	86	98	94	46	100	0.0	87.5	108	106
KITU - KCH ITU	100.0	0	0	0	0	0	58	N/A	N/A	N/A	N/A	N/A	N/A	98.3	94	108
Urgent Care																
HARB - HARBLEDOWN WARD	100.0	3	6	0	1	0	23	100	89	96	50	100	0.0	69.9	99	109
INV - INVICTA WARD	95.8	0	4	0	0	1	0	100	94	94	22	100	0.0	93.5	99	122
KCDU - EMERGENCY CARE CENTRE	100.0	0	0	1	0	0	0	NULL	NULL	NULL	24	86	10.3	91.9	N/A	N/A
KING - KINGSTON WARD	100.0	0	5	1	0	0	0	100	100	98	28	88	4.2	93.1	94	114
KNRU - EAST KENT NEURO REHAB UNIT	100.0	1	2	0	0	0	0	91	92	95	10	100	0.0	80.9	102	136
MTMC - MOUNT/MCMASTER WARD	91.3	0	4	0	1	0	13	90	68	96	31	100	0.0	90.2	104	158
TAY - TAYLOR WARD	100.0	0	0	2	0	0	0	95	86	99	77	100	0.0	77.9	71	99
TREB - TREBLE WARD	100.0	0	11	0	0	0	0	79	96	96	17	90	0.0	86.9	79	141
QEH - Queen Elizabeth Queen Mother																
Specialist																
BIR - BIRCHINGTON WARD	100.0	0	2	0	0	2	236	NULL	NULL	NULL	66	99	1.1	105.4	91	100
KIN - KINGSGATE WARD	100.0	0	1	0	0	1	29	N/A	N/A	N/A	N/A	N/A	N/A	96.5	78	86
QSCB - QEH SPECIAL CARE BABY UNIT	100.0	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	84.6	91	107
RAI - RAINBOW WARD	100.0	0	0	0	0	0	1	N/A	N/A	N/A	8	100	0.0	95.7	104	118
Surgical																
BIS - BISHOPSTONE WARD	100.0	3	7	0	0	0	0	100	100	100	18	100	0.0	83.8	104	109
CSF - CHEERFUL SPARROWS FEMALE	100.0	2	2	0	0	2	0	97	96	98	46	92	3.9	77.5	85	97
CSM - CHEERFUL SPARROWS MALE	100.0	3	5	1	0	0	1	100	100	100	47	95	0.0	86.3	76	91
QITU - QEH ITU	100.0	0	0	0	0	0	45	N/A	N/A	N/A	N/A	N/A	N/A	90.9	83	92

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QX - QUEX WARD	100.0	1	3	0	0	0	1	96	88	95	48	100	0.0	102.2	96	97
SB - SEA BATHING WARD	100.0	0	0	0	0	0	0	100	96	100	30	95	5.3	N/A	N/A	N/A
Urgent Care																
DEAL - DEAL WARD	100.0	1	6	1	1	0	0	97	95	100	0	NULL	NULL	91.2	120	128
FRD - FORDWICH WARD STROKE UNIT	100.0	0	4	0	0	0	0	100	100	100	18	100	0.0	82.9	122	140
MW - MINSTER WARD	91.3	0	10	0	1	1	26	92	64	78	0	NULL	NULL	91.7	96	101
QCCU - QEH CCU	100.0	0	0	0	0	0	32	100	97	98	56	100	0.0	89.7	88	109
QCDU - QEH CDU	100.0	0	0	3	0	0	0	NULL	NULL	NULL	17	80	6.7	92.2	N/A	N/A
SAN - SANDWICH BAY WARD	100.0	1	3	0	0	0	0	90	93	100	20	100	0.0	86.0	119	158
SAU - ST AUGUSTINES WARD	96.3	0	0	0	0	0	0	NULL	NULL	NULL	39	100	0.0	NULL	NULL	NULL
STM - ST MARGARETS WARD	100.0	1	1	0	0	0	25	100	79	98	5	100	0.0	100.6	116	108
WHH - William Harvey																
Specialist																
FF - FOLKESTONE	100.0	0	0	0	0	1	0	81	90	95	N/A	N/A	N/A	108.9	96	86
KEN - KENNINGTON WARD	100.0	0	0	0	0	1	2	NULL	NULL	NULL	46	94	2.0	80.4	81	89
PAD - PADUA	100.0	0	1	0	0	0	1	N/A	N/A	N/A	24	95	3.6	89.0	92	100
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	58	N/A	N/A	N/A	N/A	N/A	N/A	99.1	105	101
Surgical																
ITU - WHH ITU	100.0	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	96.8	96	89
KA2 - KINGS A2	100.0	0	0	0	0	1	2	98	94	95	71	95	0.0	92.0	110	136
KB - KINGS B	100.0	1	8	2	0	0	121	100	94	100	56	99	0.0	95.6	97	146
KC - KINGS C1	100.0	2	5	0	0	0	124	91	94	96	14	60	20.0	97.2	117	104
KC2 - KINGS C2	100.0	0	2	0	0	1	0	50	91	100	41	100	0.0	87.0	83	93
KDF - KINGS D FEMALE	94.4	2	0	1	0	1	103	92	89	98	34	75	0.0	87.6	N/A	N/A
KDM - KINGS D MALE	100.0	2	12	0	0	0	103	87	93	98	22	100	0.0	N/A	101	108
RW - ROTARY WARD	100.0	0	1	0	0	0	2	89	93	96	57	100	0.0	92.3	98	102
Urgent Care																
CCU - CCU	90.0	0	0	2	0	0	12	100	100	97	81	100	0.0	82.5	97	93
CJ2 - CAMBRIDGE J2	97.1	1	5	0	0	0	0	96	88	90	39	96	3.6	75.1	114	113
CK - CAMBRIDGE K	95.5	1	3	0	0	0	5	90	85	91	81	98	1.2	87.7	112	112
CL - CAMBRIDGE L REHABILITATION	92.3	3	17	0	0	0	13	50	50	50	88	100	0.0	99.3	101	133

