REGISTER OF DIRECTOR INTERESTS – 2017/2018 FROM DECEMBER 2017

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Interim Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) **(4)** Substantive Chief Executive at Dartford and Gravesham NHS Trust (DGT). A memorandum of understanding has been signed to mitigate the risks with the substantive role and the interim role. No longer a Board member at DGT. Discussed and accepted at the Board meeting held on 6 October 2017 **(5)**	16 October 2017 (Interim)
CARTER, PETER	Interim Chair	Member of the National Employer Advisory Board (NEAB) for the Ministry of Defence **(1)** Sole trader Carter Consulting, management consultancy **(2) (3)** Associate with Harvey Nash **(5)** Associate with KPMG **(5)** Liberal Democrats **(6)**	17 October 2017 (Interim)
COOKSON, WENDY	Non Executive Director	Managing Director of IdeasFourHealth Ltd, a consultancy for the healthcare industry **(2)** Sole Shareholder for IdeasFourHealth Ltd **(3)** Trustee of Bede House Charity, a local community charity in Bermondsey, London, from January 2017 **(4)**	6 January 2017 (First Term)
ADEUSI, SUNNY	Non Executive Director	None	1 November 2015 (First term)
CAVE, PHILIP	Director of Finance and Performance Management	Wife works as a Senior Manager for North and East London Commissioning Support Unit (CSU), which supports the Clinical Commissioning Group's (CCG's) of East Kent in their contracting **(5)**	Appointed 9 October 2017
ELY, JANE	Chief Operating Officer	None	Appointed January 2015

REGISTER OF DIRECTOR INTERESTS – 2017/2018 FROM DECEMBER 2017

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
LE BLANC, SANDRA	Director of HR	Justice of Peace (East Kent) and I am a specialist advisor for the CQC **(4)** Member – Scheme Advisory Board for the NHS Pension Scheme **(4)**	1 September 2014
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) **(1)**	(First term) 1 July 2017
OLLIS, JANE	Non Executive Director	Quvium UK **(1)** The Heating Hub **(1)**	8 May 2017 (First term)
PALMER, KEITH	Non Executive Director	Managing Director of Silverfox Consultancy Ltd **(1)** Sole shareholder of Silverfox Consultancy Ltd **(3)**	1 January 2017 (First term)
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	Nil	January 2004
SMITH, SALLY	Chief Nurse and Director of Quality	Nil	Interim from 1 April 2015 Substantive from 28 July 2015
STEVENS, PAUL	Medical Director	CQC Adviser **(4)** NICE Chair, Chair of the Kidney Disease Guideline and Quality Standards Groups **(4)** Executive Member of Kidney Disease Improving Global Outcomes **(4)**	June 2013

REGISTER OF DIRECTOR INTERESTS – 2017/2018 FROM DECEMBER 2017

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
TOMSON, COLIN	Non Executive Director	Nil	11 May 2015 (First term)
WILDING, BARRY	Senior Independent Director	Nil	11 May 2015 (First term)

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

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

UNCONFIRMED MINUTES OF THE EIGHTY-SECOND MEETING OF THE BOARD OF DIRECTORS FRIDAY 8 DECEMBER 2017 AT 9.30 AM BOARDROOM, KENT AND CANTERBURY HOSPITAL

PRESENT:

Mr P Carter	Interim Chair	PCa
Ms S Acott	Interim Chief Executive	SA
Mr P Cave	Director of Finance and Performance Management	PC
Ms W Cookson	Non-Executive Director	WC
Ms J Ely	Chief Operating Officer	JE
Ms S Le Blanc	Director of Human Resources	SLB
Mr N Mansley	Non-Executive Director	NM
Ms J Ollis	Non-Executive Director	JO
Mr K Palmer	Non-Executive Director	KP
Ms L Shutler	Director of Strategic Development and Capital Planning/Deputy Chief Executive	LS
Dr S Smith	Chief Nurse and Director of Quality	SSm
Dr P Stevens	Medical Director	PS
Mr C Tomson	Non-Executive Director	CT
Mr B Wilding	Senior Independent Director	BW

IN ATTENDANCE:

Ms J Cristall	Freedom to Speak Up Guardian (minute number 116/17)	JC
Mrs A Fox	Trust Secretary	AF
Ms S Robson	Board Support Secretary (*Minutes*)	SR
Ms N Yost	Director of Communications	NY
Dr M Webb	Associate Medical Director Patient Safety (minute number 116/17)	MW

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs Arif
Ms J Barker
Mrs J Cole
Mr P Curd
Mr D East
Mrs C Heggie
Mrs P Pryer
Mr J Rampton
Mr K Rogers
Mrs M Smith
Mrs J Whorwell

MINUTE NO.		ACTION
111/17	**CHAIRMAN'S WELCOME** The Chair opened the meeting and welcomed everyone present.	

112/17 **APOLOGIES FOR ABSENCE**

Mr S Adeusi (SA), Non-Executive Director.

113/17 **DECLARATION OF INTERESTS**

There were no declarations of interest.

114/17 **MINUTES OF THE PREVIOUS MEETING HELD ON 6 OCTOBER 2017**

The minutes of the previous meeting were approved by the Board.

115/17 **MATTERS ARISING FROM THE MINUTES ON 6 OCTOBER 2017**

- 75/17 – Medical Director's Report. It was noted that information regarding the hip fracture mortality review had been included in the Medical Director's report presented to the Board. A meeting with all those involved in the hip fracture mortality review pathway would be held on 9 January 2018.
- 88/17 – Transformation Board. A presentation would be made by Simon Hayward on transformation methodology at the February 2018 Board meeting.
- The updates on the other actions were noted, which were all closed.

116/17 **FREEDOM TO SPEAK UP (FTSU) GUARDIANS ANNUAL REPORT**

SSm reported that only a small amount of referrals were being received by the Guardians, and work was underway raise the profile of the Guardians throughout Trust.

It was noted that it was important for the Guardians to have allocated protected time to undertake their roles. There was a vacant post that would be recruited to. It was intended that the 'Workplace Buddies' team should be more diverse.

It was highlighted that, while the number of referrals was not the ideal performance metric for the scheme, it was the way in which the Trust would be monitored. Staff had a number of other avenues where they were able to raise concerns.

It was suggested that it might be beneficial to consider benchmarking the Trust against other Trusts.

ACTION: Review and provide feedback that there is sufficient ring-fenced resourcing allocated to the FTSU Guardians to carry out their guardian role. — SSm

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

117/17 **CHAIR'S ACTIONS**

The Chair reported that he had visited all the hospital sites and met Trust staff who were working extremely hard.

DECISION: The Board **APPROVED** the appointment of Keith Palmer as Non-Executive Director of EKMS Board. The start date was to be agreed between Keith Palmer and the EKMS Ltd Interim Chair, Geoff Benn.

118/17 **CHIEF EXECUTIVE'S REPORT**

SAc asked the Board to note the following points:

- Several staff members had received recent public recognition, which was beneficial not only for the individuals but for the Trust as a whole. SAc congratulated the staff, Dr David Hargroves and Professor Kim Manley.
- The Trust had held its successful annual Staff Awards event.
- As part of the Maternity Transformation Programme, Baroness Cumberlege had visited the Trust to meet and speak to the staff about their transformation work and achievements.
- A positive meeting had been held with NHS Improvement (NHSI) regarding the Trust's route to exit Financial Special Measures (FSM).
- The importance of shortening the length of time from recruitment to the person coming into post. The successful recruitment of Dr Jonathan Leung as Consultant in Emergency Medicine at William Harvey Hospital that would support attracting new talent to work at the Trust.

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

119/17 **FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**

It was noted that with regards to the recovery plan for the Emergency Department, the Trust was anticipating some additional funding. In regards to CRR20 – failure to send timely information to GPs on their patients who had had outpatient appointment, the risk was managed on a monthly basis through the Executive Performance Reviews. New methods had been introduced to address and improve this process as the workload involved in the administration of outpatient appointments was significant. There had been a significant improvement in the time it took for outpatient letters to be sent to GPs. It was noted that CRR12 – Inadequate Ophthalmology follow up arrangements, was a significant risk and a question was raised in regards to a progress timeline. It was explained that the list of patients had been split into risk categories in order that they could be prioritised. A plan was being developed to address and reduce the length of waiting times for patients.

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

120.1/17 **FINANCE AND PERFORMANCE COMMITTEE (FPC)**

In regards to the Financial Special Measures (FSM), it was noted that one of the main areas of concern was regarding the Cost Improvement Programme (CIP) that had slipped from the planned target by £0.6m. The Trust's Market Forces Factor

(MFF) stood at 4.5% which was significantly lower than that of any of the neighbouring or peer Trusts. It was hoped that extensive lobbying to raise the Trust's MFF would subsequently increase the Trust's baseline funding.

In regards to the Trust's month 7 position, it was still ahead of plan. While there had been slippage in month, the CIP had increased its run rate by £1m from October. While there were still some risks, the Trust was on track to deliver its control total of an £18.9m deficit.

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

120.2/17 **QUALITY COMMITTEE**

Whilst the medicine safety thermometer performance had improved, there was still room for improvement and an action plan was in place to ensure further improvements. Attendance at the Patient Experience Group meetings had been compromised due to the wider number of meetings required to be attended. The Executive Management Team had been asked to consider the structure of meetings and to support members prioritising attendance.

The Clinical Quality and Patient Safety report had been received and there had been some improvements overall. There had been one 'never event' in the area of maternity regarding a retained tampon. The Emergency Department recovery plan had been considered and provided good quality metrics that were beneficial in reviewing performance improvements. Patient flow remained a major issue. The minutes of the meetings from the divisional governance boards were received and it had been noted that compliance against duty of candour requires improvement. Divisions were working to improve compliance and additional focussed support was being provided to divisions.

SSm reported that the Trust was doing some joint work with the Community Trust with regards to Harm Free Care, in relation to improving and reducing the harms that patients were being admitted with.

The Trust's previous problems regarding the Infection Prevention and Control (IP&CT) Team and the Antimicrobial Stewardship were outlined to the Board. Both teams were now fully established. Improvements had been seen in the control of C.difficile.

DECISION: The Board **APPROVED** the Infection Prevention and Control Annual Report 2016/17.

120.3/17 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**

BW commented that the Committee had felt that the risk position had deteriorated. As a result, the risk management team had been asked to look beyond the Trust to establish whether any collaborative risk management work could be done with the Trust's partners.

It was suggested that charging for overseas visitors would be challenging to implement. Whilst the Trust was fully aware of what had to be done, work needed

to be undertaken to ensure that the correct resourcing was in place. The Trust would review other Trusts practices and models for charging overseas visitors.

ACTION: Review practices and models for charging overseas visitors from Trust's who benchmark well in this area. PC

DECISION: The Board noted the report and **APPROVED** the following:

- **APPROVED** the revised Standing Financial Instructions.
- **APPROVED** the Risk Management Strategy and Policy and Risk Management Handbook 2017/18.
- **APPROVED** the Overseas Visitor Charging Regulation Changes.

120.4/17 **STRATEGIC WORKFORCE COMMITTEE**

CT reported that a great deal of work was underway to understand the high turnover of staff along with the recruitment difficulties. Significantly improved information regarding turnover was now available and there were detailed exit interviews from staff leaving the Trust. Other measures, such as better training and support for frontline managers, had also been implemented.

It was noted that 9% of staff leavers cited their relationship with their line manager as a reason for leaving and it was agreed that this needed to be better understood.

ACTION: Data relating to the reasons why staff leavers cited issues with their managers as a reason for leaving to be examined in further detail and feedback to the Strategic Workforce Committee. SLB

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

120.5/17 **CHARITABLE FUNDS COMMITTEE**

KP reported that four applications for funding had been presented and approved by the Committee.

The Committee had received a report on the new European General Data Protection Regulations (GDPR) and a further report relating to the impact on the charity would be presented to the Committee.

BW highlighted that there was a risk that the Committee could be presented with applications for a decision to approve funding that were operational issues. It was important that the Committee ensured that this did not happen. There had been a robust debate regarding whether the Charity should support the bay curtains funding request, which was approved as it would significantly improve the patient experience as well as meeting the environment needs for people with dementia.

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

120.6/17 **TRANSFORMATION BOARD**

It was noted that the CQC Insight report had been considered and discussed by the Quality Committee and its relevance to all parts of the Trust.

The Trust was progressing the Dementia Village project and was looking to other countries to understand ways in which dementia patients could best be cared for.

A new Head of Transformation was now in place and would bring forward fresh ideas to the transformation programme, as well as reviewing the programme and discussing with staff the implementation and driving forward delivery of the projects that will address improved outcomes and better performance standards.

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

120.7/17 **MANAGEMENT BOARD**

It was noted that the Management Board was focused on performance, patient flow throughout the organisation and waiting lists.

There had been considerable discussion regarding the investment that was needed for the estate as well as expensive equipment that were key areas for the Trust to take forward. The Executive Team would be considering how investments could be made strategically and it was highlighted that the Trust faced a considerable capital funding challenge.

There had been discussions regarding the development of some local services for GPs and a community pharmacy on the Kent and Canterbury Hospital site. In regards to the establishment of a community pharmacy, planning had been approved and the provision of the pharmacy was expected to be within 18 months.

The risk relating to the Trust's inability to provide a tracheostomy service to Neuro-rehabilitation patients was noted. PS explained that the Trust provided level 2b services and would provide a brief description of the service provision.

ACTION: The risk regarding tracheostomy services as noted in the presented paper to be rewritten and included in the action table for clarity. PS

A question was raised as to whether the standard operating procedure for business continuity, which had been approved by the Management Board, required further scrutiny by IAGC. It was explained that the Management Board had agreed that, even in a critical situation, normal business of the Trust had to be maintained.

ACTION: IAGC to review the standard operating procedure for business continuity. SSm

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

121/17 **INTEGRATED PERFORMANCE REPORT**

In regards to finance, the Trust's cash position was £1m ahead of plan and it was behind on capital spending by approximately £200,000.

The pressure that the Trust was under with regards to the patient flow and bed occupancy was highlighted. The national bed occupancy target was 92% and the Trust had reached 95% in October 2017. Collaborative work to reduce the number of delayed transfers of care was underway with the Community Trust and social care colleagues.

In relation to A&E performance, October had been the first month that 2020 had worked with the Trust on the A&E Improvement Programme. As a result, there had been significant improvements in A&E performance, which had been sustained throughout November.

A significant amount of work was being undertaken to improve cancer performance and this had a marked impact on the service. The 85% target for 62-day treatment continued to be a challenge, particularly in specialties such as urology, lung and gynaecology. There had, however, been improvements overall in performance. The trajectories had been revised and work continued to ensure sustainability of the cancer performance.

A significant amount of work was being undertaken with the Clinical Commissioning Groups (CCGs) on the18-weeks Referral to Treatment (RTT) standard, in relation to capacity. This work had predominantly focused on orthopaedics but had also included general surgery and gynaecology. It was explained that a revised plan was in place to address patients who were waiting up to 52 weeks for surgery.

In terms of diagnostics wait standard, a significant amount of work had been undertaken to ensure that the Trust met the six-week target.

A question was raised as to whether the bed occupancy situation in ITU was sustainable throughout the winter period. It was confirmed that repatriation and transfers needed to be carefully managed. The position was very closely monitored on a daily basis and, while the intention was to minimise the need to move patients as much as possible, it was an option that could used as necessary. Business continuity plans were in place to utilise other beds for critical care if the situation was to arise.

It was explained that ITU capacity had been increased by two beds. It was highlighted that a decision was required as part of the clinical strategy on whether the critical care bed capacity should be increased. It was agreed that, for the time being, the key priority was to ensure that patient flow was prioritised for ITU as well as A&E.

A question was raised as to whether the Trust had the requisite number of ITU beds for the population. It was explained that the Trust was slightly under in relation to the number of ITU beds per population served.

It was explained that integrated discharge teams were in place across all of the Trust's sites to support reduction of delayed discharges. Conference calls regarding this issue and a formal bed-matching process were held daily. Patients could often be cared for more effectively in their own homes and a bid had been submitted for more care packages that could support people to be discharged home.

The Friends and Family Test (FFT) remained at 97% which was very positive. The Emergency Department (ED) FFT had not been as positive, however, this was seen to reflect the waiting times and operational pressures. There had been some

improvement in this area over recent weeks and Queen Elizabeth the Queen Mother Hospital (QEQM) had met the national average for satisfaction, which was seen as evidence of the improvement work which had taken place. Real-time inpatient surveys were also being carried out and certain areas for attention had been identified.

Mixed-sex accommodation breaches were being reported. It was highlighted that this was a matter of patient experience, and that while it was unacceptable, it was sometimes necessary to ensure that patient safety was maintained.

PS highlighted the area of mortality and noted that, while the mortality measures were good in terms of Hospital Standardised Mortality Ratio (HSMR), the figures did not indicate that the Trust had no avoidable deaths. It was noted that the areas in which avoidable deaths occurred or could occur needed to be identified, assessed and understood. There would be a review focussed on the area of acute myocardial infraction.

The area of local induction compliance was highlighted to the Board as poor, it was noted that there had been an issue with the data identified. The Divisional Heads of Nursing had completed a quality audit to ensure that inductions were taking place and were being supported by the correct documentation.

It was explained that the time to recruit had increased due to the central oversight of vacancy control. The processes within the resourcing team had been considered and the team had produced a 10-point project to address the issue. Further work was necessary and SLB was providing executive oversight to ensure that the project was progressing at the required pace.

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

122/17 **UPDATE ON WINTER CAPACITY**

Rather than a winter plan, the Board would now be provided with a demand and capacity plan on a regular basis. The Board was presented with the most recent version of the plan and the key strategies were identified. The Board was provided with an explanation of the Care Navigator Service and ways in which Health Coaches could provide individual support for regular patients and help to reduce the pressure on beds.

It was explained that the Single Health Resilience Early Warning Database (SHREWD) dashboard provided a county-wide indication of where pressure was being experienced in the system. This would allow the county's assets to be used most effectively.

DECISION: The Board discussed the report and **APPROVED** to recruiting to the workforce for this internal capacity plan.

123/17 **MEDICAL DIRECTOR'S REPORT**

It was noted that the bid for the Kent and Medway Medical School had been submitted and a response was due in March 2018.

It was noted that reports of Legionella were increasing nationally.

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

124/17 **MEDICAL REVALIDATION**

The report was presented to the Board and taken as read. PS commended Maria Asperilla, the Revalidation and Project Co-ordinator, for all her hard work and support with the medical revalidation.

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

125/17 **ANY OTHER BUSINESS**

NM reported that following a presentation at the FPC, the Surgical Services Division had been performing well. He emphasised the importance of good performance being celebrated as much as possible.

126/17 **QUESTIONS FROM THE PUBLIC**

Mrs Pryer commented that a meeting had been held between Concern for Health in East Kent (CHEK) and the Secretary of State for Health in November. This had been useful and CHEK had been able to present the Secretary of State with a number of documents. The meeting had identified the focus on counties, such as Kent, that were located on a peninsula and did not therefore have the support of neighbouring counties. She explained that CHEK wished to work with the Trust Board and could serve as the voice of the public.

It was noted that a statement made by one of the CHEK members at the previous meeting had been misreported in the minutes. The statement should have read as the 'non-reinstatement of services', rather than 'the reinstatement of services'.

It was noted that Dr Armstrong had had a very negative experience of using the Trust services. The Chair explained that the Board was aware of Dr Armstrong's concerns and the issues raised would be dealt with outside of the meeting.

Mrs Pryer presented a card containing C.diff information that could be distributed to patients. SSm would check whether the Trust had any similar materials that could be presented to patients. It was explained that any patients who had suffered a C.diff infection were flagged on the Patient Administration System.

ACTION: To check whether the Trust had any similar materials in relation to a card containing C.diff information that could be presented to patients. — SSm

Mrs Pryer commented that with regards to the charging for overseas patients, there was no continuity between systems and patients were sometimes asked for information and sometimes not. It was noted that this would be addressed within the process of charging for overseas patients.

A concern was raised about patients not being made aware of the services

available at each of the Trust's sites. It was noted that this information was available on the Trust's website.

In regards to Care Navigation, CHEK had received a presentation in January 2017. It was noted that no nurses had been involved and that a question raised as part of the presentation had received a response. The Chair explained that the Board would engage with all interested groups and that a schedule of meetings had been set out.

Mrs Whorwell raised in regards to the specialisms of the 10 newly appointed consultants. It was noted that 55 consultants had been recruited in the past year and it was agreed that further information relating to the new consultants and the specialism areas would be made available the Governor that posed the question.

ACTION: Provide information relating to the new consultants and the specialism areas to Mrs Whorwell, regarding the consultants recruited in the past year. SLB

A further question was raised in regards to the Maternity Transformation Programme and how it could be linked to community care such as health visitors. It was explained that the Maternity Transformation Programme would focus predominantly on mothers within the Trust but that it would include the community midwives who had regular communication with the health visitors. An electronic system was now in place that communicated safeguarding information to the health visitors.

ACTION: Provide Mrs Whorwell with further information about whether the Health Visitors and Midwives communicate and work together when a baby has been in Neonatal Intensive Care Unit (NICU). SSm

The Chair closed the meeting at 12.19 pm.

Date of next meeting in public: Friday 9 February 2018 at 09:30, Boardroom, Kent & Canterbury Hospital, Canterbury.

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 9 FEBRUARY 2018

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 8 DECEMBER 2017

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
OUTSTANDING ACTIONS FROM PREVIOUS MEETINGS					
88/17	08.09.17	**TRANSFORMATION BOARD** Simon Hayward to provide a presentation at the Board in February 2018 on the transformation methodology	MK	February 2018	Action will be brought forward for discussion when he joins the Trust. Date for presentation at a future Board to be confirmed.
ACTIONS FROM THE LAST MEETING HELD					
116/17	08.12.17	**FREEDOM TO SPEAK UP (FTSU) GUARDIANS ANNUAL REPORT** Review and provide feedback that there is sufficient ring-fenced resourcing allocated to the FTSU Guardians to carry out their guardian role.	SSm	February 2018	The review is planned to take place during February 2018 when the vacant post is advertised.
120.3/17	08.12.17	**INTEGRATED AUDIT AND GOVERNANCE COMMITTEE** Review practices and models for charging overseas visitors from Trust's who benchmark well in this area.	PC	February 2018	The Trust attends the quarterly Overseas Visitors Advisory Group Meeting run by Department of Health and the Home Office. The forum is attended by the majority of Trusts in England where learning is shared and best practice communicated. In addition, the Trust uses the Model Hospital to

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
					compare its performance on overseas visitor identification against other providers. EKHUFT was 16th overall in the identification of European Health Insurance Card (EHICs) nationwide and we compare favourably with other Kent Trusts in our income collection.
120.4/17	08.12.17	**STRATEGIC WORKFORCE COMMITTEE** Data relating to the reasons why staff leavers cited issues with their managers as a reason for leaving to be examined in further detail and feedback to the Strategic Workforce Committee.	SLB	February 2018	Report will be presented to the February 2018 Strategic Workforce Committee meeting.
120.7/17	08.12.17	**MANAGEMENT BOARD** The risk regarding tracheostomy services as noted in the presented paper to be rewritten and included in the action table for clarity.	PS	February 2018	This risk is CRR 64 and has been renamed 'Inadequate provision of neuro-rehabilitation for patients with a tracheostomy'. The cause of the risk is that there is no provision for level 2A acute neuro-rehabilitation beds across Kent, as the service commissioned is Level 2B. Patients requiring tracheostomy care are admitted on Treble Ward, and occasionally other wards in the Trust, which means that they do not receive the level of neuro-rehabilitation their underlying condition dictates. Harvey Ward with the Specialist Team (i.e. neuro-rehabilitation Consultant and Lead Nurse) is not a Level 2A facility and therefore does not have either

MINUTE NUMBER	DATE OF MEETING	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
					the capacity to oversee outliers and/or manage patients in the acute phase of their recovery. The effect is delayed neuro-rehabilitation treatment, potential poor outcomes for patients and reputational damage.
		IAGC to review the standard operating procedure for business continuity.	SSm	January 2018	Standard operating procedure presented and reviewed at the IAGC meeting held on 29 January 2018. Action closed.
126/17	08.12.17	**QUESTIONS FROM THE PUBLIC**			
		To check whether the Trust had any similar materials in relation to a card containing C.diff information that could be presented to patients.	SSm	February 2018	The Trust uses a green card that is given to the patients with the information leaflet.
		Provide information relating to the new consultants and the specialism areas to the Mrs Whorwell, the Governor that posed the question regarding the consultants recruited in the past year.	SLB	February 2018	Information provided on 12 December 2017. Action closed.
		Provide Mrs Whorwell with further information about whether the Health Visitors and Midwives communicate and work together when a baby has been in Neonatal Intensive Care Unit (NICU).	SSm	February 2018	Feedback provided on 12 December 2017. The Head of Midwifery confirmed that this was the case. Action closed.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**PATIENT STORY**
BOARD SPONSOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PAPER AUTHOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month's story relates to the experiences of our patients and their friends and families who have used our Emergency Departments (EDs) over the past few months. Their stories are in the context of a very busy Winter, and a very challenged system who are working hard to provide safe, effective and person-centred care for those who require an emergency attendance or admission.

The experiences cited are from the 'Care Opinion' website, email correspondence and the Friends and Family Test feedback.

The key items for the Board of Directors to note are:

- The positive feedback received by our patients;
- The context in which the staff are working and the patients are cared for;
- That safety and quality are of paramount importance and prioritised by staff;
- The improvements and support in place to ensure safe, effective and person-centred care is consistently delivered.

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

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to note the key themes of these experiences and the learning and actions outlined.

Board of Directors
Patient Experience Story
February 2018

Introduction

This month the Board of Directors are invited to hear a range of experiences patients and their family and friends have shared with the Trust about their time being cared for in the Emergency Departments (EDs) at the William Harvey Hospital, Ashford (WHH) and the Queen Elizabeth The Queen Mother Hospital, Margate (QEQM). The stories are based on feedback offered to the Trust via the Care Opinion website, email correspondence and the Friends and Family Test (FFT).

The Stories

Below is a selection of positive comments from people who have used our services and have taken the trouble to provide us with valuable feedback.

Posted on the 4 January 2018 about the WHH ED 2 hours after attending

'After two appointments with his GP, followed by a telephone conversation, my husband was advised to go to William Harvey A& E with a suspected Deep Vein Thrombosis (DVT). When we arrived the department was very very busy but we were impressed by how quickly he was seen and the efficiency with which he was dealt with. It needed a blood test to be taken and we were advised that it would take approximately one and a half hours for the results to come back. We went and had refreshments and when we returned to the waiting area my husband was seen as soon as the results arrived. He then saw Mandy who explained what the results showed and she then made an appointment for my husband to have an ultrasound at Canterbury the next day. Throughout our time in A& E we were impressed with the staff who, because of the quantity of patients, were under enormous pressure, but found time to fully discuss the procedures they were carrying out. I have nothing but admiration for how the nurses and doctors carry out their work under so much pressure when so busy'.

An Email from a Reporter from the Kentish Express from Ashford received on 25 January 2018

'I was unlucky enough to be referred to Ashford A&E this morning for the first time. Professional, friendly, dynamic, thorough, the staff were all of that and more, it was mesmerising to see.

A special mention needs to go to the doctor who saw me, I didn't have much of a chance to catch her name, I wish I did, but if there's anyway my thanks could be passed on to the powers that be it would be great.

Top work.
Best.'

From a parent at the QEQM via FFT the week commencing 1 January 2018

'The service was so efficient from start to finish. The doctor and nurses were so kind to my daughter. Listened to our concerns, explained everything'.

From a patient at the QEQM via FFT the week commencing 15 January 2018

'Received fantastic care from the ambulance crew, doctors and nurses. Felt very comfortable and confident in their care.....very professional with a human touch as well'.

From a patient at the WHH via FFT the week commencing 15 January 2018

'Long waiting time to see a nurse. Fantastic staff, very kind and caring and a great bedside manner. Julie the Healthcare Assistant (HCA) was amazing !!'

The Context

The Emergency Departments have experienced a turbulent time in recent months. They have experienced an increase in the number of people attending the Departments since the removal of the junior doctors from the medical take at Kent & Canterbury Hospital in June 2017. In addition, similar to Trusts around the country, the Trust has felt the impact of

influenza and is having a very challenging Winter, in particular during the seasonal period over Christmas and New Year. These factors have been impacted by challenges across the system that have resulted in some wards not being able to discharge an adequate number of patients, to maintain flow through the hospitals every day. This has sometimes meant that the EDs have been caring for patients who are waiting to be admitted or who could have perhaps been cared for without attending the hospital. Both EDs are running 'hot' on a daily basis, meaning that sometimes they are overcrowded and waiting times to be seen are longer than they should be. This means that staff are working at a heightened level of busyness, which can be unrelenting and tiring. Our ED staff have very high standards and they aspire to deliver safe, effective and person-centred care at all times. In times of high pressure it becomes challenging to consistently give first class care all of the time.

Some of our patients have reported anxiety about long waiting times, not knowing what is happening next and commented on how they found the ED an uncomfortable noisy environment. The Chief Nurse & Director of Quality and the Deputy Chief Nurse & Director of Quality have worked shifts in the EDs and witnessed first-hand how staff prioritise and maintain safety in times of pressure and manage the privacy and dignity of the patients during these times.

At present we receive feedback from people via the complaints and compliments process, electronically and we also receive weekly reports from the Friends and Family Test (FFT). This feedback is analysed and reported to the staff and also to the Board in the Integrated Performance Review. At present our FFT satisfaction rates are below national, although showed an improvement following the work the teams have recently commenced. The main themes from the feedback are about the environment in which patients are waiting and the long waiting times. We constantly receive compliments about the staff and how hard they are working in spite of the busyness of the departments, as well as how compassionate and kind they are. During December, the last available reporting period, we received a minimum of 65 formal compliments to every 1 formal complaint in the Trust.

Supporting Improvements

There are in progress a number of improvements and learning that has emerged based on patient feedback, as well as from staff who have spoken to their managers, leaders and directly to the Board. These are described below.

1. Improving Patient and Staff Experience: Due to the challenging working conditions and environment for patients and staff, a number of management actions have taken place. An example is the building work in both EDs to create more space to assess and treat patients and improve flow through the departments. The Board commissioned a Consultancy team to lead a programme of improvement using a collaborative style of coproduction led by the staff. These are described below with the impact of the improvement actions monitored closely by the management teams and the Board of Directors. We are also closely being monitored by our regulators and Clinical Commissioning Group (CCG) colleagues.

2. Rapid Improvement Actions: Over the past 3 months we have delivered a number of improvement 'sprints' that have focused on improving the flow of patients through the EDs and wards. These have been owned by the shopfloor staff who examine the problem they have identified, try out some improvement actions, evaluate and then try again until the desired improvements are realised. These are tested over a short period of time, hence 'rapid'. Below are a few examples of the work we have undertaken since November 2017:

    a. We have introduced a new way of managing the number of patients in the EDs, with greater focus on the length of time they are in the ED (silver command). This has released time to care for the nursing staff as non-clinical staff lead this work.

    b. Under the notion of 'see them soon, see them senior', the Consultants receive ambulance patients and rapidly assess and treat them in order to start treatment rapidly and shorten the waiting times for these patients.

c. For the wards we have built in a system to identify earlier in the day or evening before, the patients to be discharged first thing in the morning. These are called our 'Golden Safe Patients' who are ready to leave hospital much sooner with the support they need arranged.

d. We have also increased the use of the Discharge Lounges, again an achievement, as this was previously unused capacity that now allows the next patient to have a bed much sooner.

3. Governance Improvements: The Trust has strengthened the oversight of the emergency pathway and hospital sites. There are now two Managing Directors responsible for site safety based at the WHH and QEQM. As well as the twice daily Trust wide 'site status' meetings, the hospitals have 'huddles' three times per day, that engage staff from across the site with the aim to improve flow, share quality and safety issues and agree actions to rectify the position. Escalation is managed through the Operational Control Centres led by the Heads of Clinical Operations.

4. Escalation and Support: There are now daily multi agency discharge events (MADE) calls that are Chief Executive led. These calls focus on complex patients that need a very senior decision maker at the table. The Trust continues to engage in the monthly Single Oversight Meetings that are system wide and led by NHS Improvement (NHSI). We also have some additional support and help from an Improvement Director from NHSI and programme management support of the ED recovery plan from Carnall Farrar.

5. Staff Support: Regular meetings with staff are in place. The Executive and Non-Executive Directors (NEDs) visit the EDs regularly along with other senior managers in order to listen to staff and support them. We are in the process of setting up 'critical companionship' support for individuals, including the site operational teams. This enables staff to talk through work related issues in a safe space and problem solve any difficulties. Our Occupational Health department is also supporting staff and offering well-being sessions, including 'mindfulness'.

Summary

This story offers the context within which the patients attending the EDs are cared for. It also describes the impact of a busy ED on staff and explains the improvement journey we are delivering to enhance both staff and patient experience. Next steps include:

- Embed the improvements to date – weekly meetings are in place to monitor these;
- Review the physical capacity in the EDs such as the number of 'Resus' bays and develop a longer term plan;
- Undertake a 2 week 'Perfect Fortnight' with a focus from our external partners to maximise complex discharges and then for us to maximise simple discharges during week 2;
- Continue to keep close to our ED staff and help them to continue to build on the well-being work that has started;
- Continue to listen and engage with all of our staff so that they feel supported and empowered;
- Continue to respond proactively to feedback from our patients and their family and friends.

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

East Kent Hospitals University NHS Foundation Trust

Supporting Numeracy in NHS Trusts

Chris Roberts

Learner Support Coordinator

We care

National Numeracy

- Who are National Numeracy?
- Do we as a Nation have an issue with numeracy?

- 49% of adults have skills expected of children at primary school
- 78% of adults are working below Level 2 (GCSE grade D or below)
- 77% of NHS Staff assessed so far are not achieving the essentials of numeracy

Impact

- Poor numeracy, effect on patient safety
- Career progression being compromised
- National Numeracy – a different approach
- Changing attitudes to help people improve

www.nnchallenge.org.uk/ekhuft

2018 Campaign

- Train the Trainer Workshops: January

  Trust wide launch: throughout February
- Director of HR blog
- Desktop wallpaper
- Staff Zone
- Trust News
- Mid-week Newsflash
- Hub events: Kent & Canterbury (K&C) - 7 February, William Harvey Hospital (WHH) - 8 February and Queen Elizabeth the Queen Mother (QEQM) - 23 February
- Evaluation focus groups: March
- Work based Functional Skills maths workshops: Summer - K&C, Autumn - WHH and QEQM

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**CHAIR'S ACTIONS**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**TO NOTE**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

Council of Governors Update

As I reported to the Board of Directors meeting on 8 December, the Council of Governors met on 15 December 2017 to receive an update on developments with the Sustainability and Transformation Plan (STP). I also took the opportunity to update the Council on the recruitment for the Trust Chair and Chief Executive and on plans to introduce a structured programme of joint Governor and Board visits to wards and departments across the Trust's sites.

The Council agreed a suggestion that the Lead Governor meet with the Trust Chair once a month; the first of these meetings took place on 24 January and the next is scheduled for 20 February. The Council will elect a new Lead Governor to take post in March and will be debating the details of the role description at their meeting on 15 February.

Natalie Yost led the presentation on the STP, supported by Anne Neal, and responded to a range of insightful questions from the Governors.

The second substantive item on the agenda was an update on the Operation Plan from Phil Cave. Again, the Council were challenging in their questions, noting in particular the importance of attracting staff to work in Kent and the impact of the historic underfunding of Trust services.

Phil provided a further update to the Council on the Operational Plan at the formal meeting on 11 January 2018. This was in private session as the plans are currently in draft; a further iteration will be shared with Council at the Joint meeting with NEDs to be held on 15 February with a final presentation to the Council meeting scheduled for 29 March. At the private session with Council on 11 January I also shared a summary of the outcome of Sunny Adeusi's appraisal and a report on the Board Effectiveness Review.

The public session of the January meeting provided a good opportunity to update the Governors on the challenges the Trust was facing with pressures on the emergency departments. I also provided background to recent media attention; including coverage relating to a letter sent to the Trust by the Royal College of Nursing in October and updated the Council on the actions taken at the time to successfully address the concerns raised. Other key items included an update from Liz Shutler, on behalf of the Chief Executive, and a presentation from Fin Murray on Estates planning.

There were several items on the agenda relating to governance issues which were deferred

to the Joint meeting scheduled for 15 February as there was insufficient time to properly discuss and debate the papers. The involvement of the Non-Executive Directors in these discussions will be of value; in particular to items on Conflict of Interests and managing allegations of breaching the Code of Conduct.

Board members will be aware that elections are currently underway for eight vacancies on the Council of Governors – seven public governors and one staff. I am pleased to report that there has been a high level of interest in these elections with 30 public members standing for election and six members of staff. Voting will close on 20 February with the results expected the following day. The new Governors will take up post on 1 March.

I would like to take this opportunity to thank those governors who are coming to the end of their term of office for the time and energy they have given to the role. Their contributions have been of great value and they will be missed. Some are not re-standing for election: Public Governors Margo Laing, Michèle Low, Paul Durkin, Reynagh Westcar-Jarrett and Eunice Backhouse-Lyons; and Staff Governors Robert Goddard and John Rampton – with particular mention for Reynagh and Paul who have each served on the Council since its inception – a significant commitment to the Trust. Public Governors Sarah Andrews, Philip Bull, Chris Warricker and Matt Williams are all standing in the elections.

The Council also has three Partner Governor posts and two of these Governors come to the end of their terms on 28 February. Chris Wells represents the Local Authorities and Michael Lyons the Trust Volunteers – they too have been of great service to the Trust and I record my appreciation of their commitment. Michael Lyons is another who has served as a governor since the inception of the Council. New Partner Governors will be nominated to start on 1 March 2018.

As mentioned earlier in this report, a programme of Site visits is being developed so that every ward, clinical area and department across all five Trust sites will be visited by a team consisting of Governors and Board members. The teams will be linked to each site and the purpose is provide opportunities for staff to meet with members of the Board and Council and for them to see at first hand the work our Trust staff do. Summaries of these visits will be report to Council and Board via the Chair reports.

EKHUFT Chairman Recruitment

At the time of writing this report, the Council of Governors is nearing completion of recruiting to a substantive EKHUFT Chair. I will circulate an announcement once this process has concluded.

Engagement Initiatives

As part of the Trust's continuous improvement against the Well-Led Framework in terms of visibility and engagement the Chairman and Chief Executive are putting in place some new initiatives. These will strengthen the visibility of the Non-executive Directors', Executive Directors and Governors to both staff and service users; and provide additional ways for the Board and Council of Governors to understand the issues staff face, and identify and address blocks to improvement and to hear feedback directly from service users..

Site Visits

A programme is being finalised that will align Board members and Governors to a particular hospital so that over a period of 12 to 18 months they can visit each ward / department (clinical and non-clinical). Whilst the visits will be planned they should be informal and seen as an opportunity to engage with staff and service users. It is proposed that feedback from each visit will be reported through the Chairman's report at both Board and Council of Governor meetings, the feedback will focus on:

- any items of urgent concern reported.

- the three strongest impressions of the area
- any suggestions made by staff or service users which could lead to an improvement or allow positive action to be taken.
- any concerns raised by staff or service users which the team consider need to be relayed to senior management.

Patient and Staff/Clinical Stories

The Trust has routinely received patient stories at its Board meetings and on some occasions has invited staff to discuss particular topics with the Board. The proposal seeks to develop this further in line with the following principles:

- each month the Board should receive either a staff / clinical service or patient story. In either case the story should be presented by the patient / patients family or staff member(s). Where the meeting falls on a development session or where the presenter would prefer to discuss their story in private session a summary of the story will be brought to the next public board meeting to note;
- as the Board meetings rotate across the Trust's hospitals, the story should be linked to the site the meeting is on (where possible) either in terms of the patients experience / treatment or the service the staff are presenting on;
- in some instances the story may allow for the patient and clinicians to present together.

These initiatives not only provide more opportunities for "Ward to Board" and "Board to Ward" engagement but allow Board members and Governors to triangulate the information they receive through the governance structure with what they hear from the frontline staff and service users.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	N/A
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	By ensuring continuation of supply of essential goods and services.
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 of Directors is asked to note the report.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**INTERIM CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month's report covers the following:

- Future of East Kent Hospital Services
- Kent and Medway Stroke Services
- Emergency Department Improvement
- Medical School for Kent
- Financial Special Measures
- Trust Seal Activity

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

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

RECOMMENDATIONS AND ACTION REQUIRED:

To note the report.

CHIEF EXECUTIVE'S REPORT

0 Introduction

0.1 This is my first report to the Board in 2018 and this year will be a particularly important one for the Trust. It has been an exceptionally tough start to the year across the entire NHS with continued high demand upon emergency services.

0.2 During this year we will be consulting and deciding upon how to organise emergency, acute and specialist services in East Kent more effectively and sustainably. All the options on the table mean a significant investment in many of our specialties, emergency department and urgent care, which will help us improve care and outcomes for patients, as well as recruit more skilled staff.

0.3 During my short time in East Kent, I have recognised we have some impressive and dedicated staff. The consultation will enable us to bid for the capital that is needed to start the process of investment in our staff and our estate.

0.4 The Board of Directors is working hard to ensure this year brings certainty and a strong vision and strategy for a better future.

2 Future of East Kent Hospital Services

2.1 In my December 2017 report to Board, I referred to public communications around potential options for how future hospital services might be organised in East Kent. Our future strategy has moved a step forward in January 2018 with over 150 staff from across our hospitals discussing plans to improve services under each of the potential two options.

2.2 All divisions looked in detail at how emergency, acute medical and specialist services could be improved under potential options being considered by commissioners. This will inform a detailed evaluation of both options by the NHS locally over the next few months.

2.3 There are two potential options for emergency, acute medical and specialist services which will be tested and evaluated rigorously to assess which option(s) deliver greatest improvements in effective patient care; are the most accessible for the greatest number of patients; can be optimally staffed; are financially and professionally sustainable; can be delivered within the timeframe needed and best support research and education.

2.4 A reminder that more details can be found on our website: http://www.ekhuft.nhs.uk/patients-and-visitors/news/ekhuft-next-steps/

3 Kent and Medway Stroke Services

3.1 The NHS in Kent and Medway announced proposals to create three new 'hyper acute' stroke units in Kent and Medway. Although general stroke services are currently provided in Kent and Medway's hospitals, there are currently no specialist hyper acute units that in other parts of the country have been shown to improve outcomes for people who have had a stroke.

3.2 These new units will allow people to get the best possible care in the vital first few hours and days immediately after their stroke – saving lives and reducing disability.

3.3 After intensive work by doctors, nurses, therapists, other stroke specialists, stroke survivors and other members of the public to look at the evidence on best care, the NHS is proposing to turn three existing stroke units into specialist hyper acute stroke

units, providing expert care from a team of stroke specialists and therapists round the clock with consultants on the wards seven days a week.

3.4 In developing the proposals there has been a rigorous process to review combinations of existing hospitals, considering many different factors. From this we have developed a proposed shortlist of possible options for the location of hyper acute stroke units in Kent and Medway.

3.5 The proposed shortlist, which is subject to further thorough assessment and final approval, is (in no particular order of priority):

A. Darent Valley Hospital, Medway Maritime Hospital, William Harvey Hospital
B. Darent Valley Hospital, Maidstone Hospital, William Harvey Hospital
C. Maidstone Hospital, Medway Maritime Hospital, William Harvey Hospital
D. Tunbridge Wells Hospital, Medway Maritime Hospital, William Harvey Hospital
E. Darent Valley Hospital, Tunbridge Wells Hospital and William Harvey Hospital

3.6 There will be a full public consultation on the proposals to reorganise the way urgent stroke care is delivered and the potential locations of hyper acute stroke units in Kent and Medway. We will do this following further assessment of the proposed shortlist, and final approval. The consultation could start in early February.

3.7 Each option allows at least 98 per cent of people in Kent and Medway to access a hyper acute stroke unit by ambulance within an hour.

3.8 This is particularly important for people whose stroke is caused by a blood clot. They need to have clot-busting treatment, known as thrombolysis, within two hours of calling 999. Currently, only half of people in Kent and Medway who need this treatment get it within two hours. This is partly because specialist staff are spread across too many sites.

3.9 Each of the proposed hyper acute sites will also have an acute stroke unit to give patients expert care after the first 72 hours until they are ready to leave hospital, and a clinic for assessing and treating transient ischaemic attacks (TIAs or mini strokes).

3.10 With the creation of the new hyper acute stroke units, the proposals mean urgent stroke services would not be provided at the other acute hospitals in Kent and Medway.

3.11 Making these changes will require up to £40million investment in building work and equipment at hospitals and for recruiting more staff across the county, but experience from elsewhere shows costs reduce overall when patients are diagnosed and treated faster. This is because they need less care after they leave hospital with less disability, and can leave hospital sooner.

3.12 As well as the immense benefits in human terms for patients and their families from fewer deaths and less disability, these proposals should also mean long-term financial efficiencies for the NHS and social care and, therefore, significantly contribute to the longer-term sustainability of health and social care services in Kent and Medway. It is a real example of the NHS investing in change that will be better for patients, better for staff, and save money in the long-term.

4 Emergency Department Improvement

4.1 This is the first Board opportunity I have had to make special mention of our emergency department teams, who have been caring for record levels of patients with very complex conditions at our doors over Christmas and into the New Year. Both emergency departments are still extremely busy and I would very much like to thank all of them for all of their hard work to care for patients safely and make them

as comfortable as possible during the difficult conditions we have been experiencing, along with our colleagues right across the country.

4.2 I reported to the Board before Christmas the work 2020 Delivery had undertaken on a rapid improvement programme of work. This work focussed on our processes and overall management within our Emergency Departments and to help us improve our internal processes to support patient flow. 2020 concluded their work with the Trust in January 2018 and provided a 'handover' which will now be taken forward as part of our A&E Improvement Plan to sustain this important work.

4.3 Our A&E Improvement governance will be supported by Carnall Farrar, who will provide dedicated programme management (PMO). Carnall Farrar joined the Trust in January 2018 and a revised governance structure has been agreed to include the System Oversight Meetings, A&E Delivery Board, weekly EKHUFT Operational reviews and an internal ED Safety and Patient Flow group.

4.4 We have reviewed the current A&E Improvement Plan and subsequently identified five key workstreams, to ensure focus of improvement delivery and impact:

- Improve ways of working with EKHUFT staff
- Reduce activity inflow at EKHUFT
- Optimise EKHUFT site management
- Optimise discharge process and times
- East Kent system-wide capacity

4.5 We have identified, with our partners, that discharge is a key metric to improve if we are to recover from the festive period. We have asked that we, along with our partners increase discharge by 25% for a period of time. This will improve flow and allow the resumption of elective activity.

5 Medical School for Kent

5.1 Canterbury Christ Church University and the University of Kent has submitted a bid for a medical school for Kent, supported by NHS and local authority leaders across the county.

5.2 This is something that all the Chief Executives are behind because it's a hugely important opportunity that could be a game-changer for Kent's NHS.

5.3 It would change some of the very practical recruitment challenges we have, particularly here in the eastern coastal areas. Medical schools are known to boost local recruitment. We would value the prospect of being able to 'grow our own' health professionals of the future. I know there are a number of staff in our Trust who have returned here to work after undertaking some of their training here, and it would be great to be able to replicate that in far greater numbers.

5.4 Of more significance, it would change the anomaly that we are one of the largest counties in the UK yet we are without a medical school. EKHUFT is also one of the largest Trusts in the country – it should be part of our ambition to be one of the best Trusts in the country, too. A medical school becomes a magnet for attracting research and intellect to a health system. We already have an already impressive tradition of research in EKHUFT but the medical school bid could really change the nature of what we can offer to our population and to the role we could play in the wider NHS.

5.5 The bid will be evaluated by the Higher Education Funding Council for England and Health Education England and the results will be known in March 2018.

6 Financial Special Measures

6.1 Our core financial challenges continue to be well managed and shepherded by the financial and operational teams. However, as mentioned in my last report, work is on-going with NHSI to determine the risks associated with the additional costs related to our emergency department improvement plan. Our Executive Team continue to be committed to maintaining quality and patient safety whilst working to sustain our financial improvements.

7 Trust Seal Activity

The following summarises Trust Seal Activity since my last report to the Board:

- HM Land Registry: Cancellation of entries relating to a registered charge
- Building Contract: QEQM A&E Alterations
- Claim for Mandatory Relieve from Business Rates
- PET/CT Scan: Lease agreement for site
- Business Rates: Funding agreement and Matter Specification

Susan Acott
Interim Chief Executive

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**DEPUTY DIRECTOR OF RISK, GOVERNANCE AND PATIENT SAFETY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: CORPORATE RISK REGISTER (BY RESIDUAL RISK RANKING) DATED 26 JANUARY 2018** **APPENDIX 2: HIGHEST MITIGATED STRATEGIC RISKS DATED 26 JANUARY 2018**

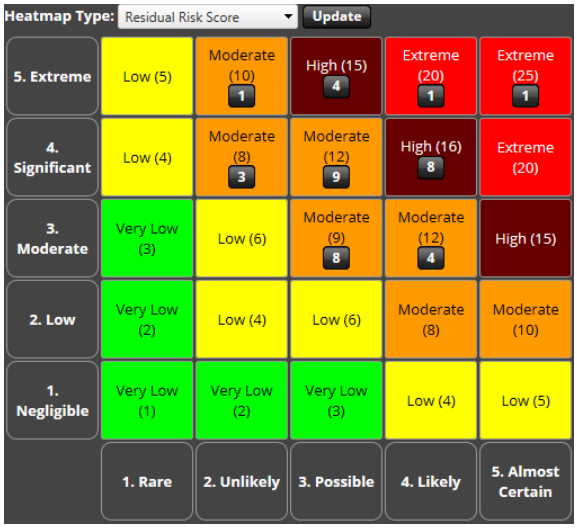
BACKGROUND AND EXECUTIVE SUMMARY

This report provides the Board of Directors with an update of the full Corporate/Highest Mitigated Strategic Risks at 26 January 2018. The risks rated as "high" post mitigation (residual) on the Strategic and the full Corporate Risk Register was last reviewed by the Board on 8 December 2017. The highest mitigated risks on the Strategic and Corporate Risk Registers was last reviewed by the Integrated Audit and Governance Committee on 29 January 2018. The highest mitigated Quality risks were last reviewed and discussed at the Quality Committee on 7 February 2018.

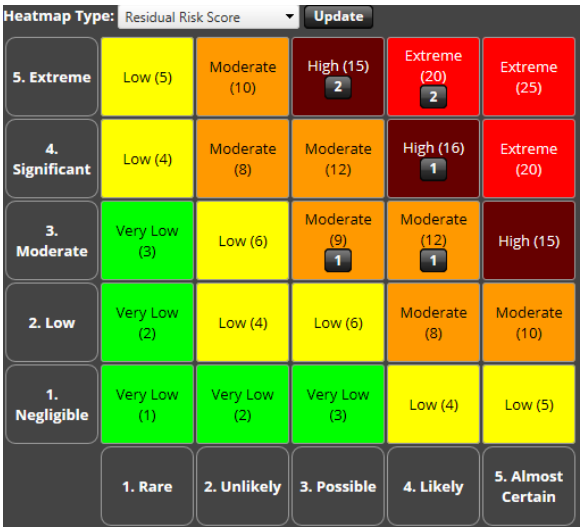
Monthly meetings are being held with the responsible Executive lead to review the scoring, actions and the specific wording for each strategic and corporate risk.

Risk Register Heat Map (by Residual risk score)

Corporate Risks



Strategic Risks



Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register

1 The changes to residual risk scores during the period under review are presented in the table below. The text in italics in the risk title column summarises the rational for the change:

Risk Ref.	Risk Title	Residual Score Nov 17	Residual Score Jan 18	Direction of travel	Target Score
SRR 2	**Failure to maintain the quality and standards of patient care** *The residual risk increased to reflect the increased operational pressures on the two acute sites and the impact on patient care.*	**15 High**	**20 Extreme**		**8 Moderate**

Corporate Risk Register

Changes to residual risk scores

2 The changes to residual risk scores during the period under review are presented in the table below. The text in italics in the risk title column summarises the rational for the change:

Risk Ref.	Risk Title	Residual Score Nov 17	Residual Score Jan 18	Direction of travel	Target Score
CRR 10	Lack of preparedness for the new European Data Protection Rules *The residual likelihood score has increased due to the proximity of the commencement of the new data protection legislation which is now only 4 months away and the NHS-specific guidance due from the national body charged to deliver it has still not been published. The combination of delayed publication of national advice and pressure on the professional resources may lead to insufficient preparedness.*	**4 Low**	**12 Moderate**		**6 Low**
CRR 40	Lack of robust antenatal and new-born screening programmes *The residual impact score has reduced due to assurances received from the Team of improvement in controls, with 99% screening compliance in some areas reported (including infectious diseases and sickle cell).*	**12 Moderate**	**9 Moderate**		**6 Low**
CRR 18	Failure to comply with the recommendations in the Mazar's report which include case note review of each and every patient death *The residual likelihood score has reduced to reflect the improvements in controls. The "Learning from avoidable deaths policy" is now being implemented. A reporting dashboard has been developed and*	**12 Moderate**	**9 Moderate**		**6 Low**

	the board have received a report detailing the process and two areas (hip fracture and patient transfer) where the structured case note review methodology has been employed. A business case for consultant time and administrative support has been prepared and will be submitted through the Trust business case approval process.				