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CM1 - CAMBRIDGE M1 SHORT STAY	94.4	1	8	0	0	0	0	88	75	91	58	86	7.1	29.7	N/A	N/A
CM2 - CAMBRIDGE M2	94.7	2	6	0	0	0	14	100	96	98	141	100	0.0	99.7	104	125
OXF - OXFORD	100.0	1	6	0	0	0	0	100	100	100	25	100	0.0	88.0	114	122
RST1 - RICHARD STEVENS 1 STROKE UNIT	95.8	4	8	0	1	0	0	91	89	87	22	93	0.0	91.4	75	72
WCDM - WHH CDU MIXED	100.0	0	0	2	0	0	12	96	93	96	15	73	18.2	90.0	N/A	N/A

East Kent Hospitals University NHS
NHS Foundation Trust

Human Resources Heatmap

	Clinical	Finance & Perform	HR & Corporate	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term
Appraisal Rate (%)	86.2	75.5	90.2	79.1	82.5	88.9	91.1	68.4
Employed vs Temporary Staff (%)	89.6	93.3	89.0	87.8	92.9	89.3	91.6	87.1
Mandatory Training (%)	92	90	93	80	84	92	85	87
NHSP Use % of Agency	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Sickness (%)	3.4	1.7	2.4	2.5	3.9	3.1	3.6	3.5
Staff Turnover (%)	13.1	8.6	18.3	16.4	12.4	12.7	10.6	14.0
Vacancy (%)	10.4	6.7	12.7	13.5	7.2	10.7	8.4	13.5

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REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**10 FEBRUARY 2017**
SUBJECT:	**REVIEW OF ISSUES ASSOCIATED WITH OVERSEAS AND INCOME RECOVERY**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE**
PAPER AUTHOR:	**DEPUTY DIRECTOR OF FINANCE**
PURPOSE:	**DISCUSSION**

BACKGROUND AND EXECUTIVE SUMMARY

This reviews the Trusts position in regard to Overseas and Injury Cost Recovery income and explains the Trusts current progress and potential risks.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to proactively manage finance risks can place the trust at risk of breach of licence resulting in NHSI imposing financial special measures
LINKS TO STRATEGIC OBJECTIVES:	**Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Linked to financial recovery and governance
RESOURCE IMPLICATIONS:	n/a
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	n/a

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to review the risks.

Trust Board
10th February 2017

Review of Issues Associated with Overseas and Accident Income Recovery

1. Introduction

The topic of overseas visitors and the recovery of income from them is currently receiving a high profile. Trusts have a duty to maximize the level of income recovered from these patients but it is recognised that the identification of appropriate patients and the recovery of money from them is challenging in most NHS Trusts. In addition when put in context the potential income from overseas patients is very low in relation to other income received by the Trust representing a potential quarter of one percent of the total income available according to Department of Health (DoH) estimates. As such the Trust must seek to maximize the income recoverable from overseas patients whilst also balancing the need to generate income from other areas.