Risks approved for closing on the Corporate Risk Register (January 2018 - Management Board)

3 There were no Corporate Risks proposed/approved for closure on the Corporate Risk Register during the period under review.

New Corporate Risks approved by the Management Board in January 2018

4 There were no Corporate Risks proposed/approved for addition to the Corporate Risk Register during the period under review.

Key issues for the Board's attention and/or discussion

Strategic Risks

5 **Risk Ref. SRR 5 – Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime**

This risk remains an extreme risk to the Trust. The Financial Recovery Plan is in progress. The Trust is on plan year to date at month 9 by £0.1m and has notified NHS Improvement (NHSI) that due to the implementation of the A&E Improvement plan and winter pressures the Trust is likely to exceed the plan by circa £10 million. This risk was discussed at the Integrated Audit and Governance Committee on 29 January 18 who felt that the risk had indeed crystallised.

The Trust has commissioned external support from PricewaterhouseCoopers (PwC) to review its readiness to exit Financial Special Measures (including a review of internal financial controls). The scope of the review has been agreed and field work commenced during the week of 15 January 2018.

Corporate Risks

6 **Risk Ref. CRR 28 – Lack of timely recognition of serious illness in patients presenting to the Emergency Departments**

This risk remains an extreme risk to the Trust. The combination of Bank Holidays over the Christmas and New Year period, deficiencies in GP cover, Integrated Care (IC) 24 (Out of Hours provider) and NHS 111 and the additional pressures on all emergency services, compounded by influenza is reducing the impact of the improvement work to enhance the flow of patients through the emergency care pathway. Key performance indices have all deteriorated through the holiday period.

The Integrated Audit and Governance Committee (IAGC) will be receiving a paper in January 2018 (separate agenda item) that includes the new governance arrangements for the Emergency Department (ED). NHS England (NHSE)/NHSI have commissioned Carnal Farrar to provide a Project Management Office (PMO) function for the Improvement Plan. There will be a fortnightly A&E Delivery Board for the whole system chaired by the Interim Chief Executive Officer (CEO). The Operational Group (with Non-Executive Director (NED) membership) meets weekly. A number of appointments have

been made to strengthen the governance structure including the Improvement Director appointed by NHSI; Two Interim Hospital Directors for Queen Elizabeth the Queen Mother (QEQM) and William Harvey Hospital (WHH) sites and a Management Consultant to focus on Discharge.

7 **Risk Ref. CRR 39 – Delays in Radiological reporting**

This risk is currently scored as a moderate risk to the Trust. However, the current situation in Computerised Tomography (CT) is deteriorating due to difficulty in sourcing support compounded by the problems with Radiology Information System (RIS) during December 2017. All the existing controls on the Corporate Risk Register (CRR) have limited assurance levels. At the risk review meeting with the Executive Lead in February 2018, a review of the assurance levels and residual risk score will be required to ensure the risk score reflects the current position.

8 **Risk Ref. CRR 62 – Failure to comply with standards for medical education and training in particular areas**

This risk remains static. Health Education England Surrey & Sussex (HEKSS) completed the Deanery visit to the Trust in December 2017. Actions from the HEKSS visits are being steadily implemented. Some are dependent on recruitment and others on the implementation of the clinical strategy.

9 **Risk Ref. CRR 57 – Inadequate supply of essential drugs/vaccines**

This risk has remained static in the past two months in terms of likelihood of occurrence but it will need to remain unchanged for longer in order to assuredly reduce the likelihood score.

10 **Risk Ref. CRR 36 – Inadequate Adult Safeguarding training arrangements Trust-wide**

This risk remains static and is being monitored monthly. At the risk review meeting with the Executive Lead in February 2018, a review of the Children's safeguarding training risk (Risk Ref. 1220) which is currently a high risk on the Specialist Services Divisional Risk Register will be required with a view to proposing escalation/merging with CRR 36.

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:

The Board of Directors are invited to:

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

Corporate Risk Register Report (By Residual Risk Ranking)

Report Date	26 Jan 2018
Comparison Date	Between 01 Dec 2017 and 26 Jan 2018

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 28	Lack of timely recognition of serious illness in patients presenting to the Emergency Departments **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Anil Verma **Last Updated:** 22 Jan 2018 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** The combination of Bank Holidays over the Xmas and New Year period, deficiencies in GP cover, IC 24, NHS 111 and the additional pressures on all emergency services, compounded by influenza is reducing the impact of the improvement work to enhance flow of patients through the emergency care pathway. Key performance indices have all deteriorated through the holiday period.	06 Jul 2016	**Cause** * Delay in assessment and evaluation of patients due to overcrowding in the Emergency Departments and 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 GP at the front door *Failure of the NHS 111 to provide appropriate advice * 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 * Difficulties with staff recruitment and problems with staff retention * Breach of licence (Contract Performance Notice) * 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)	A&E Improvement Director in place to support the delivery of the A&E Improvement Plan **Control Owner:** Jane Ely	Adequate	I = 5 L = 5 Extreme (25)	Implement increased bed capacity in the WHH site in order to support enhanced ambulatory and short stay bed capacity **Person Responsible:** Lesley White **To be implemented by:** 30 Dec 2017	High	**17 Oct 2017** A number of proposals have been put forward to utilise beds in the Arundel unit for existing services including acute surgery, gynaecology, cardiology and respiratory medicine. To date none of these have received favourable reception with the clinicians involved and further work is required	I = 4 L = 3 Moderate (12)
						A&E improvement Plan in place with work streams for Admission Avoidance, A&E Streaming, Improved Flow, Discharges and Workforce **Control Owner:** Jane Ely	Limited					
						Accident and Emergency Delivery Board in place **Control Owner:** Susan Acott	Limited		Revision and re-launch of the escalation plans **Person Responsible:** Jane Ely **To be implemented by:** 31 Jan 2018	High	**16 Jan 2018** This is on track for completion as part of 20-20 completing Sprint 3. The Improvement Director is engaged with this piece of work and will be working to refine it if needed.	
						Acute Medical Model in place **Control Owner:** Anil Verma	Limited					
						Carnal Farrar commissioned to provide a PMO service to manage the delivery of the A&E Improvement Plan **Control Owner:** Jane Ely	Adequate		Introduction and Evaluation of a Surgical Emergency unit at QEQM **Person Responsible:** Christine Hudson **To be implemented by:** 14 Feb 2018	High	**29 Dec 2017** SEAU at QEQM only operating out of one chair and one trolley. Only taking GP referrals. This will be expanded once the building moves have taken place within Urgent Care. Will do a small audit in January when there will be enough numbers to evaluate	
						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	Limited		Create medical assessment areas as part of the emergency floor at both QEQMH and WHH **Person Responsible:** Lesley White **To be implemented by:** 30 Mar 2018	High	**18 Dec 2017** The Acute Assessment Bay at QEQMH has been implemented as part of the Acute Medical Unit. WHH not completed. Plans in place to implement an Acute Assessment Bay as part of the Arundal Unit/CCU refurbishment, which are planned to be completed in March 2018.	
						Increased opening hours of the surgical emergency assessment unit **Control Owner:** Christine Hudson	Adequate					
						Interim Hospital Directors in place at WHH and QEQM to support a greater site focus **Control Owner:** Jane Ely	Limited		Implement the revised A&E Improvement Plan **Person Responsible:** Jane Ely **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** The Board will be receiving a revised paper around the governance of the A&E Improvement Plan in February 2018. NHSE/I have commissioned Carnal Farrar to provide a PMO function to manage the delivery of Improvement Plan. There will be a fortnightly A&E delivery Board for the whole system chaired by the Interim CEO. The Operational Group (with NED membership) meets weekly. NHSI has appointed an improvement Director for A&E who commenced in post in January 2018. Two Hospital Directors are now in post at QEQM and WHH; and a Management Consultant has been appointed to focus on Discharge.	
						Primary care service in place at QEQMH and WHH for a minimum of 6 hours per day, **Control Owner:** Anil Verma	Adequate					
						SAFER bundle in place at K & CH **Control Owner:** Jonathan Purday	Limited					
						SAFER bundle in place at WHH **Control Owner:** Jonathan Purday	Limited					
						SAFER bundle in place in QEQM **Control Owner:** Paul Stevens	Limited		Recruitment of acute physicians and specialty doctors establishment **Person Responsible:** Anil Verma **To be implemented by:** 31 Mar 2018	High	**16 Nov 2017** Actively recruiting to posts focusing on overseas recruitment. The recruitment pipeline is updated weekly.	
						Single Health Resilience Early Warning Database (SHREWD) has been revised . It is expected that when the Trust is under pressure the system will respond with agreed actions **Control Owner:** Jane Ely	Limited					
						Support from 2020 **Control Owner:** Jane Ely	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Weekly site based meetings in place designed to improve ownership of the emergency care pathway and reduce overcrowding in the emergency department **Control Owner:** Anil Verma	Adequate		Resolution of over-crowding within the A&E departments leading to improved flow, improvement in ambulance handover and time to first clinician review metrics **Person Responsible:** Anil Verma **To be implemented by:** 31 Mar 2018	High	**19 Dec 2017** New action added in December 2017. Progress note required by January 2018.	
CRR 51	Patient safety may be compromised as a result of the move of acute medicine, acute geriatric medicine and Stroke from the K&C site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 18 Oct 2017 **Latest Review Date:** 18 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** This remains an extreme risk to the Trust as it is linked to the Emergency Care Risk (CRR 28). Currently because we do not have enough non-elective beds to deal with the volume of emergency patients. The bed complement at K&C that is required to facilitate the discharge of medically fit patients over the Christmas and New Year has completely been swamped. The integrated discharge list of patients referred for discharge planning is greater than 20% of our bed base.	11 Apr 2017	**Cause** *Temporary transfer of acute medicine, geriatric medicine and Stroke from the K&C site *On K&C site we may not have the right level of medical cover for all the specialties that remain on the site *Ambulance handover delays *Patients transferring between sites *Imbalance between substantive consultants and locum consultant posts leading to unsatisfactory trainee doctors education experience **Effect** *Potentially avoidable moderate or severe harm or death *Overcrowding at WHH & QEQM (negative bed position) *Reputational damage *Legal challenge *Regulatory concerns *Additional costs required for changes to services	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Increased proportion of patients treated through ambulatory care **Control Owner:** Jonathan Purday	Adequate	I = 5 L = 4 Extreme (20)	Implementation of the system wide A&E recovery plan **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2018	High	**17 Jan 2018** The focus remains sticking to the plan and the maximisation of ambulatory care; only safely transferring patients back to the K&C site that meet the transfer criteria. A robust checklist is in place and reviewed by the IDT. The A&E recovery plan is progressing with a number of recent appointments made to strengthen the capacity and capability to deliver the plan.	I = 5 L = 2 Moderate (10)
						Oversight group in place **Control Owner:** Jane Ely	Adequate					
						Patients return to the K&C site only once medically optimised **Control Owner:** Jane Ely	Adequate					
									Fully implement the acute medical model on WHH & QEQM sites **Person Responsible:** Anil Verma **To be implemented by:** 05 Apr 2018	High	**09 Nov 2017** At present recruitment is still required in order to be able to implement these models	
									Recruitment to substantive medical posts to fill establishment **Person Responsible:** Anil Verma **To be implemented by:** 05 Apr 2018	High	**29 Nov 2017** Actively recruiting to posts focusing on overseas recruitment. The recruitment pipeline is updated weekly.	
									Implementation of the East Kent Clinical Strategy through the STP process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**17 Jan 2018** Consultation is likely to commence in the Spring of 2018.	
CRR 63	Failure to sustain services at the Kent & Canterbury Hospital site **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 15 Dec 2017 **Latest Review Date:** 17 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed with Jane Ely. No change in risk scores. The key mitigation for this risk is the implementation of the Clinical Strategy. The Medical Director and Chief Nurse carry out regular visits and walk rounds on the K&C site. The Communications Strategy is being implemented.	10 Nov 2017	**Cause** *Increased number of staff leaving the Trust and low staff morale following the transfer of acute medicine, geriatric medicine and stroke from the K&C site *There is only provision for Specialist Vascular and Urology surgery on the K&C site and for Surgeons to maintain core clinical competencies for general surgery they need to continue to see a breadth of patients with complex needs which is not currently the case at the K&C site *Inadequate compliance with standards for medical education and training for trainee Doctors **Effect** *Potential patient safety concerns *Reputational damage *Regulatory concerns *HEE and the GMC will deem training in a particular area or areas to be unsafe or inadequate and trainees will be removed	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Regular visits and walk rounds on the K&C site by the Medical Director and Chief Nurse **Control Owner:** Sally Smith	Adequate	I = 4 L = 4 High (16)	Implementation of the East Kent Clinical Strategy through the STP process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**18 Jan 2018** Consultation is likely to commence in the Spring of 2018.	I = 4 L = 2 Moderate (8)
						Robust Communications Strategy in place **Control Owner:** Natalie Yost	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 12	Inadequate Ophthalmology follow up arrangements **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Christine Hudson **Last Updated:** 09 Nov 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** Action plan to reduce the backlog has commenced implementation, see progress note under this action.	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. *Demand will continue to grow with treatment options for several diseases that were previous untreated, such as Wet Age related Macular Degeneration (wAMD), Diabetic Macular Oedema (DMO) and Retina Macular Oedema (RMO) **Effect** *There are 12,713 patients have been escalated as requiring an appointment that is overdue and require urgent follow-up within the specialty. Within these categories are glaucoma and medical retina patients who all carry a risk of either sight deterioration or loss *There is a lack of out-patient capacity to manage the backlog and maintain the current patient cohort. *Outpatient referrals above plan with patients waiting over 18 weeks for a first appointment	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	7 new consultant Ophthalmology posts have been recruited to **Control Owner:** Nicholas Goodger	Adequate	I = 4 L = 4 High (16)	Further investment (Phase 2 of Business case) to engage clinical staff **Person Responsible:** Christine Hudson **To be implemented by:** 29 Dec 2017	High	**29 Dec 2017** This action is being addressed under the Ophthalmology risk	I = 4 L = 2 Moderate (8)
						Open Eyes software has been introduced to facilitate ophthalmological patient flow and follow. **Control Owner:** Paul Stevens	Adequate		Review Phase 3 of business case and ensure this is still in line with current growth **Person Responsible:** Christine Hudson **To be implemented by:** 30 Jan 2018	High	**29 Dec 2017** Phase 3 will be applied for following SIG in January and the Business Plan submission due mid January 2018. Meantime an external company has been tendered to provide additional capacity	
						Ophthalmology transformation strategy in place **Control Owner:** Paul Stevens	Limited		Develop a plan to address the immediate concerns regarding length of waiting times for patients **Person Responsible:** Christine Hudson **To be implemented by:** 30 Mar 2018	High	**08 Jan 2018** 1. 10% transfer to community for stable Glaucoma patients, n = 571, as per CCG contract. 2. Reconfiguring job plans, patients likely to be dealt with through this = 1554 - on track to commence in January 2018 3. Additional weekend clinics up until January 2018 should enable a futher 821 people to be reviewed 4. Further weekend clinics Feb and March should enable approx. 547 peolpe to be seen. 5. Therapeutics, Diagnostics, Orthoptics, Contact lens, low vision action plan should enable a further 2354 to be seen by March 2018 and thereafter to sustain the position.	
									Now that ophthalmology recruitment has been implemented the division need to review their demand and capacity model to ensure that sufficient follow up capacity has been created **Person Responsible:** Christine Hudson **To be implemented by:** 30 Mar 2018	High	**29 Dec 2017** A review demand and Capacity is being reviewed as part of Business Planning and the impact of the external provider. The CCG community transfer of patients will also need to be included within Business planning	
									Agree a joint plan with the CCG to ensure the services and pathways required to transfer the agreed patient groups to the community, are in place and have the capacity necessary to deliver **Person Responsible:** Christine Hudson **To be implemented by:** 30 Mar 2018	High	**29 Dec 2017** CCG have implemented the WAMD pathways in the community for one provider, the other 3 are due to come on line in February 2018. Communications with the AO of the CCG, DCEO and DD are on going to ensure compliance with deadlines. Review in 3 months	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									Fully agreed and funded pathway with commissioners for follow up and treatment of all patients with ophthalmological conditions placing their eyesight at risk **Person Responsible:** Christine Hudson **To be implemented by:** 31 Mar 2018	High	**12 Dec 2017** The loss of the previous control which was the commissioners commissioning a community solution for follow up of these patients has brought this back to us as an action	
									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 Oct 2018	High	**10 Nov 2017** We are live on Cataract and Eye Casualty now, and just working on the next stage of medical retina. It will be another 12 months before completely going electronic. Implementation date changed to reflect this.	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 44	Failure to meet the Referral to Treatment (RTT) Standard for the Trust **Risk Owner:** Jane Ely **Delegated Risk Owner:** Christine Hudson **Last Updated:** 11 Oct 2017 **Latest Review Date:** 18 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change in risk scores. However, there remains concerns about performance against the 92% national access standard. The residual risk score is likely to increase subject to the outcome of discussions with the Delegated Risk Owner.	02 Feb 2017	**Cause** * Inability to provide enough activity to sustain waiting list sizes * Backlog rollover from previous years * Demand from CCG's higher than agreed BP * Inpatient activity (DC, inpatients) not meeting BP * Failure to access our own surgical remit for the usage of beds for surgical patients * Failure to complete job planning *Referral management mechanisms in CCGs have resulted in a higher conversion rate to Surgery *Failure to phase the seasonal plan in line with emergency demand *Continued Increase in Orthopaedic & General Surgery waiting list additions *Higher than planned demand within business plan resulting in no flexibility within capacity in key specialities such as Orthopaedics, Dermatology, Maxillo Facial and Gynaecology *Recruitment constraints in services such as Neurology an Dermatology, leading to long outpatient waits *General Surgery capacity for patients presenting with high BMI for benign disease (single handed surgeon) creating 52 week waits *Gynaecology capacity for named sub-specialty conditions resulting in 52 week waits *ENT surgical demand remains in excess of capacity in key subspecialties resulting in 52 week waits **Effect** *Poor patient outcomes *Financial loss due to outsourcing of activities to the independent sector) *Breach of licence (Contract Performance Notice) *Reputational damage *Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	A joint improvement plan is in place and supported by NHS Elect **Control Owner:** Christine Hudson	Limited	I = 4 L = 4 High (16)	Increase theatre utilisation to 50 weeks per year **Person Responsible:** Christine Hudson **To be implemented by:** 02 Apr 2018	High	**29 Dec 2017** Services are working towards a 50 week year, this has been implemented in Orthopaedics, Urology, and Ophthalmology. General Surgery, ENT and MFU are working towards this action via recruitment which should be in place by April 2018	I = 4 L = 2 Moderate (8)
						Action plans in key specialties to ensure improved performance **Control Owner:** Christine Hudson	Limited					
						Escalations of capacity for outpatients and theatres happen as required **Control Owner:** Christine Hudson	Limited					
						Focused management of undated pathways waiting over 30 weeks and risks to 52 weeks, particularly within General Surgery, ENT and Gynaecology **Control Owner:** Christine Hudson	Adequate					
						Improved Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots **Control Owner:** Christine Hudson	Limited					
						Recovery trajectory in place **Control Owner:** Christine Hudson	Limited					
						Saturday working in new consultants contracts across the trust to improve utilisation of theatre capacity and increase capacity **Control Owner:** Christine Hudson	Adequate					
						The new Interactive Patient Tracking Technology is in place which allows real time recording of patient pathways and supports the operational teams in delivery **Control Owner:** Christine Hudson	Limited					
						The Surgical Division continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations **Control Owner:** Christine Hudson	Limited					
CRR 53	Failure to deliver the CQUIN programme for 2017/18 **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 15 Nov 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk score remains static - await Q3 report.	18 Apr 2017	**Cause** *National schemes are very challenging *Communication of CQUINS inconsistent across Divisions *Lack of capacity and allocated resources to focus on the delivery of the CQUIN programme **Effect** Loss of income circa £1.6 million as of November 2017.	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Designated leads for each scheme **Control Owner:** Sally Smith	Adequate	I = 4 L = 4 High (16)	Produce and roll-out implementation plans for schemes **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2018	High	**09 Jan 2018** PLans in place being monitored.	I = 3 L = 2 Low (6)
						Monthly monitoring to ensure delivery of programme/no slippage **Control Owner:** Sally Smith	Limited					
						Two Programme Managers responsible for delivering programme **Control Owner:** Sally Smith	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 61	Failure to achieve the A&E Improvement Plan and evidence sustained improvements to the Emergency Care Pathway **Risk Owner:** Jane Ely **Delegated Risk Owner:** Lesley White **Last Updated:** 17 Jan 2018 **Latest Review Date:** 17 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change in risk scores but concerns about the winter pressure and severity of flu (added to causes). NHSE/I have commissioned Carnal Farrar to provide a PMO function for the Improvement Plan. NHSI has appointed an improvement Director for A&E who commenced in post this month. Two Hospital Directors are now in post on the QEQM and WHH sites. A Management Consultant has been appointed to focus on Discharge. Risk score will be reviewed again in one month.	18 Oct 2017	**Cause** *12 month delivery plan in place across east Kent. Concerns that there may be possible delays in delivery of the plan and that improvements may not be sustained due to: *Lack of ownership and engagement from Divisions *Conflicting priorities - operational pressures *Lack of appropriate bed base to support current capacity/ flow *Lack of capacity to deliver / implement and sustain change *Estate work delays *Inability to recruit to consultant and middle grade posts *Inability to resource the plan (finance) *Failure to engage external partners *Poor change management - inconsistent messages *Winter pressures and severity of flu **Effect** *Poor patient outcomes *Breach of licence (Contract Performance Notice) *Regulatory concerns *Reputational damage *Financial loss (circa £9.9m)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 4 L = 4 High (16)	A&E Delivery Board in place **Control Owner:** Jane Ely	Limited	I = 4 L = 4 High (16)	Produce and implement a robust demand and capacity escalation plan **Person Responsible:** Jane Ely **To be implemented by:** 28 Feb 2018	High	**17 Jan 2018** Robust demand and capacity escalation plan in place. Signed off at MB in November 2017. Identified ward based averages of daily discharges since June 2017 and applied stretch targets to enable the number of discharges to be achieved on a daily basis. These will be monitored as part of the Sentinel KPIs	I = 4 L = 3 Moderate (12)
						A&E Improvement Director in place to support the delivery of the A&E Improvement Plan **Control Owner:** Jane Ely	Adequate					
						Carnal Farrar commissioned to provide a PMO service to manage the delivery of the A&E Improvement Plan **Control Owner:** Jane Ely	Adequate		Recruitment of acute physicians and specialty doctors establishment **Person Responsible:** Anil Verma **To be implemented by:** 30 Mar 2018	High	**16 Nov 2017** Actively recruiting to posts focusing on overseas recruitment. The recruitment pipeline is updated weekly.	
						Delivery plan in place with clear milestones **Control Owner:** Jane Ely	Adequate					
						Integrated Assurance meetings in place **Control Owner:** Jane Ely	Limited		Determine the total cost of the A&E Improvement Plan and identify resources to meet the cost **Person Responsible:** Philip Cave **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** The Trust submitted a plan for £9.9m for A&E improvement in 2017/18. The Trust has received £1.5m and will therefore have a shortfall of £8.4m which will cause a financial over spend.	
						Interim Hospital Directors in place at WHH and QEQM to support a greater site focus **Control Owner:** Jane Ely	Limited					
						Monthly Executive Team project meetings **Control Owner:** Jane Ely	Adequate					
						Programme management documentation (including risk log) developed **Control Owner:** Sarah Maycock	Adequate					
						Programme Steering Group in place with sub-groups feeding into it **Control Owner:** Jane Ely	Adequate					
						Robust Communications Strategy in place **Control Owner:** Natalie Yost	Adequate					
						Single oversight meetings in place **Control Owner:** Jane Ely	Limited					
						Support from 2020 **Control Owner:** Jane Ely	Limited					
						Support from Management Consultant appointed to focus on Discharge **Control Owner:** Jane Ely	Adequate					
						Trajectory in place identified by scheme and the monitoring of metrics that have been identified by NHSI **Control Owner:** Jane Ely	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 60	Potential negative impact during transition from paper health records to T3 (Transformation Through Technology) **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Lindsey Shorter **Last Updated:** 15 Jan 2018 **Latest Review Date:** 15 Jan 2018 **Latest Review By:** Lindsey Shorter **Latest Review Comments:** Risk has been reviewed. No changes to scoring. Risk remains static as programme is still in mobilisation phase. Recruitment to the team is progressing well and governance structure is taking shape.	10 Oct 2017	**Cause** *New Trust-wide clinical transformation programme (T3 Programme) that introduces new technology to replace paper health records. This includes ePrescribing; functionality to record the management and treatment of patients; functionality to manage and document patient activity through theatres; Order Comms (requests and results for pathology etc.) and Clinical documentation. *Lack of engagement between supplier and clinicians *Supplier fails to understand clinical requirements *Lack of capacity of the Programme and operational teams *Resistance to change **Effect** *Sub-optimal system with potential gaps and/or loss of Patient information leading to: *Potential harm to Patients *Regulatory concerns *Reputational damage *Financial loss *Failure to realise benefits	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Clinical and Technical leads in place **Control Owner:** Lindsey Shorter	Adequate	I = 4 L = 4 High (16)	Recruit Programme team **Person Responsible:** Lindsey Shorter **To be implemented by:** 30 Mar 2018	High	**15 Jan 2018** Recruitment plan progressing. Additional posts identified and are included in the recruitment plan. Target date has been extended to 31/3/18 to reflect additional posts and allow for notice periods for new starters.	I = 4 L = 3 Moderate (12)
						Governance structure in place for the T3 Programme. **Control Owner:** Lindsey Shorter	Adequate					
						Programme Director in post leading the T3 Programme **Control Owner:** Andy Barker	Adequate		Agree final scope of the T3 Programme and phased plan. **Person Responsible:** Lindsey Shorter **To be implemented by:** 31 Mar 2018	High	**18 Jan 2018** New action added to the CRR in January 2018. First progress note required by February 2018.	
						Readiness of the Trust for the T3 Programme has been reviewed **Control Owner:** Richard Earland	Adequate					
						Resource plan agreed with IT Project Team **Control Owner:** Lindsey Shorter	Limited		Mobilise programme governance structure and workstreams **Person Responsible:** Lindsey Shorter **To be implemented by:** 31 Mar 2018	High	**15 Jan 2018** Currently engaging with clinical and corporate colleagues to agree roles and responsibilities as part of the governance structure to ensure service ownership.	

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 59	Potential delays in new and follow-up patient appointments **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 30 Nov 2017 **Latest Review Date:** 18 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change in risk scores. Data validation is required as regards the follow-up appointments and this is currently in progress. Report on progress will be made at the Executive Performance Review (EPR) in February 2018 and further updates made to the risk.	06 Sep 2017	**Cause** *Lack of out-patient clinic capacity to meet the increased referral and follow-up demands *Lack of visibility of the quantum of issues for specialties that do not have partial booking process for follow-up appointments **Effect** *Potential for patient harm *Failure to meet national performance standards *Regulatory concerns *Financial loss - contract performance notice/fines *Reputational loss	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	Outpatient Improvement Programme in place **Control Owner:** Mary Tunbridge	Limited	I = 4 L = 4 High (16)	Implement tiers of care for agreed specialties **Person Responsible:** Christine Hudson **To be implemented by:** 30 Nov 2017	High	**29 Dec 2017** There are not actions regarding Tiers of care in my Division with the exception of MSK pathway which has been agreed and signed off.	I = 4 L = 2 Moderate (8)
						Process in place for data validation **Control Owner:** Jane Ely	Adequate					
						Regular reporting of number of patients in each speciality that are waiting longer to be seen than the specialty milestone **Control Owner:** Jackie Tapp	Adequate		Divisions to use the follow-up framework to assess their follow-up gap **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Jan 2018	High	**04 Dec 2017** Through start of business planning for 18/19 each speciality has identified gaps in follow up capacity. Gynaecology is revisit its business case to recover activity and RTT performance. Paediatrics has a clear plan to recover activity plan and RTT performance. Dermatology plan is in progress to be completed by 14th December	
						Regular review of capacity and demand by specialty reported in performance meetings **Control Owner:** Jane Ely	Limited					
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Christine Hudson	Limited		Divisions to use the follow-up framework to assess their follow-up gap **Person Responsible:** Lesley White **To be implemented by:** 31 Jan 2018	High	**23 Oct 2017** This action is dependent on the action to develop and roll-out of a follow-up framework.	
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Trish Hubbard	Limited		Divisions to use the follow-up framework to assess their follow-up gap **Person Responsible:** Christine Hudson **To be implemented by:** 31 Jan 2018	High	**23 Oct 2017** This action is dependent on the action to develop and roll-out of a follow-up framework.	
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Lesley White	Limited		Senior review of current demand in each specialty, led by the Clinical Support Services Division and profiling of future demand with a trajectory to reduce the current backlog **Person Responsible:** Julia Bournes **To be implemented by:** 30 Mar 2018	High	**04 Dec 2017** This is being undertaken by specialties as part of business planning. The outpatient improvement programme is focusing on cancer 2WW capacity and follow up backlogs	
									Support the Specialties to improve and transform their outpatient pathways via the Outpatient Improvement Programme **Person Responsible:** Julia Bournes **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** The strategic events regards the strategic options for the Trust are being used to highlight the outpatient opportunities again. Monthly meetings are being held with specialties, however outpatient transformation is an ongoing process	
									Develop and roll-out a framework for quantifying and clinically prioritising and treating high risk patients across all Specialties **Person Responsible:** Julia Bournes **To be implemented by:** 30 Mar 2018	High	**29 Nov 2017** This action is ongoing, but proving difficult to achieve. It will not be closed by the deadline, but I will continue to provide updates.	

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									Develop a plan to ensure efficiencies in all clinics (for specialties that have implemented partial booking) **Person Responsible:** Jane Ely **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** This is closely linked to business planning but not yet mapped out for 2018/19. Meeting planned with the team to progress this.	

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 3	Inability to respond in a timely way to changing levels of demand for elective services **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 23 Jun 2017 **Latest Review Date:** 18 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change in risk scores. The Consultant job plans are progressing. So far 69% of the Consultant job plans have been signed off across the Trust. There may be a need to review the residual risk score following discussions with the Delegated Risk Owner.	05 Feb 2016	**Cause** * There is a increased and unplanned local demand for elective services that the Trust is unable to meet with the resources and infrastructure available. *Poor demand management. * Inability to recruit into Consultant and middle grade posts. *Lack of availability of Consultants due to sickness *Delays in information about Health/Screening campaigns *Backlog rollover from previous years *Demand from CCG's higher than agreed BP *No mechanism to sufficiently influence CCGs to improve pathways/tiers of care * Inpatient activity (DC, inpatients) not meeting BP * Failure to access our own surgical remit for the usage of beds for surgical patients/Emergency medical outliers in surgical beds *Failure to complete job planning *Referral management mechanisms in CCGs have resulted in a higher conversion rate to Surgery *Equipment failure leading to cancellations *Theatre unavailability **Effect** * Fail to meet RTT Standard * Harm to Patients * Breach of licence * Regulatory concerns * Reputational damage *Failure to retain STP Funding *Poor patient outcomes *Financial loss due to outsourcing of activities to the independent sector)	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Additional theatre lists in place **Control Owner:** Christine Hudson	Adequate	I = 4 L = 4 High (16)	Finalise remaining job plans **Person Responsible:** Anil Verma **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 50 out of 90 job plans completed (56%).	I = 3 L = 2 Low (6)
						Annual business plan in place **Control Owner:** Jane Ely	Adequate		Finalise remaining job plans **Person Responsible:** Nicholas Goodger **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 120 out of 158 job plans completed (76%).	
						Daily intensive review/bed matching in place for elective admissions **Control Owner:** Jane Ely	Adequate		Finalise remaining job plans. **Person Responsible:** Elhussein Rfidah **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 43 out of 76 job plans completed (57%).	
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Jane Ely	Adequate		Finalise remaining job plans **Person Responsible:** Anne Greenhalgh **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 48 out of 57 job plans completed (84%).	
						Detailed Q1 2017/18 planning in place to ensure outpatient and surgical capacity meets BP **Control Owner:** Jane Ely	Adequate		New Operational Plan (Business plan) to be agreed for 2018-2019 **Person Responsible:** Jane Ely **To be implemented by:** 29 Jun 2018	High	**17 Jan 2018** New action added in January 2018. Action Owner to provide first update by February 2018.	
						Each speciality supports dedicated validation time **Control Owner:** Christine Hudson	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					
						Escalations of capacity for outpatients and theatres happen as required **Control Owner:** Christine Hudson	Limited					
						Inpatient bed requirements for Surgical division completed **Control Owner:** Christine Hudson	Adequate					
						Numerical table of residual gap analysis in terms of capacity reported to Finance & Performance Committee **Control Owner:** Jane Ely	Adequate					
						Regular review of Performance for RTT where improvement plans have not delivered the required results **Control Owner:** Christine Hudson	Adequate					
						RTT - A joint improvement plan is in place and supported by NHS Elect **Control Owner:** Christine Hudson	Adequate					
						RTT - Recovery trajectory in place **Control Owner:** Christine Hudson	Limited					
						Support from the National Intensive Support Team (National team) - training and capacity planning (demand management for etc **Control Owner:** Christine Hudson	Limited					

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						The Surgical Division continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations **Control Owner:** Christine Hudson	Limited					
CRR 22	Failure to record/carry out timely Venous Thromboprophylaxis (VTE) risk assessments **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Gillian Evans **Last Updated:** 17 Oct 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** Performance in December dipped to 93.77% but performance in January to date is 95.06%	26 May 2016	**Cause** *Ineffective VTE risk assessment process - two step process that involves paper-based prescribing and electronically based VTE risk assessment **Effect** - Non-compliance with NICE CG92 - Non-compliance with NICE Quality Standard (QS3) VTE in adults - Harm to patients - Reputational damage - Increased Complaints - Legal Claims - Financial Loss (£7.2million potential contract penalty to EKHUFT for non-compliance) - Breach of licence (Contract Performance Notice)	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)	Review of divisional VTE assessment recording progress in EPR meetings monthly until 95%+ performance has been achieved and sustained for >4 months **Person Responsible:** Paul Stevens **To be implemented by:** 28 Feb 2018	High	**12 Dec 2017** The Trust has achieved VTE assessment recording of 95% for the last 2 months	I = 3 L = 2 Low (6)
						Email alert from VitalPAC for patients whose VTE assessment has not been completed has been introduced. **Control Owner:** Paul Stevens	Limited					
						No Patient is allowed to leave Clinical Decisions Units/A&E without VTE assessment **Control Owner:** Jonathan Purday	Limited		Produce and Implement Trust-wide VTE Action Plan 2017/18 **Person Responsible:** Gillian Evans **To be implemented by:** 30 Mar 2018	High	**16 Nov 2017** Progress to be added by the Action owner. Reminder sent.	
						No patient is allowed to leave the Theatre recovery area without VTE assessment being recorded **Control Owner:** Nicholas Goodger	Limited		Ensure e-Prescribing is compatible with the VTE electronic risk assessments and is confirmed in build **Person Responsible:** Chiara Hendry **To be implemented by:** 28 Sep 2018	High	**01 Dec 2017** 01/12/17 - WW (Director of Pharmacy) has requested follow up (with no response at time of writing) from contact at Trust using potential e- prescribing system. WW visiting site using e-prescribing and aware of need for VTE risk assessment or forcing function to be built into electronic prescribing system. CH requested VTE risk assessment included in build/contract or spec for e-prescribing in interim.	
						Trust-wide VTE Action Plan in place to ensure compliance (£7.2million potential contract penalty to EKHUFT for non-compliance) **Control Owner:** Chiara Hendry	Limited					
						VTE assessment recording data extracted from the VitalPAc system **Control Owner:** Paul Stevens	Adequate					

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CRR 19	Delays in the cancer pathway of over 100 days **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Trish Hubbard **Last Updated:** 09 Nov 2017 **Latest Review Date:** 12 Dec 2017 **Latest Review By:** Paul Stevens **Latest Review Comments:** There have been some improvements noted, particularly in the urology pathway with achievement of 2 week wait and 31 day treatment targets and an improvement in 62 day target to 65.3%	24 Apr 2016	**Cause** * Diagnostic delays predominantly in the colorectal and prostate cancer pathways (access to endoscopy and MRI diagnostics) * Lack of outpatient capacity * Lack of treatment capacity **Effect** * Possible harm to Patients * Reputational damage * Regulatory concerns *Loss of STF	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Cancer 62 day treatment recovery plan **Control Owner:** Trish Hubbard	Limited	I = 5 L = 3 High (15)	NHSI and Intensive Support Team joint review of the Urology PTL and MDM (including the prostrate pathway) **Person Responsible:** Trish Hubbard **To be implemented by:** 29 Dec 2017	High	**04 Dec 2017** Feedback report shared with Divisions and cancer action plans updated. Follow up visit from IST scheduled for 13th December to review progress and to undertake a piece of work demand and capacity with Radiology.	I = 5 L = 2 Moderate (10)
						Diagnostic capacity is reviewed at the KPI meeting and also within the Clinical Support Divisions **Control Owner:** Trish Hubbard	Limited					
						Increased endoscopy resource achieved through outsourcing using an agency contract which will run for 1 year whilst internal resource is being created **Control Owner:** Lisa Neal	Adequate		Achieve JAG accreditation of QEQM and K&CH sites **Person Responsible:** Lisa Neal **To be implemented by:** 29 Dec 2017	High	**15 Nov 2017** Application not yet made. The Architects have been to QEQM to review the Privacy and Dignity Standards in Recovery. Currently awaiting architects drawings.	
						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:** Nicholas Goodger **To be implemented by:** 31 Dec 2017	High	**13 Nov 2017** 2 surgeons have been accredited at QEQM and awaiting 2 to become accredited at WHH.	
						The pathway for the cancer of unknown primary is through the upper GI MDT with onward referral to the relevant MDT if the primary becomes known **Control Owner:** Trish Hubbard	Adequate		Implement cancer 62 treatment recovery plan **Person Responsible:** Trish Hubbard **To be implemented by:** 31 Mar 2018	High	**15 Dec 2017** Action added during the December 2017 risk review cycle. Progress required by January 2018.	
						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					
						WHH endoscopy unit JAG accredited **Control Owner:** Lisa Neal	Substantial					
CRR 57	Inadequate supply of essential drugs/vaccines **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Will Willson **Last Updated:** 10 Nov 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** During the past 2 months this risk has remained stable in terms of likelihood of occurrence but will need to remain unchanged for longer in order to assuredly reduce the likelihood score.	18 Aug 2017	**Cause** Supply shortages from manufacturers (examples of current shortages of Enoxaparin, Hepatitis B vaccine, Bacille Calmette-Guerin (BCG - TB vaccine) and Tazocin (antibiotics) **Effect** *Trust running out of drugs/vaccines at short notice *Potential harm to patients and staff *Patients in community on long term treatment unable to source supply from local pharmacies so coming into hospital for stock/as a result of treatment failure *Unavailability of vaccines to existing and new clinical staff in accordance with the DoH Green Book guidance. *Financial risk as off contract/alternatives can be significantly more expensive	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	Clinical Pharmacy in place **Control Owner:** Rebecca Morgan	Adequate	I = 5 L = 3 High (15)	**Person Responsible:** **To be implemented by:**			I = 4 L = 2 Moderate (8)
						National Pharmacy procurement arrangements in place **Control Owner:** Will Willson	Adequate					
						PGDs in place for Hep B vaccine change to new manufacturer **Control Owner:** Lorraine Crawley	Adequate					
						Pharmacy procurement process in place **Control Owner:** Heather McAdam	Adequate					
						Regular review and monitoring of effect of not providing BCG **Control Owner:** Lorraine Crawley	Adequate					
						The OH Service maintain a recall list of staff who require Hep B vaccine through the OH software **Control Owner:** Lorraine Crawley	Adequate					

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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:** 06 Sep 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** Implementation of the EWS plus lactate alerting should lead to an improved identification of patients benefiting from sepsis screening	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. *Financial loss - failure to achieve CQUIN payments.	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	A local rule base for coding for sepsis and severe sepsis **Control Owner:** Michelle Webb	Adequate	I = 5 L = 3 High (15)	Complete the linking of EWS scores >4 with blood lactate > 2 mmol/L to alert clinicians to sepsis screening **Person Responsible:** Paul Stevens **To be implemented by:** 28 Feb 2018	High	**08 Jan 2018** This linking is currently in the test system and should shortly go live	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					
						BEACHES course in place for HCA's **Control Owner:** Deborah Higgs	Limited		BEACHES course for HCA's to be rolled out. This is a nationally recognised course that improves HCA's understanding, recognition and response to deteriorating patient. **Person Responsible:** Deborah Higgs **To be implemented by:** 31 Dec 2018	High	**12 Dec 2017** Started in November. Half day. Was well received and evaluated. Dates in the diary for next year, 10 or 12 over the course of the year.	
						Clinical staff issued with aide-memoire on sepsis management and compliance tested using CEM audit and local audit **Control Owner:** Michelle Webb	Adequate					
						Deteriorating Patient Steering Group in place that brings together the various work streams (AKI, sepsis, recognition and escalation, NIV). **Control Owner:** Michelle Webb	Adequate					
						Documentation in all EDs revised to consistently record patients vital signs and blood test results **Control Owner:** Michelle Webb	Adequate					
						National Sepsis CQUINS in place **Control Owner:** Michelle Webb	Limited					
						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					
						Strengthened mandatory training and opportunities at induction to ensure all staff are aware of existing DOPs and local tools for screening and management of deteriorating patient, including sepsis. **Control Owner:** Michelle Webb	Adequate					
						Update of eCasCard to accurately flag patients requiring sepsis screening in the EDs **Control Owner:** Michelle Webb	Adequate					
						VitalPac in place in all inpatient adult areas (exception labour wards) allowing for electronic capture of observations and automatic calculation of early warning risk score. **Control Owner:** Michelle Webb	Adequate					

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CRR 10	Lack of preparedness for the new European Data Protection Rules **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Michael Doherty **Last Updated:** 07 Dec 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** Risk is currently unchanged	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 = 4 L = 4 High (16)	Appointment of IAO for records containing personal information (primarily staff) **Control Owner:** Sandra Le Blanc	Adequate	I = 4 L = 3 Moderate (12)	Internal Audit review of GDPR Preparedness **Person Responsible:** Michael Doherty **To be implemented by:** 30 Mar 2018	High	**09 Jan 2018** This is with the internal auditors, who are working on formulating an audit plan by the end of February.	I = 4 L = 1 Low (4)
						Appointment of Information Asset Owner IAO for all clinical systems including health records. **Control Owner:** Paul Stevens	Substantial		Comprehensive review of the IG function and succession planning arrangements to identify core gaps internally. **Person Responsible:** Paul Stevens **To be implemented by:** 31 Dec 2018	Medium	**12 Dec 2017** The action requires identification and training of potential medical director candidates	
						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					
						Information Governance strategy in place that includes compliance with the EU General Data Protection Regulation. **Control Owner:** Michael Doherty	Limited					
						The appointment of a Data Protection Officer for the purposes of the Regulation **Control Owner:** Michael Doherty	Adequate					
						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					

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CRR 56	Inadequate critical care capacity **Risk Owner:** Sally Smith **Delegated Risk Owner:** Christine Hudson **Last Updated:** 09 Oct 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk remains unchanged although being monitored and plans discussed.	02 Aug 2017	**Cause** *Significant growth in emergency demand nationally for critical care beds insufficient to meet acuity *More people surviving with comorbidities * Increased activity of the PPCI service in WHH - out of hospital cardiac arrests who require increased length of stay **Effect** *Potential harm to patients/patient safety concerns *Cancellations of elective surgery *Nursing patients outside the foot print of the Critical Care Unit, theatre recovery and ED *Increase in non-medical transfers between sites *Inability to recruit and retain medical and nursing staff *Delays in admitting patients *Financial loss - no funding if patients are not in a critical care beds *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	Admissions, Discharge and Transfer policy in place **Control Owner:** Deborah Higgs	Limited	I = 3 L = 4 Moderate (12)	Deliver on the clinical strategy to create two larger Units to meet population needs. **Person Responsible:** Deborah Higgs **To be implemented by:** 31 Mar 2019	High	**13 Dec 2017** Division is meeting with Liz Shutler to discuss.	I = 2 L = 3 Low (6)
						Movement of nursing staff across sites to support activity **Control Owner:** Deborah Higgs	Limited					
						The Critical Care Escalation plan (part of the Admission, Discharge and Transfer Policy) includes plans for a surge in demand for the 3 acute sites. **Control Owner:** Deborah Higgs	Limited					
						Utilise critical outreach team to care for patients outside of the critical care unit **Control Owner:** Deborah Higgs	Limited					
						Utilise skilled staff to ensure patient safety **Control Owner:** Deborah Higgs	Limited					
						Utilising extended recovery in a planned way for a period of 9 months. 5 key competencies will be developed to support recovery staff and both the ITU and theatre matrons will manage **Control Owner:** Jane Kirk-Smith	Adequate					
						Utilising extended recovery in a planned way for a period of 9 months. 5 key competencies will be developed to support recovery staff and both the ITU matron and theatre manager will manage **Control Owner:** Deirdre McFarlane	Adequate					
CRR 41	Failure to manage Patients with challenging behaviour (Dementia and other mental health challenges) **Risk Owner:** Sally Smith **Delegated Risk Owner:** Sally Hyde **Last Updated:** 06 Apr 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and update to be sought.	07 Nov 2016	**Cause** *Increased number of long-stay Patients/delayed discharge *National shortage of Mental Health Nurses **Effect** *Potential harm to Patients, Staff and Visitors	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Dementia friendly services, environment and specialist team **Control Owner:** Sally Smith	Adequate	I = 3 L = 4 Moderate (12)	Monitor compliance with the Smart tool usage through the Safeguarding & Dementia teams **Person Responsible:** Jane Christmas **To be implemented by:** 31 Oct 2017	High	**09 Jan 2018** No new concerns raised with staffing and support sourced with patients with challenging behaviour.	I = 3 L = 3 Moderate (9)
						Psychiatric Liaison services to the EDs at QEQM will be 24 hours per day as well as 7 days per week. At WHH and the MIU at K&C the service remains the same. **Control Owner:** Sally Smith	Adequate					
						Smart tool usage at Wards & Departments with Patients who display challenging behaviour **Control Owner:** Sally Hyde	Limited					
						Specialling Policy is in place **Control Owner:** Sally Smith	Adequate					
						Use of NHSP registered mental health nurses **Control Owner:** Sally Smith	Limited					
						Use of Safe Assist to maintain safety of Patients and Staff **Control Owner:** Fin Murray	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 48	Challenges in embedding a mature and developed Patient safety culture across Obstetrics and Maternity **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 11 Dec 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Transformation work continues.	07 Feb 2017	**Cause** *Reports from both the Royal College of Obstetrics and Gynaecology (RCOG) and the Local Supervisory Authority (LSA) identified gaps in regulatory compliance and also other areas for improvement in maternity services *Recurrent incident themes *Difficulty in gaining engagement among some teams *Delays in prioritising quality transformation and education work streams *Low mandatory training figures *Failure to comply with policies/procedures **Effect** *Poor patient outcomes (potential harm to both pregnant women in our care and neonates) *Increased complaints/claims *Regulatory concerns *Reputational damage *Adverse effect on staff professional development	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Contract monitoring is in place bi-monthly with the CCGs. This provides assurance and progress against the plans and dashboard. **Control Owner:** Sharon Curtis	Adequate	I = 4 L = 3 Moderate (12)	Produce and implement a transformation programme for Maternity which incorporates the outstanding actions from the existing action plans (including the RCOG Action Plan). **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Mar 2018	High	**09 Jan 2018** Delivery remainns on track.	I = 3 L = 2 Low (6)
						Maternity Services Patient Safety Plan is in place and being implemented and monitored by the Division and Executive and CCGs. **Control Owner:** Sharon Curtis	Adequate					
						Monthly performance meetings are in place as well as support meetings by the Executive Team. **Control Owner:** Sally Smith	Adequate		Ensure mandatory training is prioritised and staff undertake the required training **Person Responsible:** Trish Hubbard **To be implemented by:** 31 Mar 2018	High	**11 Dec 2017** Still achieving the Trust Standard.	
						Support in place from the Service Improvement Team, Dr Ciaran Crowe leading transformation and the Executive team. **Control Owner:** Sally Smith	Adequate					
						The RCOG and LSA Combined Action Plan in place **Control Owner:** Graham Ross	Limited					