The Injury Cost Recovery Scheme (ICR) is a separate scheme where the fundamental principle is that those responsible for causing injury to others should meet the cost of NHS treatment. NHS costs are recovered only where personal injury compensation is paid, for example after a road traffic accident. Funds recovered come primarily from a third party compensator/insurer. The scheme includes the recovery of ambulance journey costs, and enables contributory negligence (where the person accepts or is found to have, an element of responsibility for the injury sustained) to be taken into account when calculating the charges due. This money goes directly to the trust which provided the treatment, whether NHS Trust, NHS foundation trust (FT) or an ambulance trust, for reinvesting in improving patient services. The monies recovered are not “additional” funding but the recovery of resources already expended.

2. Overseas Income

The Trust is obliged to do its upmost to identify and record patients who reside overseas who are not entitled to free NHS care. There are 2 main categories of such patients a) Patients who are subject to a reciprocal agreement between governments to refund the cost of care. This represents the biggest part of foreign income and the majority of these are patients from Europe b) patients from countries where no reciprocal agreements exist who are responsible to pay for most non emergency care.

For all types of overseas patients the main factor is the identification that the patient is nonresident in the UK. If the patient is identified as potentially nonresident by asking a couple of simple questions then they should be referred to our Overseas Patient Officer who will contact them and complete follow up work to confirm the patients entitlement. If the patient is determined to be in group a) the DoH will be informed and they will recover the income from the foreign government. Clinical Commissioning Groups (CCGs) pay for this activity but the Trust receives an additional 25% from the DoH.

If the patient is identified as not linked to a reciprocal agreement the Private Patient Officer will contact them to agree an appropriate form of payment.

The Trust has been focusing on the recovery of overseas patient income over the last 3 years and has improved its performance significantly.

1. How the Trust is performing regionally – European Patients

Trust	April 2013 to March 2014		April 2014 to March 2015		April 2015 to Jan 2016	
	Number of EHICs reported	EHIC Income Recognised	Number of EHICs reported	EHIC Income Recognised	Number of EHICs reported	EHIC Income Recognised
East Kent Hospitals NHS Foundation Trust	0	£0	122	£80,266	183	£150,831
Maidstone and Tunbridge Wells NHS Trust	0	£0	52	£82,865	192	£188,274
Medway NHS Foundation Trust	44	£68,340	64	£85,671	42	£42,192
Dartford and Gravesham NHS Trust	4	£5,837	18	£28,956	18	£37,811

As can be seen from the above table the Trust has moved from no recognition of European patients in 2013/14 to 183 cases in 2015/16. In the first 7 months of 2016/17 the Trust has already identified more patients than during the whole of 2014/15.

2. How the Trust is performing regionally – Non- Reciprocal Activity

Trust	April 2014 to March 2015			April 2015 to March 2016		
	Income Recognised	Income Received*	Amount Written Off	Income Recognised	Income Received*	Amount Written Off
East Kent Hospitals NHS Foundation Trust	£84,000	£57,000	£27,000	£281,000	£173,000	£105,000
Maidstone and Tunbridge Wells NHS Trust	£3,000	£0	£0	£71,000	£42,000	£14,000
Medway NHS Foundation Trust	£145,000	£126,000	£132,000	£132,000	£84,000	£18,000
Dartford and Gravesham NHS Trust	£212,000	£83,000	£136,000	£229,000	£58,000	£36,000

Again as can be seen from the above table the Trust improved its identification of non-European patients nearly 3 fold between 2013/14 and 2014/15. In the first 7 months of 2016/17 the trust has identified 90% of the number of cases it identified through all of 2015/16.

Scrutiny of Overseas Income

As can be seen from above the Trust has made significant strides over the last 3 years in identifying, recording and recovering overseas income. In addition to the internal focus the DoH carried out a review of the Trusts processes in regard to overseas patient income recognition in February 2015. In addition the Trust commissioned an internal audit to review of our internal processes in this area in early 2016.

The internal audit report findings were presented to the IAGC in July 2016 where they were reviewed by NEDs. The internal audit report identified the overseas income processes and systems as providing the Board with its top level of "substantial assurance" in this area.