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 55	Inadequate sharing of Patients healthcare records with Community Trusts **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 08 Aug 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed. Remains unchanged.	02 Aug 2017	**Cause** *EKHUFT patient healthcare records (entire hard copy) are being sent to various locations within Kent Community Health NHS Foundation Trust (KCHFT) and other providers of continuing care across Kent, at the point of discharge * Historical practice - transferring the actual healthcare record, rather than a copy of the relevant sections of the healthcare record and an electronic discharge notification (eDN), has been in place for decades *Data protection concerns regarding EKHUFT as remaining the data controller and medicines governance issues as the Community Trust use the prescription chart from EKHUFT **Effect** *Potential data protection breach - As the data controller of the HCR, the Trust would be responsible and liable for any breach of the Data Protection Act 1998; the role of KCHFT would only be as a data processor. The DPA draws a distinction between a 'data controller' and a 'data processor' in order to recognise that not all organisations involved in the processing of personal data have the same degree of responsibility. It is the data controller that must exercise control over the processing and carry data protection responsibility for it. *Potential delays in releasing healthcare records by KCHFT - resulting in delays in completion of adult safeguarding reviews and sending records to HM Coroners *Potential patient safety concerns - The use of EKHUFT prescription charts for the on-going administration of medication. This process again places the total liability with this Trust for any error with the medication. This practice also places the individual prescriber at risk for any prescribing error even if the error is made within a location under the responsibility of KCHFT. There are associated professional implications. *There is a financial impact associated with potential missed income as the coding information is only obtained from the eDN and may not contain a complete history for diagnoses and procedures performed. The clinical coding team are therefore reliant only on the eDN. *There is a second financial impact associated with the storage of the Healthcare Records generated by KCHFT. These are currently stored with in the EKHUFT Healthcare Records rather than by KCHFT. *Legal challenge *Reputational damage to the Trust	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 4 L = 4 High (16)	Electronic Discharge Notification (eDN) in place and two weeks' supply of drugs **Control Owner:** Helen Goodwin	Adequate	I = 4 L = 3 Moderate (12)	Agree action plan with KCHFT and implement proposed changes to the sharing process **Person Responsible:** Helen Goodwin **To be implemented by:** 31 Dec 2017	High	**17 Nov 2017** Meeting with KCHFT on 13/11/2017. Further revisions to the SOP approved. It was decided however, in view of the risks still being carried by this Trust, a more formal agreement will be required. This will require a MOU signed by both parties. No HCR will be shared with Westview or Westbrook House in future.	I = 4 L = 2 Moderate (8)
						Healthcare Records Standard Operating Procedures (SOPs) and Policy in place **Control Owner:** Helen Goodwin	Limited					
						Memorandum of Understanding in place with Community Trust **Control Owner:** Helen Goodwin	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 16	Poor complaints management **Risk Owner:** Sally Smith **Delegated Risk Owner:** Jane Christmas **Last Updated:** 11 Aug 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Achieved compliance this month.	24 Apr 2016	**Cause** -There is an increasing complexity in the scope and nature of concerns raised. - The processes in divisions and within the Patient Experience Team have resulted in delays across the whole pathway. - There is a gap in communication between the PET and the divisional governance teams. - The divisional teams do not receive timely notification of written complaints. - Staff shortages are impacting on the management of complaints. **Effect** - The ability of the Trust to respond to the agreed first response time frame and within the 30 days of receipt is not being met consistently. - The time-frame agreed with the complainant is often being met but the quality of the Trust's response is sometimes failing to meet expectation. - There are a number of returners and dissatisfaction - Reputational loss	AO1: Patients. Help patients take control of their own health	I = 3 L = 5 High (15)	Complaints team in place with staff based on the three main sites. **Control Owner:** Jane Christmas	Adequate	I = 3 L = 4 Moderate (12)	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 2018	Medium	**11 Dec 2017** Awaiting the start of clinical induction to include this aspect.	I = 3 L = 3 Moderate (9)
						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		Redeployment of the corporate staff to improve the support for Urgent care management. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Mar 2018	High	**09 Jan 2018** Compliance to the standard has improved.	
						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		Work with HR Systems to ensure training records are captured. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Mar 2018	Low	**11 Dec 2017** This will be captured as part of the induction process. Action will be closed once the training is set up within clinical induction.	
						The Trust responds to its legal and professional duty of candour **Control Owner:** Paul Stevens	Limited					
						Web-based complaints management system in place **Control Owner:** Jane Christmas	Adequate					
CRR 64	Inadequate provision of neurorehabilitation for patients with a tracheostomy **Risk Owner:** Paul Stevens **Delegated Risk Owner:** **Last Updated:** 12 Dec 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** This risk is unchanged	04 Dec 2017	**Cause** *There is no provision for level 2A acute neuro-rehabilitation beds across Kent, as the service commissioned is Level 2B. *Patients requiring tracheostomy care are admitted on Treble Ward, and occasionally other wards in the Trust, which means that they do not receive the level of neurorehabilitation their underlying condition dictates. Harvey Ward with the Specialist Team (i.e. Neuro-Rehabilitation Consultant and Lead Nurse) is not a Level 2A facility and therefore does not have either the capacity to oversee outliers and/or manage patients in the acute phase of their recovery. **Effect** *Delayed neurorehabilitation treatment *Potential poor outcomes for patients *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 4 L = 3 Moderate (12)	Major Trauma patients are repatriated by the "single point of contact" who is aware of the limits of care on Harvey Ward **Control Owner:** Deborah Higgs	Limited	I = 4 L = 3 Moderate (12)	To persuade Specialist Commissioning to commission a Level 2A neurorehabilitation service in East Kent **Person Responsible:** Paul Stevens **To be implemented by:** 31 Dec 2018	High	**12 Dec 2017** Currently even without tracheostomy patients the neurorehabilitation service provides level 2A care in roughly 50% of cases but in order to also provide tracheostomy care this level of service needs to be commissioned in order to provide the correct staffing	I = 4 L = 2 Moderate (8)
						Patients are admitted on Treble Ward **Control Owner:** Anil Verma	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 46	Delays in signing off and implementing Consultant job plans **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 15 Nov 2017 **Latest Review Date:** 03 Jan 2018 **Latest Review By:** Jonathan Purday **Latest Review Comments:** The change forms for the previous delayed job planning round are now finally being signed off. The new job planning policy for 2018 is just being finalised.	02 Feb 2017	**Cause** Complexity of job planning not well understood Original timetable was not realistic Competing demands **Effect** *Potential mismatch between capacity and demand. *Potential Poor Patient outcomes *Reputational damage *Financial loss (Circa £840k) *Negative impact on clinical engagement	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 4 High (16)	Diary card templates are available for doctors to use to help inform and populate their job plans **Control Owner:** Paul Stevens	Adequate	I = 4 L = 3 Moderate (12)	Review the job plan policy **Person Responsible:** Jonathan Purday **To be implemented by:** 28 Feb 2018	High	**08 Jan 2018** The job planning policy has been revised and has gone to LNC - we are hoping to re job plan everyone in the next 3 months	I = 3 L = 2 Low (6)
						Job planning policy in place **Control Owner:** Paul Stevens	Limited		Finalise remaining job plans **Person Responsible:** Anil Verma **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 50 out of 90 job plans completed (56%).	
						Job Plans in place **Control Owner:** Sandra Le Blanc	Limited		Finalise remaining job plans **Person Responsible:** Nicholas Goodger **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 120 out of 158 job plans completed (76%).	
									Finalise remaining job plans **Person Responsible:** Anne Greenhalgh **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 48 out of 57 job plans completed (84%).	
									Finalise remaining job plans **Person Responsible:** Elhussein Rfidah **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** 43 out of 76 job plans completed (57%).	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 20	Failure to send timely information to GPs on their patients who have had an outpatient appointment **Risk Owner:** Jane Ely **Delegated Risk Owner:** Mary Tunbridge **Last Updated:** 16 Oct 2017 **Latest Review Date:** 17 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change in risk scores.The Divisional GP Action Plans are progressing well with progress reported to EPR monthly. Last report in November 2017 as there was no EPR in December 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 * Patients ongoing care is delayed * Breach of licence (Contract Performance Notice) - financial penalty up to 10% of monthly income (circa £3.3m) * Reputational damage * Potential harm to Patients *Increased pressure on staff leading to low staff morale	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 3 L = 5 High (15)	Deep-dives carried out with corresponding action plans in place **Control Owner:** Mary Tunbridge	Adequate	I = 3 L = 4 Moderate (12)	Trust-wide Administrative review to ensure design of new roles to focus on patients pathway (including ensuring correspondence are delivered in a timely way) - part of CIP programme **Person Responsible:** Christine Hudson **To be implemented by:** 30 Mar 2018	High	**16 Nov 2017** Progress to be added by the Action owner. Reminder sent.	I = 3 L = 2 Low (6)
						Dual reporting in place **Control Owner:** Julia Bournes	Adequate		Implement Divisional GP Letter Action Plans **Person Responsible:** Elizabeth Mount **To be implemented by:** 30 Mar 2018	High	**16 Oct 2017** Progress reported at EPR monthly	
						Performance standards for response times agreed and monitored against the standards **Control Owner:** Mary Tunbridge	Adequate		Implement Divisional GP Letter Action Plans **Person Responsible:** Christine Hudson **To be implemented by:** 30 Mar 2018	High	**16 Oct 2017** Progress reported at EPR monthly	
						Process for Vacancy Panel approval in line with agreed priority in place **Control Owner:** Jane Ely	Adequate		Implement Divisional GP Letter Action Plans **Person Responsible:** Mark Dwyer **To be implemented by:** 30 Mar 2018	High	**16 Oct 2017** Progress reported at EPR monthly	
						Regular feedback from GPs highlighting concerns **Control Owner:** Mary Tunbridge	Adequate		Implement Divisional GP Letter Action Plans **Person Responsible:** Lesley White **To be implemented by:** 30 Mar 2018	High	**16 Oct 2017** Progress reported at EPR monthly	
						Typing of letters outsourced to an external provider with clear turnaround targets **Control Owner:** Mary Tunbridge	Adequate		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 Oct 2018	High	**17 Oct 2017** We are live on Cataract and Eye Casualty now, and just working on the next stage of medical retina. It will be another 12 months before completely going electronic. Implementation date changed to reflect this.	

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 34	Inadequate Health & Safety (H&S) systems embedded within the Divisions **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 15 Dec 2016 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. Risk remains static and a moderate risk to the Trust. Some progress has been made in embedding H&S across the Divisions. The Human Factors training is being rolled out with initial Train the Trainer sessions being held before it is rolled out Trust-wide	09 Sep 2016	**Cause** * Failure to address H&S issues/incidents/themes within Divisions * Lack of appropriate H&S systems *Inconsistency in H&S processes **Effect** *Potential breach of H&S regulations which may result in penalty notices and significant fines *Harm to Staff *Reputational damage *Financial loss *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Annual H&S Toolkit Audit **Control Owner:** Elizabeth Shutler	Adequate	I = 4 L = 3 Moderate (12)	Implement the recommendations from the H&S Internal Audit 2016/17 including; - Implementing the H&S Training Plan; - Implementing action plans from the H&S toolkit audit; and - Transferring Divisional H&S risks to 4Risk **Person Responsible:** Christine Hudson **To be implemented by:** 30 Mar 2018	High	**16 Nov 2017** Previous actions closed and merged into one in November 2017. 1st progress update due in December 2017.	I = 4 L = 2 Moderate (8)
						Divisional deep-dives presented to IAGC by the Divisions **Control Owner:** Elizabeth Shutler	Limited		Implement the recommendations from the H&S Internal Audit 2016/17 including; - Implementing the H&S Training Plan; - Implementing action plans from the H&S toolkit audit; and - Transferring Divisional H&S risks to 4Risk **Person Responsible:** Lesley White **To be implemented by:** 30 Mar 2018	High	**16 Nov 2017** Previous actions closed and merged into one in November 2017. 1st progress update due in December 2017.	
						Divisional H&S Improvement Trajectory in place **Control Owner:** Fin Murray	Limited		Implement the recommendations from the H&S Internal Audit 2016/17 including; - Implementing the H&S Training Plan; - Implementing action plans from the H&S toolkit audit; and - Transferring Divisional H&S risks to 4Risk **Person Responsible:** Mary Tunbridge **To be implemented by:** 30 Mar 2018	High	**16 Nov 2017** Previous actions closed and merged into one in November 2017. 1st progress update due in December 2017.	
						Divisional H&S structures in place **Control Owner:** Fin Murray	Adequate		Develop and Roll out Human Factors training for high-risk Clinical and Non-Clinical areas **Person Responsible:** Fin Murray **To be implemented by:** 30 Mar 2018	Medium	**08 Jan 2018** All members of the Strategic Health and Safety Committee and some Linked Workers will be involved in the next train the trainer session. Following which it will be rolled out Trustwide.	
						Divisional nominated H&S Link workers **Control Owner:** Fin Murray	Adequate		Implement the recommendations from the H&S Internal Audit 2016/17 including; - Implementing the H&S Training Plan; - Implementing action plans from the H&S toolkit audit; and - Transferring Divisional H&S risks to 4Risk **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Mar 2018	High	**04 Dec 2017** Divisional Away Day scheduled for January 12018 to focus on Health and Safety and H & S risks.	
						H&S KPIs reported to Board monthly via the IPR **Control Owner:** Fin Murray	Adequate					
						H&S module part of mandatory training for all staff **Control Owner:** Andrea Ashman	Adequate					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Lesley White	Limited					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Trish Hubbard	Adequate					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Christine Hudson	Limited					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Mary Tunbridge	Adequate					
						Oversight by Trust Board **Control Owner:** Elizabeth 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					
						Strategic H&S Committee in place **Control Owner:** Elizabeth Shutler	Adequate					
						Training programme in place **Control Owner:** Fin Murray	Adequate					

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Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 58	Failure to embed Risk Management within the Divisions **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 25 Oct 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Support to UC&LTCs in place. Risk score remains unchanged until actions embedded.	21 Aug 2017	**Cause** *The need for improved engagement from Divisions in the Trust Risk Management process; this is reflected in the failure to provide assurances on risks escalated to the Corporate Risk Register *Inconsistency in Risk Governance arrangements across Divisions *Ineffective risk management support structure at Divisional level *Poor usage of new risk system (4Risk) *Lack of knowledge of risk management *Absence of risk registers in some Wards, Specialties and Departments **Effect** *Failure to deliver the Trust Strategic Priorities (4Ps - Patients, Provision, People, Partnerships) *Potential patient safety concerns *Financial loss *Regulatory concerns (This risk also links to the revised NHS Improvement Leadership and Improvement Capability Themes (Well-Led) within the Single Oversight Framework (SOF) where risk management is now specifically expressed) *Reputational damage *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	4Risk face to face training completed for key staff **Control Owner:** Dorothy Otite	Adequate	I = 4 L = 3 Moderate (12)	Finalise and communicate the Trust Risk Leadership Behaviours **Person Responsible:** Dorothy Otite **To be implemented by:** 28 Feb 2018	Medium	**10 Jan 2018** The Trust Risk Manager facilitated a risk session with the Trust Board in September 2017 where each BoD recorded their individual opinion of the Risk Leadership Behaviours expected of leaders across the Trust. The output of the session has been used to produce the Draft Trust Risk Leadership Behaviours which underpins the Risk Management Strategy. This will be presented to the Trust Board for approval in February 2018.	I = 4 L = 1 Low (4)
						4Risk Training resources in place (training videos, guidance and help manuals) **Control Owner:** Dorothy Otite	Adequate					
						Annual Risk Management Refresher Training/Workshop for Divisional Leaders **Control Owner:** Dorothy Otite	Limited		Complete the Risk Management Refresher Training/Risk Workshop for Divisional Leaders for 2017/18 **Person Responsible:** Dorothy Otite **To be implemented by:** 28 Feb 2018	High	**10 Jan 2018** Risk Management Refresher Training/Risk Workshop will commence with the first Group of leaders - Specialist Services on 15 January. The session with UCLTC did not hold in December 2017 as planned and is now planned for February 2018.	
						Annual Risk Maturity Assessment in place **Control Owner:** Dorothy Otite	Adequate					
						Dedicated Risk Management resource in place for the Trust (at Corporate level) **Control Owner:** Helen Goodwin	Adequate					
						Divisional risk registers on the 4Risk system **Control Owner:** Dorothy Otite	Limited		Consider introducing the role of Divisional/Local Risk Champions in 2017/18 to support embedding Risk Management across Divisions **Person Responsible:** Dorothy Otite **To be implemented by:** 30 Mar 2018	High	**09 Jan 2018** Additional support in place for UC&LTCs.	
						Local Risk Registers on the 4Risk system **Control Owner:** Dorothy Otite	Limited					
						Quarterly risk review meetings with Divisional Risk Owners **Control Owner:** Dorothy Otite	Limited					
						Risk Management communicated to staff via various channels - including dedicated risk management page on Staff Zone, risk management blogs, bi-monthly 4Risk Drop-in sessions in QII Hubs at QE, WH and K&C **Control Owner:** Dorothy Otite	Adequate		Divisions to review their Risk Management Governance arrangements to ensure alignment with the Trust Risk Management Policy **Person Responsible:** Dorothy Otite **To be implemented by:** 30 Mar 2018	High	**10 Jan 2018** This will form part of the scope of the Internal Audit on Divisional Risk Management in 2017/18.	
						Risk Management Governance arrangements in place at Risk Group, EPR, Management Board, Strategic H&S Committee, Divisional Governance Board, IAGC and Board **Control Owner:** Helen Goodwin	Limited		Carry out and implement actions from Internal Audit review of Risk Management arrangements in Divisions **Person Responsible:** Dorothy Otite **To be implemented by:** 30 Mar 2018	High	**10 Jan 2018** This is linked to the Internal Audit on Divisional Risk Management which is planned for early 2018.	
						Risk Management Handbook in place that provides detailed guidance on the Trust Risk Management process **Control Owner:** Dorothy Otite	Adequate					
						Risk Management Strategy and Policy in place **Control Owner:** Dorothy Otite	Adequate		Complete transfer of all Local Risk Registers to 4Risk **Person Responsible:** Karina Greenan **To be implemented by:** 31 Mar 2018	High	**14 Nov 2017** 62% of local risk registers for UCLTC have been transferred to 4Risk.	

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									Complete transfer of all Local Risk Registers to 4Risk **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2018	High	**14 Nov 2017** 82% of local risk registers for CSSD have been transferred to 4Risk.	
									Complete transfer of all Local Risk Registers to 4Risk **Person Responsible:** Heather Munro **To be implemented by:** 31 Mar 2018	High	**12 Jan 2018** the surgical division is working across it remit to ensure risks are discussed, added and updated	
									Complete transfer of all Local Risk Registers to 4Risk **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2018	High	**14 Nov 2017** 57% of local risk registers for Specialist Services have been transferred to 4Risk.	
CRR 39	Delays in Radiological reporting **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Paul French **Last Updated:** 05 Sep 2017 **Latest Review Date:** 12 Jan 2018 **Latest Review By:** Paul French **Latest Review Comments:** Current position in CT is deteriorating due to difficulty is sourcing support and the impact of RIS problems at the beginning of December 17. Support is schedule to come on stream from w/c 15th January 2018 and FTC starts on 15th January at QEQM.	04 Oct 2016	**Cause** *Increased demand *Lack of reporting capacity - Radiologist and Reporting Radiographers *Problems with PACS and RIS *Lack of scan capacity *Gaps in workforce (including staff turn over within Consultant Radiologist team) **Effect** *Failing to consistently meet 2WW and 18 week pathway access standards *Delays in Patients diagnosis and start of treatment *Potential harm to Patients *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	A number of weekday and weekend consultants are in place; and substantive radiologist in place. **Control Owner:** Paul French	Limited	I = 4 L = 3 Moderate (12)	Source substantive and fixed term radiologist **Person Responsible:** Paul French **To be implemented by:** 31 Mar 2018	High	**12 Jan 2018** Three FTC appointed. One anticipated start 15.1.18	I = 2 L = 3 Low (6)
						Additional outsourcing of reports. Increased allocation to existing providers and engagement with another company. **Control Owner:** Paul French	Limited					
						Ca pathway and urgent referrals are prioritised by CT/ MRI, **Control Owner:** Paul French	Limited					
						Reporting of CT & MRI capacity. Review of activity against reporting. **Control Owner:** Paul French	Limited					
						Seeking full time locum radiologists . In the interim adhoc at weekends and weekday **Control Owner:** Paul French	Limited					

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CRR 47	Inability to prevent deterioration in the number of healthcare associated infection metrics **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Valerie Harmon **Last Updated:** 12 Dec 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** Legionella incident has been closed. Water Safety Group refreshed.	07 Feb 2017	**Cause** Lack of adherence to basic infection prevention control policies and procedures **Effect** * Increased exposure of Patients to Healthcare Associated Infections (HCAIs) such as MRSA, E.coli, C.difficile and Glycopeptide Resistant Enterococcus (GRE). *Potential hospital acquired water borne infection such as Legionella and Pseudomonas *Poor patient outcomes Increased hospital length of stay *Failure to meet targets *Financial loss - financial penalty *Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Back to basics campaign with a focus on hand hygiene rolled out **Control Owner:** Valerie Harmon	Adequate	I = 4 L = 3 Moderate (12)	Agree and implement an infection prevention and control action plan which encompasses reporting on indicators, mandatory training etc. **Person Responsible:** Valerie Harmon **To be implemented by:** 31 May 2018	High	**08 Jan 2018** Awaiting comments from CCG and NHSI - organising updates to the action plan to reflect recent implementations and will table at the appropriate meetings when addressed	I = 4 L = 2 Moderate (8)
						Dedicated Infection Prevention and Control Team (IP&CT) **Control Owner:** Paul Stevens	Adequate					
						Detailed annual programme of infection and prevention control in place **Control Owner:** Paul Stevens	Adequate					
						Environmental cleaning audits in place **Control Owner:** Valerie Harmon	Adequate					
						Infection prevention and control action plan in place which encompasses reporting on indicators, mandatory training etc. **Control Owner:** Valerie Harmon	Adequate					
						Water Safety Group terms of reference updated in line with the independent review recommendations and Health Technical Memorandum 04-01: Safe water in healthcare premises **Control Owner:** Finbarr Murray	Adequate					
CRR 7	Potential delayed treatment of vascular and urology 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:** 15 Aug 2017 **Latest Review Date:** 03 Jan 2018 **Latest Review By:** Jonathan Purday **Latest Review Comments:** There have been no new critical incidents related to this risk that I am aware of. This risk will only be fully mitigated by the clinical strategy.	10 Feb 2016	**Cause** There is only provision for specialist vascular and urology surgery on the Kent and Canterbury site. In the past general surgical intervention, when needed, was covered by vascular surgeons. With the introduction and further development of Specialist Medical Training (Calman Report) the ability of surgeons to be deemed competent to perform procedures outside their registered speciality has decreased. **Effect** Patients requiring acute general surgical intervention may require subsequent transfer to either the WHH or QEQMH after stabilisation. Some vascular surgeons do maintain core clinical competencies for general surgery but there is no acute general surgical rota at the K&CH site and this can result in delays to treatment.	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Change to SECAmb conveyance criteria to prevent patients with acute general surgical emergencies being conveyed to the K&CH site. These changes became live on the 9th May 2016. Further changes have occurred on 19th June 2017 when acute medical admissions are diverted to QE and WHH **Control Owner:** Paul Stevens	Adequate	I = 5 L = 2 Moderate (10)	Implementation of the East Kent Clinical Strategy through the Kent & Medway STP process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**18 Jan 2018** Consultation is likely to commence in the Spring of 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:** Nicholas Goodger	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					
						The Urgent Care centre has now become a sole Minor Injuries Unit **Control Owner:** Paul Stevens	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 30	Failure to implement the Accessible Information Standard **Risk Owner:** Sally Smith **Delegated Risk Owner:** Bruce Campion-Smith **Last Updated:** 12 Sep 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Correction - delivery of the actions by Dec 18.	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 * Potential financial penalty * Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 3 L = 4 Moderate (12)	Action plan in place with monthly monitoring at the meetings. **Control Owner:** Bruce Campion-Smith	Limited	I = 3 L = 3 Moderate (9)	Implement Accessible Information Standard Action Plan **Person Responsible:** Bruce Campion-Smith **To be implemented by:** 31 Dec 2018	High	**04 Dec 2017** Synertec Implementation for production of Trust wide patient letters in appropriate formats is unlikely to be completed before 31/12/18.	I = 3 L = 2 Low (6)
						Audit tool in place. **Control Owner:** Bruce Campion-Smith	Adequate					
						Diversity and Inclusion Steering Group in place. **Control Owner:** Bruce Campion-Smith	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 40	Lack of robust antenatal and new-born screening programmes **Risk Owner:** Sally Smith **Delegated Risk Owner:** Dee Davies **Last Updated:** 18 Dec 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Assurance received from the team that controls are effective with 99% of screening in several areas reported.	07 Nov 2016	**Cause** *Lack of the awareness in the importance of offering haemoglobinopathy screening, the timeframes involved and the need to meet national standards. *Lack of tracking through the pregnancy adequately, including checking blood test results. *Lack of adequate follow up plan for women who have consented to screening and not had the blood test taken. *Discrepancy between documentation in hand held record and electronic records. *Obstetric ultrasound capacity utilisation is currently >95% *Lack of robust fail safe for the FASP screening program *NIPE Poor tracking of neonatal health care records *NIPE suspected congenital dislocation of the hips, lack of awareness within the radiology of the two week pathway. *New born blood spot screening programme, poor understanding of the national requirements within the acute hospital setting in particular NICU and SCBU. *Poor administration/process management and monitoring *PACS and RIS have further impacted on the First trimester and Fetal anomaly screening programmes **Effect** *Non-compliance with National Standards (haemoglobinopathy; chromosomal abnormalities (Down's or Edwards'/Patau's syndromes); Congenital dislocation of the hip; NIPE (newborn physical examinations); newborn blood spot and TB screening) *Potential harm to unborn and new born babies *Delay in diagnosis of foetal abnormality *Legal challenge *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Antenatal Screening Steering Group in place for all stakeholders of the Screening Programme **Control Owner:** Rachael Chapman	Limited	I = 3 L = 3 Moderate (9)	Implement workforce and recruitment plans to address staffing shortfalls in imaging and retention of skilled ultra-sonographers **Person Responsible:** Carolyn Wilson **To be implemented by:** 31 Mar 2017	High	**10 Jan 2018** The new ultrasound recruits have still not commenced in post yet, this appears due to problems in the recruitment department. There are now only three new sonographers waiting to be put into post. Radiology is advertising/recruiting and for new sonographers. In the meantime some locum sonographers have been used, however, it is almost impossible to get locum sonographers who will scan obstetric patients. Another sonographer has left 22/12/17 and one other has handed in her notice to leave on the 1/3/18. Unable to offer good working conditions within East Kent due to the pressure of providing a timely service, this could help with retention of staff. Unable to offer flexible working or reduced hours of working due to the pressures and this results in sonographers leaving East Kent Hospitals University Trust.	I = 3 L = 2 Low (6)
						Electronic referral system for US scan in place **Control Owner:** Rachael Chapman	Adequate					
						Fail safe tracking system for the New born blood spots screening programme (National/Local database) **Control Owner:** Rachael Chapman	Limited					
						FASP - Daily review of demand, potential breaches and allocating appointments **Control Owner:** Vicki Fisk	Adequate					
						FASP - Escalation process in place to accommodate requests for first trimester scans when there is a late booking and to highlight women due to have scans within timelines **Control Owner:** Rachael Chapman	Limited					
						FASP - Fail safe tracking system for combined screening for chromosomal abnormalities (Down's or Edwards'/Patau's syndromes) **Control Owner:** Rachael Chapman	Limited		Review and update both the antenatal and postnatal screening guidelines incorporating new standards. **Person Responsible:** Rachael Chapman **To be implemented by:** 29 Dec 2017	High	**15 Jan 2018** Both guidelines are still in progress of being re written. Aiming for draft of each one to be completed by 31/01/2018	
						FASP - Monthly meetings held between Maternity and Ultrasound teams **Control Owner:** Rachael Chapman	Limited		Workforce and recruitment plans to address staffing and create resilience within the current service **Person Responsible:** Sharon Curtis **To be implemented by:** 31 Dec 2017	High	**11 Dec 2017** Recruitment in progress. 3 band 6 midwives recruited. 9 vacancies remaining.	
						FASP Tracking system commenced October 2017. **Control Owner:** Rachael Chapman	Limited		To submit final evidence to allow PHE to sign off QA inspection form 2014. **Person Responsible:** Rachael Chapman **To be implemented by:** 30 Jan 2018	Medium	**23 Jan 2018** PHE cancelled meeting for Monday 22nd January. PHE QA lead is drafting a letter to the Trust's CEO effectively closing the QA inspection from Sept 2014. Given that the a lot has changed in ANNB screening in the last 31/2 years the letter will also highlight recommendations for the Trust to prepare for the new inspection in October 2018.	
						IDSP/SCT - Community midwives keep a form of log book to check screening results within the recommended period. **Control Owner:** Rachael Chapman	Adequate					
						Mandatory training and education programmes is in place for midwives across the Trust. **Control Owner:** Rachael Chapman	Adequate					
						Maternity Information Task and Finish Group in place to review the Maternity Pathway **Control Owner:** Rachael Chapman	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						New born blood spot. Nominated midwives, MCAs and nurses have been trained as 'blood spot champions'. **Control Owner:** Rachael Chapman	Limited		Maternity Information Task and Finish Group to review the maternity pathway (including standardising the booking process) **Person Responsible:** Hannah Horne **To be implemented by:** 31 Mar 2019	High	**02 Oct 2017** 02/10/2017 - Electronic booking form used in test mode and sample data reviewed. PTL in development, aim to roll out electronic booking 1/11/2017 and from 1st Jan 2018 to go live with electronic system and no paper bookings will be accepted. Work continues with EKBI on product development	
						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					
						Nominated person appointed to oversee the NIPE screening program. **Control Owner:** Jeanett Salisbury	Adequate					
						Screening guidelines in place and available to staff on SharePoint, Antenatal, Post-natal, Infectious diseases etc. **Control Owner:** Rachael Chapman	Limited					
						Short term planning in place to increase obstetric ultrasound capacity by introducing one appointment only for the nuchal/dating scan. **Control Owner:** Paul French	Limited					
						Tracking of babies who require referral for abnormalities of the heart, eyes, hips and testes following NIPE screening **Control Owner:** Rachael Chapman	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 6	Ineffective Clinical Audit Programme (including National Audits, Audit of the implementation of NICE guidance, compliance of NCEPOD recommendations and key local audits) **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Robin Ufton **Last Updated:** 24 May 2017 **Latest Review Date:** 11 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Delegated Risk Owner. No change to risk scores. Audit plans are progressing well. Q2 progress report was presented to the Quality Committee on 3 January 2018. Overall Trust wide, 76% of the plan is on target for completion (1% increase from Q1).	09 Feb 2016	**Cause** * Lack of consistent participation in all areas of the national clinical audit programme * Limited audit of implementation of NICE guidance and compliance with NICE Quality Standards * Limited audit of compliance with NCEPOD recommendations * Inconsistent completion of divisional clinical audits **Effect** * The Trust is unclear of the areas where improvements are required * Loss of opportunities to learn from audits * Reduced standards of care	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 3 L = 4 Moderate (12)	Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Elhussein Rfidah	Limited	I = 3 L = 3 Moderate (9)	Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Anil Verma **To be implemented by:** 31 Mar 2018	High	**11 Jan 2018** Q2 progress has been reported to the Quality Committee on 3 January 2018. 71% of the plan is currently on target for completion 5% drop from Q1).	I = 2 L = 2 Low (4)
						Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Jonathan Purday	Limited		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Nicholas Goodger **To be implemented by:** 31 Mar 2018	High	**11 Jan 2018** Q2 progress has been reported to the Quality Committee on 3 January 2018. 76% of the plan is currently on target for completion (4% drop from Q1).	
						Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Nicholas Goodger	Limited		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Anne Greenhalgh **To be implemented by:** 31 Mar 2018	High	**11 Jan 2018** Q2 progress has been reported to the Quality Committee on 3 January 2018. 79% of the plan is currently on target for completion (6% improvement from Q1).	
						Division clinical audit programme for 2017 - 18 agreed **Control Owner:** Anne Greenhalgh	Limited		Divisional Governance Teams to ensure all Audits are implemented by the due date **Person Responsible:** Elhussein Rfidah **To be implemented by:** 31 Mar 2018	High	**11 Jan 2018** Q2 progress has been reported to the Quality Committee on 3 January 2018. 77% of the plan is currently on target for completion (7% improvement from Q1).	
						Quarterly review of progress against the Clinical Audit Programme **Control Owner:** Robin Ufton	Limited					
						Six key improvement areas agreed with Divisions **Control Owner:** Robin Ufton	Limited					
						There are other quality improvement programmes in place that are nationally, regionally and locally driven that support the Trust clinical audit activity e.g. Renal Registry Returns, National Diabetes Returns **Control Owner:** Paul Stevens	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 9	Inadequate Planned Preventative Maintenance of clinical equipment **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Julie Barton **Last Updated:** 18 May 2017 **Latest Review Date:** 07 Nov 2017 **Latest Review By:** Julie Barton **Latest Review Comments:** The management of the community respiratory equipment is progressing. All the site based equipment used within cardio respiratory has been installed. The focus of the EME service is to implement PPM for the community based equipment. The challenge for this work is facilitating effective pathways for the return, maintenance and management of this equipment.	22 Feb 2016	**Cause** * Lack of delivery of a servicing plan * Poor staff capacity to service equipment on a rolling basis * Lack of knowledge of equipment that need servicing **Effect** * Clinical equipment in direct Patient use will have passed their target date for PPM * Potential harm to Patients	AO3: Provision: Provide the services needed and do it well	I = 3 L = 4 Moderate (12)	All equipment previously managed by Estates are included in the PPM Programme **Control Owner:** David Attwell	Adequate	I = 3 L = 3 Moderate (9)	Ensure Community Respiratory Equipment owned by the Trust are included in the PPM Programme **Person Responsible:** David Attwell **To be implemented by:** 29 Dec 2017	Medium	**10 Nov 2017** The management of the community respiratory equipment is progressing. The focus of the EME service is to implement PPM for the community based equipment. The challenge for this work is facilitating effective pathways for the return, maintenance and management of this equipment.	I = 2 L = 2 Low (4)
						Each major site has access to an equipment library where items are cleaned and checked before re-use **Control Owner:** Paul Stevens	Adequate					
						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		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:** 29 Dec 2017	High	**10 Nov 2017** The vacancies within EME are not yet fully recruited. This is due to vacancies within the wider team, but also delays in consultation with staff at risk. The schedule to complete the consultation is the end of December 2017. The remaining vacancies are all in the active recruitment phase. There is confidence within the service that the vacancies will be successfully filled.	
						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					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 18	Failure to comply with the recommendations in the Mazar's report which include case note review of each and every patient death **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 12 Dec 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** Business case for consultant time and administrative support has been prepared and will be submitted through the Trust business case approval process	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 = 3 Moderate (9)	Submit business case for approval through the Trust's business case approval process **Person Responsible:** Paul Stevens **To be implemented by:** 31 Mar 2018	High	**18 Jan 2018** Business case for consultant time and administrative support has been prepared and will be submitted through the Trust business case approval process	I = 3 L = 2 Low (6)
						Established programme of Mortality and Morbidity meetings across all specialties **Control Owner:** Paul Stevens	Adequate					
						Learning from avoidable deaths policy in place **Control Owner:** Paul Stevens	Adequate					
						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	Adequate					
						Training programme for clinicians undertaking reviews will commence in early 2018 **Control Owner:** Paul Stevens	Adequate					
CRR 8	Lack of timely mental health interventions for Patients with mental health problems **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 13 Jun 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and updated.	22 Feb 2016	**Cause** *They are unable to recruit into their current vacancies and they have relied on agency cover to maintain their rotas. *There is a national shortage of in-patient mental health beds. **Effect** *Patients with recognised mental health disorders may not be treated in a timely way. *There are an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. *Other patients and staff are put at risk of harm from violent episodes. *Patients who require in-patient mental health care are managed in acute facilities which are not fit for this purpose.	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	Agency RMN used **Control Owner:** Jane Ely	Adequate	I = 3 L = 3 Moderate (9)	Seek CQC registration for the care of mental health patients in the ED. **Person Responsible:** Alison Fox **To be implemented by:** 30 Apr 2018	Low	**08 Jan 2018** This requirement is linked to Emergency Department plans and link to the move to 24/7 cover. The requirement to register this with the CQC will be revisiting in April 2018.	I = 3 L = 2 Low (6)
						Agreed SOP in place to order additional nursing staff when a mental health patient has attended or is admitted. RMN, then RN, the HCA if the others are not available. **Control Owner:** Sally Smith	Adequate		Plans being formulated to ensure 24 hour cover across the Trust by 2020. Mental Health Commissioner locally is leading the commissioning intentions up to this date. **Person Responsible:** Jane Ely **To be implemented by:** 31 Mar 2020	Medium	**17 Jan 2018** 24 hour Psychiatric Liaison cover commenced at QEQM on 20th November. The COO receives daily reports and there are reduced numbers at QEQM. Plans for WHH have not yet been shared - but we are agreeing business case content that we can support.	
						Increase in cover arrangements for a 12 hour period across all 3 sites in place **Control Owner:** Jane Ely	Adequate					
						Nominated consultant psychiatric cover for each site with Band 7 RMN and 5xBand 6 support to cover 08.00 to 20.00 hours. **Control Owner:** Jane Ely	Adequate					
						Regular escalation and meetings between the Trust COO and the COO of KMPT and the CCGs is in place. **Control Owner:** Jane Ely	Adequate					
						Single point of access for referrals for emergency and urgent patients from 01 April 2016 with a separate crisis team covering this area. Arrangements for other patients, including self-referrals and existing patients set up through GPs and NHS111. **Control Owner:** Jane Ely	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 13	Inability to fund an adequate asset replacement programme for high cost and high risk medical equipment approaching the end of their asset life **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 18 May 2017 **Latest Review Date:** 10 Nov 2017 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. This risk remains static. The outstanding action regarding staffing is progressing. The vacancies within EME are not yet fully recruited. This is due to vacancies within the wider team, but also delays in consultation with staff at risk. The schedule to complete the consultation is the end of December 2017. The remaining vacancies are all in the active recruitment phase. There is confidence within the service that the vacancies will be successfully filled.	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:** 29 Dec 2017	High	**07 Nov 2017** The vacancies within EME are not yet fully recruited. This is due to vacancies within the wider team, but also delays in consultation with staff at risk. The schedule to complete the consultation is the end of December 2017. The remaining vacancies are all in the active recruitment phase. There is confidence within the service that the vacancies will be successfully filled.	I = 3 L = 2 Low (6)
						Prioritised list of replacement equipment for 2017/18 in place **Control Owner:** Sarah Charman	Adequate					
						Risk based approach to re-prioritising the capital programme in place **Control Owner:** Elizabeth Shutler	Adequate					
						The Medical Devices Group prioritises the replacement programme using a risk-based model outlined in the Medical Devices Policy. **Control Owner:** Elizabeth Shutler	Adequate					
						The Planned Preventive Maintenance Programme identifies and manages equipment used in the care of patients **Control Owner:** Julie Barton	Adequate					
						There is an annual capital allocation, under the auspices of the Medical Devices Group that make decisions on the priorities for purchase and replacement. **Control Owner:** Fin Murray	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 36	Inadequate Adult Safeguarding training arrangements Trust-wide **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 10 May 2017 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed. Being monitored monthly.	09 Sep 2016	**Cause** *Lack of access to current training data *Failure to prioritise training attendance **Effect** *Regulatory concerns *Legal challenge *Reputational loss	AO2: People: Identify, recruit and develop talented staff	I = 3 L = 4 Moderate (12)	Adult Safeguarding training delivered by e-Learning with face to face training every 3 years at level 2 **Control Owner:** Helen Goodwin	Adequate	I = 3 L = 3 Moderate (9)	HR systems to check training record database matches training needs analysis that has been reviewed. **Person Responsible:** Fiona Hammond **To be implemented by:** 31 Jan 2018	High	**29 Dec 2017** Since September 2016, ESR (training record database) has the training needs required for level 1 and 2 Safeguarding Adult recorded against each individual's record. The TNA was provided by the Safeguarding Adult team. Compliance has been reported at Division level since this date, along with an individual employee report. Although the TNA in ESR has the requirement for other staff groups it was initially requested that the compliance report be produced based on staff within the Nursing & Midwifery staff group only. On 4th December 2017 I met with Emma Kelly, Quality Improvement Programme Manager who requested a change to the compliance report following her discussion with Sally Hyde, Head of Adult Safeguarding. It was agreed to include all staff groups required by the TNA, Nursing & Midwifery including Theatre Practitioners, Medical & Dental staff, and all staff in the Allied Health Professionals staff group. The compliance report was re-produced with the amendments, and in addition a breakdown between level 2 classroom based training and level 2 e-learning updates as produced as requested. It has been agreed to provide the compliance report, and individual employee report in the revised format going forward.	I = 3 L = 2 Low (6)
						Monthly training sessions on all sites **Control Owner:** Helen Goodwin	Limited					
						Safeguarding Team in place **Control Owner:** Sally Smith	Adequate					
						Training needs analysis and Training Programme in place. Training support provided using QIIHubs **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:** Elisa Steele **To be implemented by:** 31 Mar 2018	High	**09 Oct 2017** Divisional mandatory training is at 85% in August.	
									Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Heather Munro **To be implemented by:** 31 Mar 2018	High	**12 Jan 2018** discussed at CQC surgical exception meeting. discussed the fact that sessions being cancelled for mid Feb in early Jan when staff had booked them many month ahead. waiting for Dec data and will be included in the Jan BB for the surgical division	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2018	High	**09 Oct 2017** August mandatory training stats at 92%.	
									Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2018	High	**09 Oct 2017** August mandatory training 82%. Adult safeguarding improved by 11% in month.	

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 31	Exposure to Cyber Security Attacks **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Robert Nelson **Last Updated:** 08 Jun 2017 **Latest Review Date:** 18 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Delegated Risk Owner. The risk remains static. Progress continues to be made in ensuring this risk remains under control. The cyber essentials assessment and accreditation which will provide independent assurance for this risk is still in progress. We are aiming to be one of the first Trusts to achieve compliance by the end of 2017/18.	12 Aug 2016	**Cause** * External hacking *Staff non-compliance with internal processes * Unpatched or unsupported operating systems **Effect** * Loss to Trusts systems confidentiality and availability * Reputational damage * Potential financial and legislative penalties * Financial loss	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Application Delivery Controllers with application firewall are in place **Control Owner:** Mark Williams	Adequate	I = 4 L = 2 Moderate (8)	SIG to review Medical Device exposure to potential cyber threats with a view to producing a plan to address it **Person Responsible:** David Attwell **To be implemented by:** 30 Mar 2018	High	**13 Dec 2017** Good progress has been made to mitigate Trust's exposure to Cyber -attack. This includes firewalling, predominantly, radiology equipment. SIG has provided funding and the Medical Devices Team is working through a prioritised plan that deals with the most significant risks and also areas were inexpensive and easily implemented solutions provide good cost-benefit outcomes.	I = 3 L = 1 Very Low (3)
						Automatic patching is in place **Control Owner:** Sue Lang	Adequate					
						Home and Mobile working processes in place **Control Owner:** Robert Nelson	Adequate					
						Incident management in place for reporting on cyber incidents **Control Owner:** Robert Nelson	Adequate					
						Information risk management regime in place **Control Owner:** Robert Nelson	Adequate		Complete the assessment for Cyber Essentials Plus Accreditation **Person Responsible:** Mark Williams **To be implemented by:** 31 Mar 2018	High	**13 Dec 2017** Assessment is underway. We are aiming to be one of the first trusts to achieve compliance, we have engaged and are already working with our assessor currently and it is looking positive so far. We are aiming to achieve full compliance this financial year. We are working with the assessor to complete accreditation for Cyber Essentials by 31.03.18.	
						Information Sharing Agreements (ISAs) in place with some third parties for access to Trust information **Control Owner:** Michael Doherty	Adequate					
						IT Technical Security Assurance Group in Place **Control Owner:** Mark Williams	Adequate					
						Known SSSP documents have been moved to the electronic system **Control Owner:** Mark Williams	Adequate					
						Malware prevention in place **Control Owner:** Robert Nelson	Adequate					
						Management of user privileges in place **Control Owner:** Robert Nelson	Adequate					
						Migration of medical devices secure network overlay complete and in place **Control Owner:** David Attwell	Limited					
						Network Security in place (e.g. Boundaries, firewalls and internet gateways) **Control Owner:** Robert Nelson	Adequate					
						New network monitoring in place **Control Owner:** Mark Williams	Adequate					
						Ongoing monitoring in place taking into account previous security incidents and attacks and other factors **Control Owner:** Robert Nelson	Limited					
						Regular audits of electronic access to systems **Control Owner:** Michael Doherty	Adequate					
						Removable media controls in place **Control Owner:** Robert Nelson	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Secure configuration in place for IT systems **Control Owner:** Mark Williams	Adequate					
						Testing of the Disaster Recovery processes in place/complete **Control Owner:** Mark Williams	Adequate					
						User education and awareness in place for Staff **Control Owner:** Michael Doherty	Adequate					
CRR 62	Failure to comply with standards for medical education and training in particular areas **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Bandipalyam Prathibha **Last Updated:** 17 Nov 2017 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** Actions from HEKSS visits are being steadily implemented; some are dependent on recruitment and some on clinical strategy implementation	09 Nov 2017	**Cause** Poor performance in any/all of the following GMC domains for standards of education and training: *Inadequate learning environment and culture *Poor governance and leadership *Inadequate educational and pastoral support *Failure to support educators to meet their education and training responsibilities *Failure to develop and implement curricula and assessments to enable trainees achieve the learning outcomes required by their curriculum **Effect** HEE and the GMC will deem training in a particular area or areas to be unsafe or inadequate and trainees will be removed	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 4 High (16)	Additional workforce in place to help with workload, including new roles. **Control Owner:** Bandipalyam Prathibha	Adequate	I = 4 L = 2 Moderate (8)	Roll-out of FROST (Foundation Realistic On Call Simulation) course for FI Trainees **Person Responsible:** Bandipalyam Prathibha **To be implemented by:** 30 Mar 2018	High	**17 Nov 2017** FROST has recently been introduced for F1 Trainees. Roll-out is in progress and on-going.	I = 4 L = 1 Low (4)
						Business partnering model has been introduced with Medical Education BPs working closely with divisions. **Control Owner:** Bandipalyam Prathibha	Limited		Sign off the completed HEKSS action plan from the May 2017 visit **Person Responsible:** Bandipalyam Prathibha **To be implemented by:** 30 Mar 2018	High	**08 Jan 2018** This has been partially signed off by HEKSS but there are additional actions that need to be completed.	
						Introduction of 'Clinical Training week' as part of the medical rota at QE and WHH **Control Owner:** Bandipalyam Prathibha	Adequate					
						Investment in Simulation to enhance training **Control Owner:** Bandipalyam Prathibha	Limited					
						Regular feedback from trainees in high risk areas (Medicine at QE and WHH, Anaesthetics, Urology, Vascular and Foundation at K&C) **Control Owner:** Bandipalyam Prathibha	Adequate					
						Review of all medical education and training including the GMC training survey results quarterly through the Local Academic Board meetings **Control Owner:** Bandipalyam Prathibha	Adequate					
						Revised education governance structure in place for medicine **Control Owner:** Bandipalyam Prathibha	Adequate					
						Revised training programme in place in K&C for all trainees (following move of trainees in medicine from the K&C site) **Control Owner:** Bandipalyam Prathibha	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 37	Potential negative impact of PAS system implementation on 18 weeks Referral to Treatment (RTT) **Risk Owner:** Jane Ely **Delegated Risk Owner:** **Last Updated:** 15 Nov 2017 **Latest Review Date:** 17 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Jane Ely. No change to risk scores. Further testing is being done to ensure outpatients information migrates over. Existing controls will be reviewed ahead of the new go live date.	04 Oct 2016	**Cause** *Potential reduction of clinics for outpatients for a three week period *Inability to accurately record timeliness from referral to treatment **Effect** *Potential harm to Patients *Reputational damage *Financial loss (circa £200k) *Regulatory concerns (linked to Trust License)	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Detailed Information Database linking back to demand and capacity model that quantifies activity and the plans to bring the activity forward and any alternative provision if unable to do so **Control Owner:** Julia Bournes	Adequate	I = 4 L = 2 Moderate (8)	Review existing controls in light of the new PAS Implementation date. **Person Responsible:** Jane Ely **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** Further testing is being done to ensure outpatients information migrates over. Existing controls will be reviewed ahead of go live date .	I = 4 L = 2 Moderate (8)
						Lessons learned/Advise received from other Trusts that have implemented PAS **Control Owner:** Julia Bournes	Adequate		Ensure plans are reviewed at Speciality level to accommodate extended clinics instead of reducing them **Person Responsible:** Trish Hubbard **To be implemented by:** 30 Mar 2018	High	**04 Dec 2017** Close management of annual leave through the start of April 2018 will be undertaken to understand levels of activity expected to run vs what is required to be delivered through the plan.	
									Implementation of Staff Training plan to ensure no disruption in activities during go-live period **Person Responsible:** Debbie Lowes **To be implemented by:** 31 May 2018	High	**08 Jan 2018** Ops group overseeing progress on training and other operational impacts.	

Highest Mitigated Strategic Risks Report

Report Date	26 Jan 2018
Comparison Date	Between 01 Dec 2017 and 26 Jan 2018

Highest Mitigated Strategic Risks Report

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score

Highest Mitigated Strategic Risks Report

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 5	Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime **Risk Owner:** Philip Cave **Delegated Risk Owner:** Baines **Last Updated:** 15 Dec 2017 **Latest Review Date:** 16 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Phil Cave. No change to risk scores. The Financial Recovery Plan is in progress. The Trust is on plan year to date at month 9 by £0.1m and has notified NHSI that due to A&E and Winter pressures the Trust is likely to exceed the plan by circa £10m.	20 Jan 2016	**Cause** Due to: * Failure to reduce the run rate * Poor planning * Poor recurrent CIP delivery (See Risk Ref. 1037) * Inability to collect income due * Poor cash management * Operational pressures relating to Emergency Care, High Agency usage *Failure to deliver RTT, A&E and cancer targets (See CRR 28) * Political climate (Brexit) and price inflation *Inability to deliver the planned levels of activity and collect the planned levels of income *Workforce pressures including inability to recruit (See SRR 9) *Lack of capability and Capacity of Finance and PSO staff *Lack of capacity and capability to deliver operational and financial performance (See SRR 12) *Inability to secure external support for key projects *Demand from CCG's higher or lower than annual plan *Failure to secure all the contractual income due from commissioners (See Risk Ref. 101) *Failure to deliver the CQUIN programme (See CRR 53) *Financial Special Measures governance not embedded *Additional costs of reconfiguring services across sites due to temporary move of acute medicine, acute geriatric medicine and Stroke from the K&C site(See CRR 51) *Negative impact of the new PAS and EMR implementation (See CRR 37) *Inability to resource the Trust's A&E improvement plan (estimated at £9.5 million) **Effect** Resulting in * Potential breaches to the Trust's Monitor licence * Adverse impact on the Trust's ability to deliver all of its services * Impact on ability to deliver the longer term clinical strategy * Poor reputation * Impact on organisational form	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	Cash Committee in place **Control Owner:** Philip Cave	Substantial	I = 5 L = 4 Extreme (20)	Develop the Cost Improvement Plan for 2018/19 **Person Responsible:** Philip Cave **To be implemented by:** 31 Jan 2018	High	**16 Jan 2018** The Trust has identified £20.7m of 18/19 CIPS (PID, QIA and goal, method outcome). Further CIPS are being reviewed as part of the Strategy week.	I = 5 L = 2 Moderate (10)
						Clinical engagement in delivery of CIPs requiring Clinical Practice changes **Control Owner:** Paul Stevens	Limited					
						Cost Improvement Plan targets in place with workstream in support **Control Owner:** Philip Cave	Adequate		External support from PwC on readiness to exit FSM and review internal financial controls **Person Responsible:** Philip Cave **To be implemented by:** 06 Feb 2018	High	**16 Jan 2018** Scope agreed and field work started week commencing 15 January 2018.	
						Financial Improvement Committee in place **Control Owner:** Philip Cave	Adequate					
						Financial Improvement Director in place to provide support **Control Owner:** Susan Acott	Substantial		Design and implement training for clinicians **Person Responsible:** Elisa Llewellyn **To be implemented by:** 30 Mar 2018	Medium	**16 Nov 2017** Roll-out in progress over the next six months. Implementation date revised to end March 2018.	
						Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Philip Cave	Adequate					
						Financial Recovery Plan in place **Control Owner:** Philip Cave	Substantial		Deliver the Financial Recovery Plan **Person Responsible:** Philip Cave **To be implemented by:** 31 Mar 2018	High	**16 Jan 2018** The Financial Recovery Plan is in progress. On plan year to date at month 9 by £0.1m and CIP behind plan by £0.2m. Detailed progress reviewed at FIOG, FIC, FPC, EMT, MB, EPRs, Board and with NHSI.	
						Fortnightly confirm and challenge meetings with the Divisions (including Corporate) **Control Owner:** Philip Cave	Adequate					
						Monthly Financial Special Measures (FSM) review meetings with NHSI **Control Owner:** Philip Cave	Substantial		Ensure that the development of the Trust's clinical strategy, "Delivering Our Future" and that of the wider Kent & Medway STP, drive financial improvement and recovery in the Trust through to 2020/21. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**08 Jan 2018** Consultation is likely to commence in the Spring of 2018.	
						New approach to developing CIPs in place **Control Owner:** Philip Cave	Substantial					
						Payment by results infrastructure (coding and data quality) **Control Owner:** Philip Cave	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:** Philip Cave **To be implemented by:** 31 Jul 2018	High	**16 Jan 2018** The revised EY/Plum proposal has been presented to EMT in 20 December 2017; 31 January 2018 to Management Board with a view to commencing the programme in the Spring of 2018.	
						Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Philip Cave	Adequate					
						Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Philip Cave	Adequate					
						Programme Support Office (PSO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Philip Cave	Adequate					

Highest Mitigated Strategic Risks Report

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Regular reporting on the Trust's Financial position to the Trust Board and senior management team (including ensuring the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood). **Control Owner:** Philip Cave	Adequate					
						Robust plans in place for the delivery of operational performance targets **Control Owner:** Jane Ely	Limited					
						Signed MoU in place that provides greater clarity on specific areas of agreement which were previously disputed **Control Owner:** Philip Cave	Adequate					
						Vacancy Control Panel in place **Control Owner:** Susan Acott	Adequate					
						Workforce and Agency Control Group in place **Control Owner:** Sandra Le Blanc	Adequate					

Highest Mitigated Strategic Risks Report

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 2	Failure to maintain the quality and standards of patient care **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 09 Jan 2018 **Latest Review Date:** 09 Jan 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk score has increased due to additional pressure in the system. The controls have been evaluated. A change to the assurance level of the Quality Strategy has been made in light of the increased complexity of this risk.	20 Jan 2016	**Cause** *The Trust recently came out of Quality Special Measures and needs to ensure the momentum for the improvement journey is sustained. * The withdrawal of the junior doctors in medicine from the K&C site and the level of uncertainty about where services will be delivered has added operational pressure across the Trust, in particular the WHH & QEQM sites. **Effect** - Loss of autonomy; - Impact on staff morale; - Increased operational pressure on the two acute sites; - Staff health and well being issues; - Staff retention issues; - Reputational damage; - Decline in pace and development of services; and - Regulatory concerns	AO1: Patients. Help patients take control of their own health	I = 5 L = 5 Extreme (25)	Agreed Improvement Plan in place with supporting Divisional plans. **Control Owner:** Sally Smith	Adequate	I = 5 L = 4 Extreme (20)	Delivery of the emergency pathway improvement work. Actions as per CRR 28 & 61 **Person Responsible:** Jane Ely **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** Implementation in progress and monitored weekly as a minimum.	I = 4 L = 2 Moderate (8)
						External Consultancy and NHSI/E support in delivering the improvement programme. **Control Owner:** Jane Ely	Adequate		Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2018	High	**09 Jan 2018** Delivery largely on track - exceptions are being prioritised and managed by the central team with the Divisions. This will be reported at the Improvement Plan Board.	
						External help from Community Trust, social care, CCGs to deliver improvements in the emergency pathway. **Control Owner:** Jane Ely	Limited		Strengthen the Improvement Team by recruiting staff to its former level. **Person Responsible:** Emma Kelly **To be implemented by:** 31 Mar 2018	Medium	**08 Jan 2018** Band 7 (1 WTE) Quality Improvement Facilitator for CQC Programme appointed. Due to start on 5th March 2018. Recruitment not yet agreed for Programme Lead or Programme Support/Administration maternity cover but being discussed by executive team. Programme Support last working day 1st March 18 and Programme Lead 23rd March 18. Clinical Lead still involved but PAs to be agreed formally via job planning (proposal 2x PAs if time allows in job plan).	
						Quality Strategy is in place. **Control Owner:** Sally Smith	Limited		Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2018	High	**09 Jan 2018** Overall progress good - exceptions are ED performance and number of Never Events reported.	
									Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**09 Jan 2018** Consultation is likely to commence in the Spring of 2018.	