In addition The Finance and Performance Committee reviewed the Trust Financial governance improvement plans on in May 2016 which include plans to improve the recognition of overseas patient Income.

The DoH report was fed back to the trust in CEO lead meetings with DoH representatives. The DoH report produced an estimated benchmark potential for both forms of overseas income of £1.4M. Based on its benchmarking EKHUFT was recognised as delivering well compared with other Trusts in the region. However based on 2015/16 data there was a circa £0.9m potential in further improvement possible. Based on current progress in 2016/17 nearly half of this potential is expected to be realised this year. The DoH identified the need to systemically use baseline questions when patients enter the Trust to identify those potentially liable to charges. The Trust is working on adding these questions into both the maternity and the new Patient Administration System (PAS) to improve the situation. In addition the Trust agreed an investment of one post in the Overseas Income team to improve the access of Trust staff to training and information and to increase review and follow up of patients flagged by the increased awareness.

The Board also discussed the potential for increasing overseas income in 2016/17 and agreed at the board meeting on the 7 October a target of £0.2M in income generation improvement from these areas.

3. Injury Cost Recovery Scheme (ICRS)

Current legislation places a legal obligation on insurers and solicitors to inform the Secretary of State whenever a claim is made for personal injury compensation. Day-to-day operation of the scheme is carried out by the Compensation Recovery Unit (CRU) part of the Department for Work and Pensions, so in practice notification is made to them

The CRU will send details of claims to NHS providers and asks the Trust to confirm basic treatment details. These details are returned on a central system from which the CRU can calculate how much will be payable in NHS charges if the compensation claim for the patient is successful. They use a simple average tariff system, currently standing at £817 per day for inpatient treatment (which includes an element for subsequent outpatient treatment) and a one-off charge of £665 for outpatient treatment, irrespective of how many outpatient appointments are needed.

There is also an overall cap on the amount that can be recovered in NHS charges for any one injury, currently standing at £48,849.

Once CRU calculates the amount of NHS charges they bill the insurer and pas any money received to the Trust.

Approximately 77% of identified claims notified to Trusts result in payments being received and as a result the FT ARM required Trusts to recognise notified debt but accrue a provision of 23% for expected write offs. The Trust follows this policy. In 2015/16 the Trust received £1.7M of income from the CRU and wrote off £0.63M of income which was unrecoverable.

4. On-going and Future Risks

The main risks in regard to Overseas issue can be split into 3 areas:-

- Identifying all Overseas patients
    - This is a requirement of front line admin and clinical staff to ask 2 questions which will flag potential Overseas Patients. The Staff should then flag these

patients to the Overseas Patient Officer. There is a need for staff to understand this role and recent communications and staff training have been undertaken to enhance this understanding.
    - There is reluctance by some staff to undertake this role and this may be helped by a senior communication stressing the importance of this task.
- Billing and collection of income
    - Once identified the Overseas Patient Officer will communicate with the patient to assess the patient's eligibility and raise an invoice. Guidance is that this should be flagged to patients as soon as possible and preferably before treatment starts. Due to the fact identification of patients is often during treatment rather than during booking this can be an issue. In addition the Trust only has one Overseas Patient Officer to service all sites. Further resources were agreed to extend this but are currently held up by the Trusts recruitment freeze

As the ICRS is a centrally administered process whereby the Trust receives all appropriate funds due the risk associated with the scheme are:

- The amount of irrecoverable income exceeds the 23% provision leading to further write offs in the accounts. This was the case in 2015/16 but the excess was relatively small £97K
- The trust also has a risk of failure to comply with FT Annual Reporting Manual (ARM) in relation to proper accounting for debt. The Trust follows appropriate accounting treatments for this income.

Summary

The area of overseas patient income is an important focus of the Trust both in terms of delivering on our responsibilities and driving income to assist with our financial position. There has been NED, CEO and DoH scrutiny of the progress of the Trust in identifying appropriate patients and, whilst more work still remains, the Trust has demonstrated significant improvement in this area and is now one of the leading trusts in the country (ranked 7th) in this respect. There is a need for all operational staff to become more involved in identification and reporting of patients. In addition the Trust has approved resources to further improve our delivery of income in this area but these resources have been delayed by the current vacancy freeze.

The injury cost recovery scheme is a centrally administered scheme the income for which is being accounted for in line with FT ARM requirements.