Highest Mitigated Strategic Risks Report

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 16	Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes **Risk Owner:** Susan Acott **Delegated Risk Owner:** Simon Hayward **Last Updated:** 20 Dec 2017 **Latest Review Date:** 17 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by the Delegated Risk Owner (Head of Transformation). No change in risk score. A further review of the risk will take place once the new plan is agreed. A review and assessment of the current Transformation Programme is now complete . A meeting is planned with the CEO and Deputy CEO to discuss the new plan (including identifying areas to be included in the programme). Once agreed meetings will be arranged with the Executive and Divisional Leads during January and February 2017. The plan will be reviewed at the Transformation Board on 16 February 2018 with a view to developing the plan further.	27 Feb 2017	**Cause** * Lack of experience / capability in the particular area of change * Lack of capacity of those who need to lead and embed the change * Lack of resources to deliver / implement and sustain change * Trust's lack of appetite for change in some areas to be implemented *Unavailability of the space and physical resources to implement and embed the change * Architecture / governance for change is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to delivery the transformation required to exit Financial special measures * Licence restrictions *Regulatory concerns * Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Financial Improvement Director appointed by NHS Improvement following financial special measures. The FID brings vast experience in "turnaround" and has implemented a new methodology for identification and development of improvement programmes. Working alongside the Executive and Programme Support Office. **Control Owner:** Susan Acott	Substantial	I = 4 L = 4 High (16)	Approval for 2nd Phase of the Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Jan 2018	High	**17 Jan 2018** The revised EY/Plum proposal was presented to EMT on 20 December 2017. It will presented to the Management Board for approval on 31 January 2018 with a view to commencing the programme in the Spring of 2018.	I = 4 L = 2 Moderate (8)
						Non-executive directors experience in finance and transformation provides additional input into plans / governance. Linked to individual work-streams to provide advice / challenge **Control Owner:** Susan Acott	Adequate		Agree a Transformation programme of work with clear owners and milestones that links to the Strategic Objectives **Person Responsible:** Simon Hayward **To be implemented by:** 30 Mar 2018	High	**17 Jan 2018** A review and assessment of the current Transformation Programme is now complete . A meeting is planned with the CEO and Deputy CEO to discuss the new plan (including identifying areas to be included in the programme). Once agreed meetings will be arranged with the Executive and Divisional Leads during January and February 2017. The plan will be reviewed at the Transformation Board on 16 February 2018 with a view to developing the plan further.	
						Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Sandra Le Blanc	Adequate					
						Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS and European / International hospitals **Control Owner:** Elizabeth Shutler	Adequate					
						Time limited implementation team in place for the Transformation Programme **Control Owner:** Simon Hayward	Limited					
						Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	Adequate					

Highest Mitigated Strategic Risks Report

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 8	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** Andrea Ashman **Last Updated:** 09 Jan 2018 **Latest Review Date:** 18 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Sandra Le Blanc. No changes to risk scores. Actions are progressing with regular progress on key actions reported to the Strategic Workforce Committee.	23 Feb 2016	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff *Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) *Uncertainty due to the STP plans *Increase in acuity of patients **Effect** * Potential negative impact on patient outcomes and experience *High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups	AO2: People: Identify, recruit and develop talented staff	I = 5 L = 4 Extreme (20)	The Trust has a plan in place that supports the retention of the majority of newly qualified nursing staff locally. **Control Owner:** Sally Smith	Adequate	I = 5 L = 3 High (15)	Devise & work towards implementing revised recruitment process **Person Responsible:** Andrea Ashman **To be implemented by:** 30 Mar 2018	High	**05 Dec 2017** The 10 projects have been reviewed and a proportion have been completed. The corporate governance structure for workforce CIPs has been reviewed and new work streams identified including oversight of the recruitment projects. These are currently being worked up but projects are on track.	I = 5 L = 2 Moderate (10)
						Divisional Great Place to Work Action Plans in place **Control Owner:** Jane Waters	Adequate					
						Hard to recruit plan in place and being implemented **Control Owner:** Andrea Ashman	Limited		Develop and implement a plan to recruit nurses from the UK and Europe **Person Responsible:** Jaz Mallan **To be implemented by:** 31 Mar 2018	High	**09 Jan 2018** A working group has been established. December 2017 meeting deferred. 1st meeting will now be held in January 2018. The working group will be looking at employer brand, career development, recruitment incentives, reward framework, quality and presentation of recruitment materials, return to practise, advertising and strategy & a recruitment events planner.	
						implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Adequate					
						New People Strategy agreed by the Board incorporating attraction, retention, engagement and development of staff **Control Owner:** Sandra Le Blanc	Limited		Implement plan for recruitment to hard to fill roles **Person Responsible:** Jaz Mallan **To be implemented by:** 31 Mar 2018	High	**15 Dec 2017** This is an on-going plan which is reviewed and updated on a monthly basis by the Resourcing Team and Head of Strategic Resourcing, and in turn sent to the HRBP's for review and further updates prior to reporting by the Trust Secretary to the BoD's.	
						Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Adequate		Implementing a long term workforce plan that enables us to attract and retain high calibre staff **Person Responsible:** Andrea Ashman **To be implemented by:** 29 Jun 2018	High	**09 Jan 2018** Strategic Development Days to review Clinical Strategy to be held third week in January 2018. This will feed the modelling of workforce requirements and targeted recruitment plans.	
						Recruitment process in place **Control Owner:** Andrea Ashman	Limited		Develop and agree set of KPIs to measure the effectiveness of the People Strategy which will be reported regularly to the SWC **Person Responsible:** Sandra Le Blanc **To be implemented by:** 29 Jun 2018	High	**09 Jan 2018** Inaugural meeting has taken place. Progress is being made with agreeing KPIs.	
						Staff Performance Appraisals in place **Control Owner:** Jane Waters	Limited					
						Training plans in place in each division / corporate area that supports staff development. **Control Owner:** Andrea Ashman	Adequate		Revise and implement Divisional Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 29 Mar 2019	High	**18 Jan 2018** Action added in January 2018. First progress update require by February 2018.	
						Working Group in place to review Consultant vacancies and recruitment **Control Owner:** Sandra Le Blanc	Adequate					

Highest Mitigated Strategic Risks Report

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									To produce and implement a People Strategy that focusses on attracting, developing, engaging and retaining staff. **Person Responsible:** Sandra Le Blanc **To be implemented by:** 01 Apr 2019	High	**12 Dec 2017** People Strategy is progressing. KPIs were presented to the SWC in November 2017. Progress of the implementation plan will be reported to the SWC in January 2018.	
SRR 10	Non-delivery of a timely Sustainability and Transformation Plan that can be resourced **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 08 Jan 2018 **Latest Review Date:** 08 Jan 2018 **Latest Review By:** Dorothy Otite **Latest Review Comments:** Risk reviewed by Liz Shutler. No change in risk scores. The medium list of options has been approved for public consultation in the Spring of 2018.The CCGs have set up a joint PCBC group and the first meeting is being held during the week of 8 January 2018.	01 Jun 2016	**Cause** - STP timescales slip due to national management of the process - Parliamentary timing may not be conducive to timely implementation - Lack of CCG leadership **Effect** - Delay to EKHUFT clinical strategy - Poor patient care - Emergency transfer of services will become necessary - Enforcement actions - Trust's provider licence (finance)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	Clinical standards reviewed **Control Owner:** Elizabeth Shutler	Substantial	I = 5 L = 3 High (15)	Produce Financial Plan linked to delivery of the STP **Person Responsible:** Philip Cave **To be implemented by:** 28 Feb 2018	High	**17 Jan 2018** The Trust is fully engaged with the STP programme and is feeding into the wider plan. The Board is kept informed.	I = 5 L = 2 Moderate (10)
						East Kent Delivery Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Elizabeth Shutler	Adequate		Presentation of the capital requirements to the NHSE Investment Committee as part of the Pre-consultation Business Case **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**08 Jan 2018** The CCGs have set up a joint PCBC group and first meeting is being held during the week of 8 January 2018.	
						Internal Clinical Strategy Group in place **Control Owner:** Elizabeth Shutler	Adequate		Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Apr 2018	High	**18 Jan 2018** Consultation is likely to commence in the Spring of 2018.	
						Kent and Medway STP Programme Board in place **Control Owner:** Elizabeth Shutler	Substantial					
						STP submission to NHS England **Control Owner:** Elizabeth Shutler	Substantial					

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**REPORT FROM THE MANAGEMENT BOARD**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: EMERGENCY DEPARTMENT (ED) RECOVERY PLAN UPDATE**

BACKGROUND AND EXECUTIVE SUMMARY

The purpose of the Management Board is to oversee the effective operational management of the Trust (including achievement of statutory duties, standards, targets and other obligations) and the delivery of person centred care and to support the Trust Board in setting and delivering the Trust's strategic direction and priorities.

Previous reporting from this Committee was included within the Chief Executive's Report. A separate report will now be provided to the Board of Directors.

The following sets out key discussion points and decisions made at the last meeting held on 31 January 2018:

The Integrated Performance Report (IPR) was received and key elements of quality, finance, performance and estates/health & safety were discussed. A copy of the IPR is a main agenda item for the Board of Directors; the Quality Committee and Finance and Performance Committee have also received and discussed the key headlines in detail and a summary will be included in their Chair Reports to Board.

A separate paper was received on Emergency Department (ED) Recovery and is appended to this report for the Board's information and discussion. The paper was also taken to the Finance and Performance Committee for discussion and a summary will be included in the Chair Report to Board. Work was focussed both internally and with the wider system in the following key areas:

- Delayed discharges were causing pressure on the whole system. At the time of writing this report, the Trust was planning with external partners a 'Perfect Two Weeks' campaign with the main focus being on discharges. In addition, the Trust would be working with CCGs to implement community schemes to improve patient flow.
- The Trust had been invited to join an operational group to discuss SECAMB conveyance.
- Strengthening escalation processes internally and externally.

As reported to the Board in the CEO Report, Carnall Farrar had set up a Performance Management Office to support the whole system in driving forward improvements.

Performance against CQUINs is a standard report to Management Board to support monitoring of progress, early identification and escalation of risks to achievement of milestones and mitigations in place. The financial risk associated with the general contract CQUINs is £1.2m forecast at year end (79% achievement). The Finance and Performance Committee receive regular reports for monitoring.

Management Board received preliminary staff survey results. The reports would be

published nationally in March 2018.

A staff turnover report was received. The third quarter reported at 12.76%. The Strategic Workforce Committee received periodic reports and a summary is included in the Chair Report to Board.

Management Board noted the Trust's intention to progress a commercial strategy. Work would be progressed as part of the Trust's clinical strategy.

The Trust had used national guidance to build a more accurate and transparent picture of its backlog maintenance position. Maintenance will be prioritised in line with capital allocation.

Management Board received a report setting out the options which were made public for the future of Kent and Medway Stroke services.

Management Board approved the following recommendations:

- Phase 2 of the Trust's Leadership Programme;
- A guideline to assist managers around Secondary Employment Approval/Working Time Directive Opt-Out Agreement;

The Corporate Risk Register was discussed noting changes to the corporate risk register, proposed closure of risks and new and emerging risks. The Risk Register is then reported to the Quality Committee each month and reported to Board through the Committee Chair Report.

The Board Assurance Framework was received for information and awareness of the Trust's strategic risks and performance against the Board Annual Priorities. The Board Committees are tasked with gaining assurance in relation to the mitigations in place and actions to reduce the level of the risk and for triangulating the information they have in terms of achieving the Annual Priorities. Summary is included in Chair Reports to Board.

Information Reports

Regular information reports are received and noted from:

- Information Assurance Board
- Vacancy Control Panel
- Strategic Investment Group
- Horizon Scan

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Management Board receives reports covering a broad range of performance and governance issues.
LINKS TO STRATEGIC OBJECTIVES:	**Provision:** Provide the services people need and do it well.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	The Management Board receives reports covering a broad range of performance, governance and risk management issues.
RESOURCE IMPLICATIONS:	Key financial decisions and actions may be taken on the basis of this report
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

To discuss and note the report.

REPORT TO:	**BOARD OF DIRECTORS (BoD) AS PRESENTED AT MANAGEMENT BOARD**
DATE:	**31 JANUARY 2018**
SUBJECT:	**EMERGENCY CARE RECOVERY PLAN UPDATE**
BOARD SPONSOR:	**CHIEF OPERATING OFFICER**
PAPER AUTHOR:	**CHIEF OPERATING OFFICER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: EMERGENCY CARE RECOVERY PLAN**

December performance for the 4 hour target was 73.6%, against the NHS Improvement trajectory of 90.0%.This is a decreased performance compared to the previous month, as has been seen nationally.

The evidence is clear that the cause of the additional pressure on the system is due to an increased length of stay and a reduction in discharges each day (as a result of higher acuity and reduced capacity to meet needs).

The 2020 improvement programme continued in the first two weeks of December and then resumed in January and the team left the Trust on 19th January. The summary outputs from the rapid improvement work by our teams has been concluded and handed over to our Divisions, our internal Improvement Team and the site Hospital Directors to take forward.

Carnall Farrar have reviewed the previous A&E Improvement Plan and the rapid improvement work supported by 2020 and combined this work into five key work streams, to ensure focus of improvement delivery and impact:

1. Improve ways of working with EKHUFT staff
2. Reduce activity inflow at EKHUFT
3. Optimise EKHUFT site management
4. Optimise discharge process and times
5. East Kent system-wide capacity

In the week of 29th January – a “perfect” week is commencing where our partners will come into the hospital and support a review of every patient in our hospitals. This will provide a greater understanding of the cause of delays and actions will be taken. In this week the plan will be to also focus on releasing capacity on the community so that in the following week there will be significantly more discharges that will enable EKHUFT to return to an improved bed occupancy that is nearer to 92%.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	1) Failure to achieve the required changes in service delivery and patient flow to enable achievement of improvement trajectory 87.7% by December 2017. *<u>Action:</u> Programme Management and governance structure established, supported by fortnightly Single Oversight Meetings.* 2) Inability to recruit sufficient Medical staff to deliver the required changes. *<u>Action:</u> Recruitment pipeline established to track recruitment progress. Alternate workforce models being sought.*

	3) Inability to retain existing staff to enable delivery and ensure sustainability *<u>Action:</u> Maximise clinical involvement and ensure regular communications. Work with 2020 Delivery to enable staff to achieve small, consistent 'wins' and celebrate success.* 4) Lack of external engagement and delivery of initiatives such as Frailty and Pneumonia pathways *<u>Action:</u> Fortnightly Single Oversight Meetings and Improvement Plan updates to support escalation.*
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	CRR61: A&E Plan
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

Specific actions are required of the Board members to support the immediate work for the "perfect" week:

- To emphasise the need for good practice and ensure that Consultants supporting their teams to have clear written care plans for patients (with required outcomes) to support discharge.
- To ensure that Consultants are undertaking (daily) ward rounds as required supporting discharges.
- For the Divisions to continue to improve the number of discharges at weekends by supporting additional consultant sessions, Matron of the Day, additional Therapy support etc.
- To support our teams to escalate more appropriately in relation to improved diagnosis and commencement of treatment for individual patients in our Emergency Departments (EDs).
- To support our teams to escalate more appropriately in relation to improved discharge.
- To support our teams to escalate issues that they are unable to solve for our patients
- For all divisions and corporate functions to make sure that they have facilitated the "ward liaison" roles (buddied up with wards) that could come from Finance, HR and Information business partners – a few hours in a day will make such a difference.
- To consider offering over time to ward clerks and other key support roles that will support the Emergency department and wards for the next 2 weeks.

Emergency Care Recovery Plan

Summary Performance

December performance for the 4 hour target was 73.6%, against the NHS Improvement trajectory of 90.0%.This is a decreased performance compared to the previous month, as has been seen nationally. There were two 12 Hour Trolley Waits for December compared to zero for the previous three months. The number of patients who left the department without being seen remained compliant, but increased from last month to 3.34%. Unplanned reattendances increased further to 9.03%.

Key Performance Indicators

73.59%	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Green
4 Hour Compliance	70.57%	75.94%	80.16%	76.93%	76.78%	78.15%	71.18%	70.10%	70.51%	75.34%	79.91%	73.59%	95%
12 Hour Trolley Waits	2	0	0	0	0	1	1	2	0	0	0	2	0
Left without being seen	4.87%	3.53%	3.08%	3.82%	3.57%	3.62%	5.05%	4.51%	4.48%	3.44%	2.65%	3.34%	<5%
Unplanned Reattenders	8.20%	8.62%	9.11%	8.48%	9.04%	9.45%	10.00%	9.22%	8.75%	8.68%	8.32%	9.03%	<5%
Time to initial assessment (15 mins)	76.1%	76.4%	77.8%	77.9%	93.8%	93.9%	92.4%	92.3%	93.4%	90.6%	91.1%	88.6%	90%
% Time to Treatment (60 Mins)	39.8%	40.8%	40.7%	39.4%	51.1%	51.6%	46.7%	46.1%	45.9%	47.8%	54.6%	53.3%	50%

2017/18 Trajectory (NHSI Return 7th June 2017)

-16.41 %	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
Trajectory	75.0%	75.0%	80.0%	83.0%	87.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	95.0%	
Performance	76.9%	76.8%	78.2%	71.2%	70.1%	70.5%	75.3%	79.9%	73.6%				

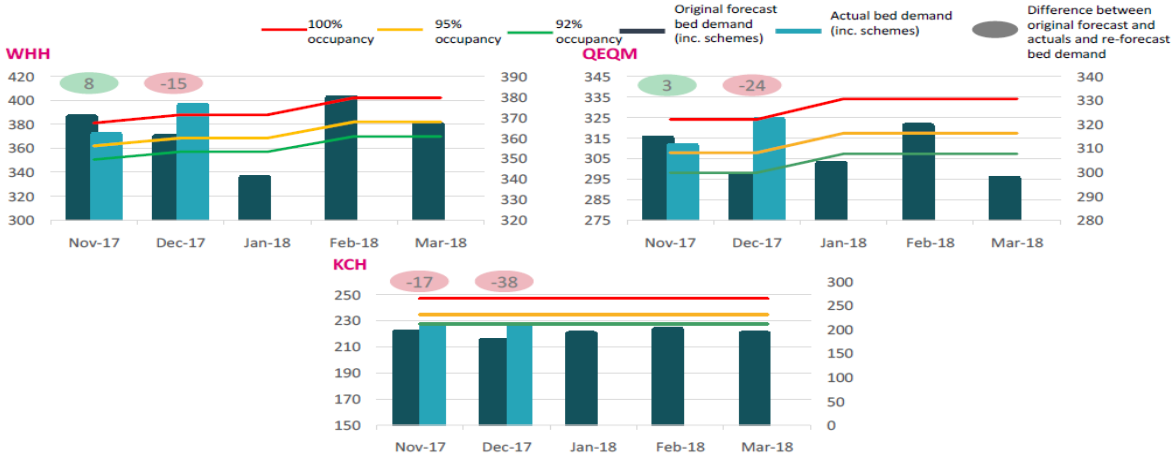
The priority and focus for December has been to maintain safe patient care; improving performance and patient flow across the whole emergency patient pathway. There has been a slight increase in activity, with high numbers of medically unwell patients attending ED (emergency department) by ambulance. Patient acuity has been high with notable respiratory illness. The increase in acuity has put increasing pressure on the staff in ED to maintain safe patient care and in order to mitigate this risk additional consultant acute physician hours have been allocated to ED and also ambulatory care and the Acute Medical Unit. Additional Consultant Physician sessions have also been implemented to ensure that, where possible, patients on the medical wards, including patients in winter escalation beds or outliers have been reviewed 7 days per week.

The evidence is clear that the cause of the additional pressure on the system is due to an increased length of stay and a reduction in discharges each day (as a result of higher acuity and reduced capacity to meet needs) as evidenced below:

Actual occupancy was significantly higher than planned in December, reinforcing the urgent need to improve patient flow

Forecasted demand against capacity thresholds

beds, November '17 – March '18



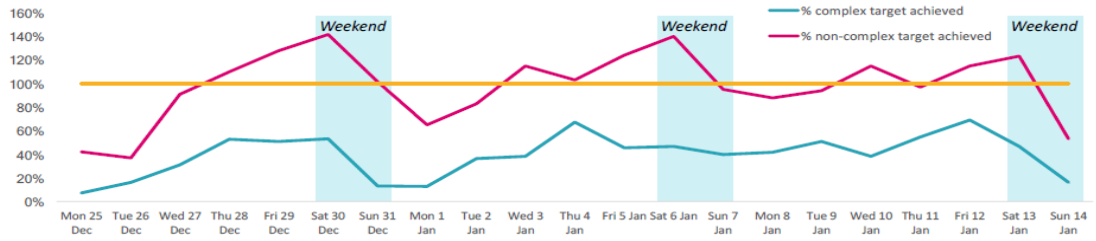
NB: Capacity estimates include planned capacity changes over winter. CCG initiatives including all initiatives in the Winter Plan with time adjustment for the following: Commission 12 additional Hospice beds, Additional Dementia / Challenging Patient Beds, Bed Bureau Management Efficiencies, Generic Workers. CCG initiatives in the Winter Plan that did not receive winter monies have had the impact removed from the "original forecast".

Source: East Kent Demand and Capacity Escalation Plan 2017-2018, extracted from the East Kent A&E Delivery Board Winter Plan 2017-2018; Winter monies highlight reports Jan 2018; ERP data 2017; Carnall Farrar analysis

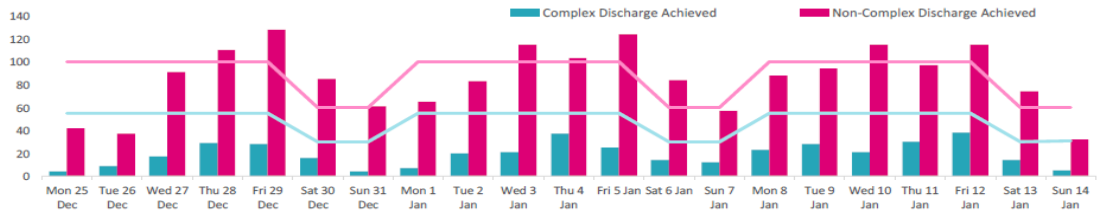
Despite a recent focus on complex discharge, performance against discharge targets is much lower for complex than non-complex

Performance against discharge targets by discharge type

% target achieved



Abs. # discharges versus target



Source: Weekly SOM reporting, Daily ERP reports, 25 December through 14 January; Carnall Farrar analysis

A meeting focused on discharge planning was held on 11th January, where system leaders agreed four key areas of work

	Initiatives	Description	Lead	Deadline	Progress
1	**Non-complex discharges**	Accelerating non-complex discharges, putting in support from clinical staff (GP or nursing) to work alongside EKHUFT staff	Hazel Smith	Fri 12 Jan	• Felicity Cox has shared examples from elsewhere
				Thu 18 Jan	• Hazel Smith discussed with EKHUFT on what clinical support to provide
2	**Spot purchase step-down beds**	Spot purchase additional capacity, incl. MDT step-down beds (as per last February)	Hazel Smith	Thu 25 Jan Thu 18 Jan	• Work is ongoing to spot purchasing dementia packages, currently looking to expand to the level of last year • Extra person for CHC fast track has been secured and will be based in hospital starting from 15th Jan • Hazel to describe what type of capacity is required where, including e.g. step-down beds
3	**Bed bureau**	Immediate support to mobilise the bed bureau	Paul Bentley with Carnall Farrar support	Thu 25 Jan	• Carnall Farrar has met with: - Caroline Selkirk, James Lowell, Stuart Jeffery on learnings from what's worked well in other systems - Oena Windibank and Bill Millar on progress to-date - Paul Bentley to develop objectives, operating model and implementation plan
4	**MADE calls**	Set up daily MADE calls to check progress against the above actions	Susan Acott	Fri 12 Jan	• Susan has made the MADE calls daily with provider chief execs, commissioner leads and Home First Group leads
				Fri 19 Jan	• CF is supporting the structuring of the MADE calls

Source: Outputs from 11th January discharge planning meeting with system leaders

Internal Improvement Plan

The 2020 improvement programme continued in the first two weeks of December and then resumed in January and the team left the Trust on 19th January. The summary outputs from the rapid improvement work by our teams has been concluded and handed over to our Divisions, our internal Improvement Team and the site Hospital Directors to take forward:

The approach emphasised hands on support and collaboration, underpinned by observations and analysis for rigour

East Kent Hospitals University NHS Foundation Trust

Examples of activities undertaken

Hands on Improvement Support	Engagement	Communications	Observations and Data Analysis
• Initiation of 10 improvement interventions • Support during PDSA cycle to get/keep initiatives going • Offering positive challenge to existing practice, i.e. escalation or board round practice • Project management of Discharge Lounge improvements • Design of supporting material and guides, i.e. Standards and GP streaming protocol • Research comparable Trust practice for benchmarking • Coaching and management support	• Engaged with ~400+ Trust staff to initiate and sustain the PDSA cycles • Attending huddles and post-huddle coaching sessions • Workshops to develop initiative ideas and build support • Engagement sessions with junior and senior doctors • Stalls at Quality Hubs • Interviews and conversations with key members of all staff groups	• Develop simple tools for keeping initiatives visible and prominent • Best practice flash cards for junior doctors • At-a-glance information flyer on Discharge Lounge • Support on Trust newsletter article about Discharge Lounge • Daily updates on rapid improvement project to COO & Head of Comms • Trial of WhatsApp groups • Learning videos of initiatives • Weekly video-conferencing across Trust	**Observations:** • ED delay studies ("what are patients waiting for next?") • ED night studies • Bed transfer follows • Board round observations • Doctor cycle time **Data analysis:** • Bottleneck identification • Workforce capacity review • ED demand & flow against staffing • Pathology turnaround times for ED • Patterns of admissions v. discharges over the week

The teams have got the tools for improvement and standardised protocols that will enable them to embed the initiatives such as: Identifying a golden patient from each ward to support early morning discharge, and the increased use of the Discharge Lounge. A priority is to focus on improving the bed allocation process to reduce any unnecessary time delays from when a bed is allocated to a new patient arriving on the ward.

The Emergency Care Improvement Plan will now be supported by Carnall Farrar, who will provide dedicated programme management (PMO). A revised governance structure has been agreed to include the System Oversight Meetings (monthly), Local A&E Delivery Board (fortnightly), and weekly EKHUFT Operational reviews and an internal ED Safety and Patient Flow group.

Carnall Farrar have reviewed the previous A&E Improvement Plan and the rapid improvement work supported by 2020 and combined this work into five key work streams, to ensure focus of improvement delivery and impact:

1. Improve ways of working with EKHUFT staff
2. Reduce activity inflow at EKHUFT
3. Optimise EKHUFT site management
4. Optimise discharge process and times
5. East Kent system-wide capacity

EKHUFT Initiatives: Progress Update

Not yet started | Behind plan | On track | Complete

Workstream	Initiatives	Plan in Place?	Plan Developed?	Metrics Set?	Targets and Trajectory Set?	Metric	Target	Data Source	Performance 21/01/18 and trend from 14/01 WHH	QE
1. Improve ways of working	1.1 Huddles and Golden Safe patients *Mary Tunbridge and Trish Hubbard*	✓				% of discharges before midday	25% by end of March National target is 33%	ERP	13.8%.	15.5%
						# of golden safe patients identified per day	1 per ward per day: WHH 17 QEQM 15	PTL*		
						% golden safe patients discharged by midday	100%	PTL*		
						# discharges before 10am	10 per site	ERP	18	12
						# discharges before 12pm	TBC			
						% of discharges that occur through the discharge lounge (to be broken down per ward)	TBC – should this be tracked here or at discharge lounge initiative?	PTL*		
	1.2 ED – Early Assessment (First Hour Focus) *Lesley White*	✓				4-hour ED compliance % for majors	TBC	ERP		
						4-hour ED compliance % for minors	98% or 100%?	ERP		
						Clinician Seen - 1st Assess. < 1hr (%)	60%	ERP	50.9%	41%
	1.3 Bed Management *Mary Tunbridge and Trish Hubbard*					Time to refill beds	45 mins –split out deep clean needed?	PTL* / Serco?		
						Time from DTA to bed allocated		PTL*		
						Time from bed allocated to ward admission		PTL*		
	1.4 Night time breaches *Lesley White*	✓				Midnight to 8am admitted and non-admitted breaches	95% compliance, 90% by end of March	Sentinel	348 (weekly total)	305 (weekly total)
	1.5 Culture and behaviour diagnostic *Mary Tunbridge and Trish Hubbard*					TBC				

Notes:
**PTL data tracking to be developed*

1.1 33% of discharges before midday – national SAFER target
1.5 still to be scoped

Workstream	Initiatives	Plan in Place?	Plan Developed?	Metrics Set?	Targets and Trajectory Set?	Metric	Target	Data Source	Performance 21/01/18 WHH	QE
2. Reducing activity inflow at EKHUFT	2.1 ED - GP streaming at front door *Lesley White and Oena Windibank*	✓				% attends streamed to GP	30% - is this aligned with contract?	ERP	5.0%	9.8%
	2.2 Hospital at home *Chris Hudson*					Number of beds in virtual wards	45	PTL*	32	
						Occupancy of virtual wards	85% - 100%?	PTL*	95%	
	2.3 Ambulatory care (inc. acute assessment unit) *Elisa Steele*	✓				#, % patients diverted from ED	TBC	AC PTL?		
						# patients sent from GP to ambulatory care	TBC	AC PTL?		
						% of patients seen by ambulatory care discharged on the same day	60%	AC PTL?		

Notes:
**PTL data tracking to be developed*
*** Tracking to be discussed with the information team*
2.1 GP Streaming – target taken from Luton and Dunstable University NHS Foundation Trust best practice case study (CF)
2.3 Ambulatory Care targets taken from CF best practice case studies – Mid Cheshire
AC PTL requested from Elisa Steele

Workstream	Initiatives	Plan in Place?	Developed? Plan	Metrics Set?	Targets and Trajectory Set?	Metric	Target	Performance 21/01/18	Trend from previous week
3. Optimise EKHUFT site management	3.1 EKHUFT Capacity management *Mary Tunbridge and Trish Hubbard*	✓							
	QEQM additional 10 beds at Cheerful Sparrows	✓				Number of additional beds available	10, then 0	10	
	QEQM Surgery to medicine at Quex Ward	✓				Number of additional beds available	19	19	
	WHH additional ward at Arundel Unit	✓				Number of additional beds available	30 (Feb)	--	
	Kings C2 as a swing medical ward	✓				Number of additional beds available	24, then 0	24	
	3.2 Enhanced site management *Mary Tunbridge and Trish Hubbard*					Ensure 4.5 wte are employed (including band 7 site practitioners)			
	3.3 ED Protocols, Policies and Roles & Responsibilities *Elisa Steele*					Number of policies updated	4		

Workstream	Initiatives	Plan in place?	Developed Plan	Metrics Set?	Targets and Trajectory Set?	Metric	Target	Data Source	Performance 21/01/18 WHH	QE
4. Optimise discharge process and times	4.1 Practitioner led discharge *Sally Smith*					% discharges before 10am	25%	ERP	Same metrics as Huddle and Golden Safe Patients	
						# discharges before 10am	10	ERP		
						% discharges before 12pm	33%	ERP		
						# discharges before 12pm		ERP		
						Number of nurse-led discharges	?	PTL*		
	4.2 Discharge lounge *Mary Tunbridge and Trish Hubbard*	✓				% of discharges that occur through the discharge lounge (to be broken down per ward)	?	PTL*		
						# patients sent to discharge lounge, by ward	?	OCC app		
	4.4 SAFER Initiatives *Karina Greenan*	✓				% of patients having senior review before midday	100%	PTL*		
						% of patients with EDD	100%	SAFER dashboard		
						% of patients discharged before midday	33% 25% by end of March	ERP	13.8% ↗	15.5% ↗
						% of patients with LoS>7 reviewed by MDT	TBC	PTL*		

Notes:
**PTL data tracking to be developed*
*** Tracking to be discussed with the information team*
SAFER dashboard requested from Elisa Steele

Non-EKHUFT Initiatives: Progress Update

★ Winter funding ◯ Not yet started ◔ Behind plan ◑ On track ● Complete

Workstream	Initiatives	Plan in place?	Plan Developed?	Metrics Set?	Targets and Trajectory Set?	Metric	Target	Performance over Last Period	Trend	Budget	Spend to date
2. Reducing activity inflow at EKHUFT	★ 2.4 Generic Workers *KCHFT*		●	●	◔	Number of generic workers recruited	30	8 (verbally accepted)	↗	£150k	
						Admissions avoided		1,973	↗		
4. Optimise discharge process and times	4.3 Home First *Janice Duff*	✓	◑	●	◔	% of patients receiving CHC assessment in acute setting	<15%				
						# DTOC patients					
						#, % stranded patients					
						#, % super stranded patients					
5. Creating capacity East Kent system Wide *Bill Millar*	★ 5.5 10 care packages dementia / challenging behaviour		◔	●	◑	Number of packages identified	10	4		£153k	£35k
						Number of packages filled	10	4			
	★ 5.6 Expand Hilton NWB patient capacity 7 to 20 patients	✓	●	●	●	Number of patients supported	20	16		£200k	
						Effect on readmission rate					
	★ 5.7 Extend Hilton package by 2 days (from 3 to 5 days)	✓	●	●	◯	Number of patients supported Effect on readmission rate				£350k	
	★ 5.8 Commission 12 Hospice beds (currently working for 4)	✓	◔	●	◑	Number of additional beds purchased	12 (now 4)	4		£200k	
						Number of additional beds filled	12 (now 4)				
	★ 5.9 Transfer of Care (Bed Bureau)		◔	◯	◯					£75k	
	★ 5.10 Health and Social Care village beds		◑	●	◯	% of beds occupied by DTOC patients		23%	↘	£800k	On track for full spend by 31 Jan

Workstream	Initiatives	Plan in place?	Plan Developed?	Metrics Set?	Targets and Trajectory Set?	Metric	Target	Performance over Last Period	Trend	Budget	Spend to date
5. Creating capacity East Kent system Wide *Bill Millar*	★ 5.11 Dementia crisis intervention service	✓	●	◑	◯	Admissions avoided				£193k	
	★ 5.12 Enhanced STR support for A&E	✓	●	◑	◯	Number of STR workers recruited				£88k	
	★ 5.13 GP extended hours	✓	●	◑	◑	Appointment activity Admissions avoided				£717k	
	5.14 CHS Healthcare	✓	●	●	◑	Number of discharges facilitated	20	0			~£20k
	5.15 Link with British Red Cross (WHH)	✓	●	◯	◯						
	5.16 Age Concern UK discharge support	✓	●	◯	◯						

Immediate Actions:

The agreed four actions as a system are being implemented and EKHUFT is leading on the M.A.D.E (Multi agency discharge event) calls. There is a daily call at 1.00pm, with all partners at an operation al level, where first escalation takes place and discharge decision are made. If any decisions are unresolved these are then escalated to a CEO level call at 5.00pm on a daily basis.

In the week of 29th January – a “perfect” week is commencing where our partners will come into the hospital and support a review of every patient in our hospitals. This will provide a greater understanding of the cause of delays and actions will be taken. In this week the plan will be to also focus on releasing capacity on the community so that in the following week there will be significantly more discharges that will enable EKHUFT to return to a improved bed occupancy that is nearer to 92%.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**9 FEBRUARY 2018**
SUBJECT:	**INTEGRATED PERFORMANCE REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PAPER AUTHOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: INTEGRATED PERFORMANCE REPORT**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Performance Report is produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The Integrated Performance Report provides assurance to the Board that all areas of performance are monitored with sentinel indicators, allowing the Board to gain assurance regarding actual performance, Trust priorities and remedial actions.
Below are the highlights from the November report. The report has been discussed in detail by the Board's Quality Committee, Finance and Performance Committee and Strategic Workforce Committee.

Performance

Emergency department waiting times and patient flow remain an area of absolute priority for us. Our performance position is reporting at 73.6% which is a decrease compared to the previous month. The priority of focus for us continues to be to maintain safe patient care and improve performance and patient flow. Peaks in activity and slow-down of discharges during the Christmas period has impacted and added to the operational pressure.

As mentioned in our last report a dedicated programme management office (PMO) has been established to help improve governance over the improvement plan. 2020 Delivery, who were commissioned to work with us for a 12 week period to deliver a rapid improvement programme of work, have now left the Trust and the PMO will concentrate on embedding this work. A revised governance structure has been put in place to include the System Oversight Meetings, A&E Delivery Board and a weekly EKHUFT Operational Review meeting.

As mentioned in our last report the A&E Improvement Plan has been reviewed and actions are clustered around five key work streams:

- Improve ways of working with EKHUFT staff
- Reduce activity inflow at EKHUFT
- Optimise EKHUFT site management
- Optimise discharge process and times
- East Kent system-wide capacity

There is an immediate focus in commencing a "Perfect Fortnight" aimed at increasing discharges and reducing delayed transfers of care. The Executive Directors and Divisional Directors have refined their responsibilities to give a stronger site focus and improve operational grip.

18 Weeks Referral to Treatment performance decreased by 2% to 78.67%. This 2% reduction was anticipated (and was in line with previous years) due to bank holidays and high annual leave through the festive period which meant we were unable to deliver capacity

in line with demand.

The number of patients waiting over 52 weeks has increased to 80 due to slippage of capacity schemes which were due to commence in September 2017, in particular gynaecology and general surgery. Schemes are now confirmed for October 2017 but risks remain linked to pressures on our emergency pathways and winter bed pressures. Work will be necessary to review patients on elective pathways to mitigate the risk for 52 week breaches. Amongst other actions being taken which are detailed in the full report, a new patient tracking technology has been implemented which allows for real time recording of patient pathways.

Cancer performance reported at 74.48% against our improvement trajectory of 86% and validation continues in line with the national timetable. Daily cancer meetings have been implemented for lung, lower gastrointestinal (GI), urology and head and neck with the focus on prevention of breaches. Since these meetings have been implemented, there has been a reduction in the number of patients waiting over 62 days and 104 days.

A successful visit from NHS Improvement (NHSI) and Intensive Support Team (IST) in October resulted in a number of key actions to include demand and capacity modelling for diagnostics and urology. We have also been successful in obtaining funding from NHSI to support improvement in our 62 day performance.

Patient Experience, Safety and Effectiveness

- Overall patient experience remains green and there has been sustained improvement in overall patient satisfaction.
- Friends and Family Test (FFT) inpatient satisfaction survey remains positive at 97% recommended.
- The ratio of complaints to compliments reported positively with 48 compliments to every single complaint.
- There are a high number of mixed sex breaches reported within our Clinical Decision Unit linked to patient flow and decongesting our emergency departments to maintain safety. An NHS England and NHS Improvement task and finish group was established to ensure a consensus of the definitions of reporting arrangements of the national guidance. Revised guidance will be implemented from 1 February 2018.
- The rate of hospital acquired pressure ulcers improved compared to last month. During December 2017 awareness campaigns and bespoke ward based teaching continued. The Tissue Viability Team are 'walking the floor' of our emergency departments at least twice daily to ensure prevention strategies are in place during the period of winter pressure.
- Despite our operational challenges, compliance with venous thromboembolism (VTE) risk assessment remains green registering 93.8, albeit a slight decreased compared to the previous month. It is important to note that the specialities have achieved >95% for the previous 12 months. In addition, sepsis screening reported a strong performance as doses of administration of IV antibiotics within the first hour of arrival at hospital are reported.
- The rate of falls has increased during December. However, year to date the Trust reports a falls rate below the national average. Our sites have been under extreme pressure and staff issues have also impacted on close observation of some high risk patients. Mitigating actions include: continuation of the 'fall stop' programme at WHH; daily ward checks; training; and weekly audits of risk assessment compliance.
- The Trust was disappointed to report a further Never Event in this reporting period. Specific action to be undertaken is to hold an Executive led Never Event Workshop to review the circumstances and establish the key learning which needs to be taken out to the organisation, a strategy for embedding that learning and a review process to check that the learning has been embedded.
- Bed Occupancy has increased to 96% and the non-elective length of stay as increased by almost half a day. Key drivers links to our operational challenges and additional

challenges associated with norovirus and influenza.

Financial Performance

Performance is monitored in detail by the Finance and Performance Committee and reported to the Board of Directors. Below summarises the December position.

The Trust's detailed finance position can be found on page 43 of the report. The Trust's Income and Expenditure (I&E) deficit position in December (month 9) reported at £3m (consolidated position excluding Sustainability and Transformation Funds, and after technical adjustments) against a planned deficit of £2.9m. The year to date I&E deficit is £17.1m, reporting on plan. We continue to work with our regulators to monitor the Trust's Financial Recover plan. The Trust has worsened its forecast in Month 9 by £11m to recognise the expected impact of additional A&E pressures and winter costs which will deliver a £30m deficit for the full year.

Human Resources

Page 32 of the report provides the Trust's workforce data as at December 2017. December reported a vacancy rate of 11.2% after the previous three months reported above 12%. The Trust's turnover rate in month is 13.09%. There is a continued focus on our hard to recruit roles, particularly within nursing and some Medical specialties. Our Human Resources Team is working hard with Divisions to identify new ways and methods of recruitment in a more timely way and to explore different workforce models. Exit interviews are analysed and a detailed report is provided periodically to the Board's Strategic Workforce Committee and reported to Board through the Chair Report.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The report links to the corporate and strategic risk registers.
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	The report links to the corporate and strategic risk registers.
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Quality Committee Finance and Performance Committee Strategic Workforce Committee.

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

RECOMMENDATIONS AND ACTION REQUIRED:

(a) Discussion.

East Kent Hospitals University NHS
NHS Foundation Trust

DECEMBER 2017

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS
NHS Foundation Trust

Chief Executive's Summary

Please note that the CEO Summary now forms part of a report front sheet and is not included within the main IPR pack.

East Kent Hospitals University NHS
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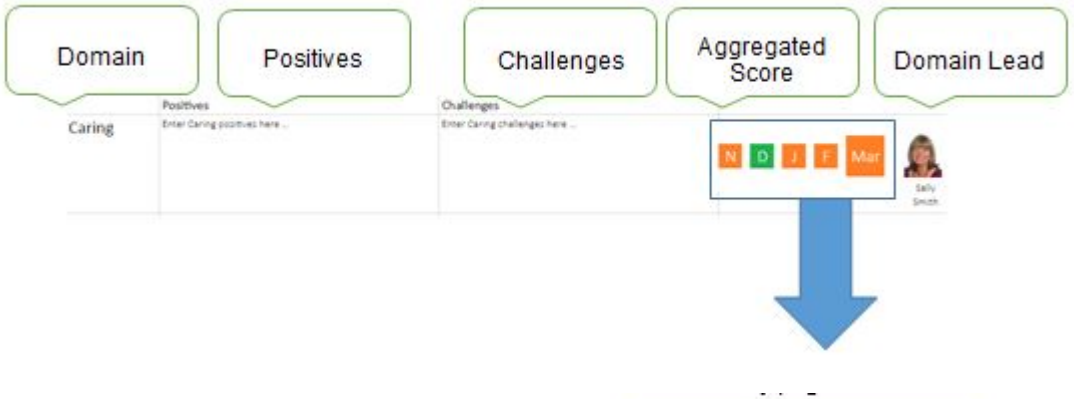
Understanding the IPR

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.

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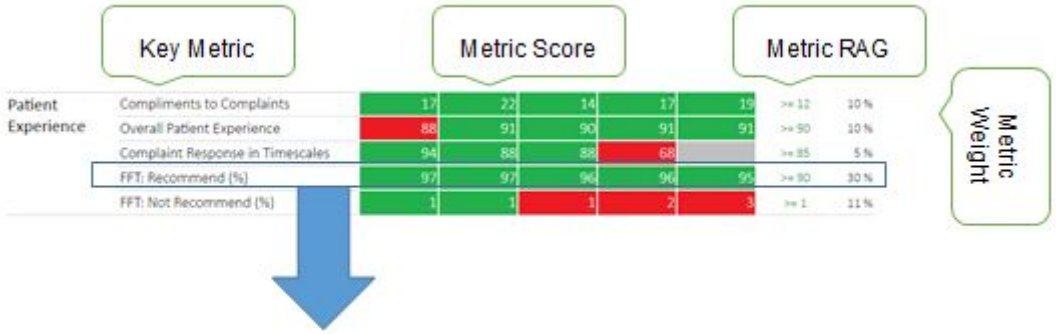
Understanding the IPR

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.

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Strategic Priorities

East Kent Hospitals University NHS
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Contents

East Kent Hospitals University NHS
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Headlines

	Positives	Challenges	
Caring	Overall patient experience, as per the real-time inpatient survey remains green with overall patient experience rated at 91%. The friends and family test inpatient satisfaction rate remains positive at 97% recommended. The percentage of responders not recommending the Trust as a place to receive care is the lowest (best) it has been for 5 months. The ratio of compliments to complaints is also positive with 48 compliments to every single complaint.	We are still reporting a high number of mixed sex breaches in the Clinical Decision Units and in some of the escalation areas. This is due to patient flow and decongesting the Emergency Departments to maintain safety. Complaints response times are registering amber this month. Improvement actions are in place to recover the position.	A S O N Dec  Sally Smith
Effective	Reportable delayed transfers of Care (DTOC), has improved slightly in December. Readmissions after an elective and non-elective admission has not changed which is positive considering the significant challenges. Planned preventative maintenance for medical equipment has maintained the improvement of 84% which is a great achievement. Clinical audit programmes remain on track as planned.	Bed Occupancy has increased to 96% and the non-elective length of stay as increased by almost half a day. DNA rates for new and follow up appointments have not improved this month which is a common trend seen each year. Theatre utilisation is still a significant challenge and cancellations on the day for non-clinical reasons have increased to 1.9%.	A S O N Dec  Jane Ely

Responsive	Cancer performance overall has improved with 2 week wait, 31 day diagnosis to treatment, and 62 days from screening referrals and consultant upgrades now compliant. The 62 day standard from GP referral has improved by over 3% in the month to 74.48%. The Urology review has been undertaken and the Lung pathway will be under taken in January to determine when compliance for the 62 day from GP referral will be achieved. Diagnostic waits performance has been maintained.	Despite the continued improvement in our internal processes through our Rapid Improvement Programme, performance against the A&E 4 hour standard dropped in December to 73.59%. It is evident that the cause was due to reduced patient flow as a result of a reduction in discharges and increased length of stay. Our Clinical Commissioning Groups were granted additional funding in December to support the need for additional beds, yet this could not be fully implemented in time to meet the increased demand. We opened additional acute beds in December and into January and our whole system partners are now increasing a refocus in planning and promoting discharge through a concentrated two week period with an aim to get the bed occupancy back into balance. Referral to Treatments (18 weeks RTT) performance has fallen again to 78.67% and the number of patients waiting for treatment beyond 52 weeks has increased further, the majority of these are still in general surgery and gynaecology. Revised plans are being developed.	A S O N Dec	 Jane Ely
Safe	The rate of hospital acquired pressure ulcers improved compared to last month. Despite the very real challenges to emergency care although as anticipated overall VTE assessment recording dipped below 95% to 93.8%. Specialties have achieved >95% for all of the last 12 months. Sepsis screening within the busy EDs remains extremely good as does administration of IV antibiotics with the first hour of arrival at hospital.	This period has been hugely challenging with a high bed occupancy and additional challenges from Norovirus and a surge of influenza. The Trust has reported a further never event during this reporting period and this period has also seen an increase in the number of incidents with moderate harm. There was also a severe harm incident recorded in relation to staff stress within the WHH emergency department. Harm Free Care remains static at 'amber'. This includes patients admitted with harms as well as those who acquire a harm in hospital. The rate of falls has increased during December registering red. Year to date, however, we remain below the national average for falls rate. We reported 1 avoidable deep ulcer during December.	A S O N Dec	 Paul Stevens

Well Led	Finance is on plan in month after NHSi adjustments, and also on plan ytd I&E CIPS of £21.7m reported against a plan ytd of £22m Sickness is unchanged at 3.9% - Amber rated £2.6m of cash was borrowed in December Appraisal rates improved slightly to 82.2% (previously 81.9%)	Forecast has been altered adding £11m of cost to the expected deficit giving a forecast of £30m (after NHSi adjustments) driven mainly by winter pressures and other previously flagged adjustments. CCG challenges remain a further risk. Vacancies increased 0.2% (to 11.8% from 11.6%)- still red RAG rated Staff turnover has increased to 13.6% form 13.2% prior month- still red RAG rated Temporary staff costs increasing and still running well above budget (inc. Bank and Over time) at £4.8m in month A&E recovery plan requires significant funding Pressure on CIP delivery as to recover Bite 4 schemes e.g. Patient Flow 2 and Agency reductions.	A S O N Dec	 Susan Acott

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Caring

	A	S	O	N	Dec	
OVERALL DOMAIN SCORE						Weight
Patient Experience	A	S	O	N	Dec	90 %

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Caring

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Patient Experience	Compliments to Complaints (#/1)	17	27	34	51	48	>= 12	10 %
	Mixed Sex Breaches	150	90	134	146	223	< 1	10 %
	Overall Patient Experience %	91	91	91	90	91	>= 90	10 %
	Complaint Response in Timescales %	83	77	80	87	79	>= 85	5 %
	FFT: Recommend (%)	96	97	97	97	97	>= 90	30 %
	FFT: Not Recommend (%)	1.3	1.5	1.7	1.5	1.2	>= 1	10 %

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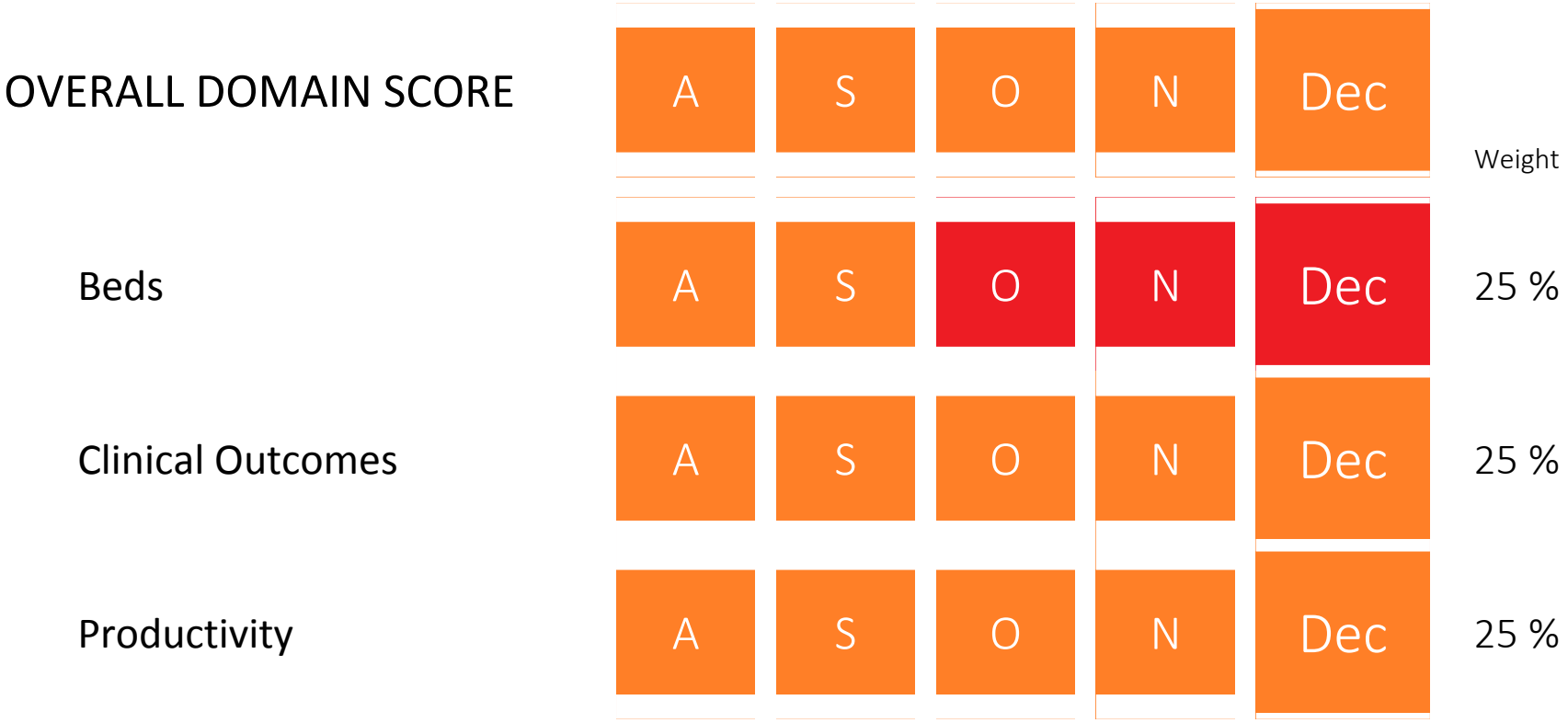
Effective



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Effective

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Beds	Bed Occupancy (%)	93	94	95	93	96	<= 92	60 %
	IP - Discharges Before Midday (%)	13	12	12	13	12	>= 35	10 %
	DToCs (Average per Day)	43	50	55	55	49	< 35	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3.4	3.3	3.3	3.3	3.4	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	15.9	15.7	15.4	15.4	15.2	< 15	15 %
	Clinical Audit Prog. Audit	3	3	3	3	3	>= 3	5 %
	Audit of WHO Checklist %	100	100	100	100	100	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	6.9	7.0	6.7	6.5	7.3	< 7	
	DNA Rate: Fup %	6.5	6.0	6.3	6.1	6.8	< 7	
	New:FUp Ratio (1:#)	0.3	0.3	0.3	0.3	0.3		
Productivity	LoS: Elective (Days)	3.1	3.0	2.8	2.7	2.7		
	LoS: Non-Elective (Days)	6.2	6.4	6.6	5.9	6.3		
	Theatres: Session Utilisation (%)	82	84	80	82	80	>= 85	25 %
	Theatres: On Time Start (% 30min)	76	78	76	77	74	>= 90	10 %
	Non-Clinical Cancellations (%)	1.5	1.7	1.4	1.6	1.9	< 0.8	20 %
	Non-Clinical Canx Breaches (%)	4	5	2	6	6	< 5	10 %
	EME PPE Compliance %	81	81	82	84	84	>= 80	20 %

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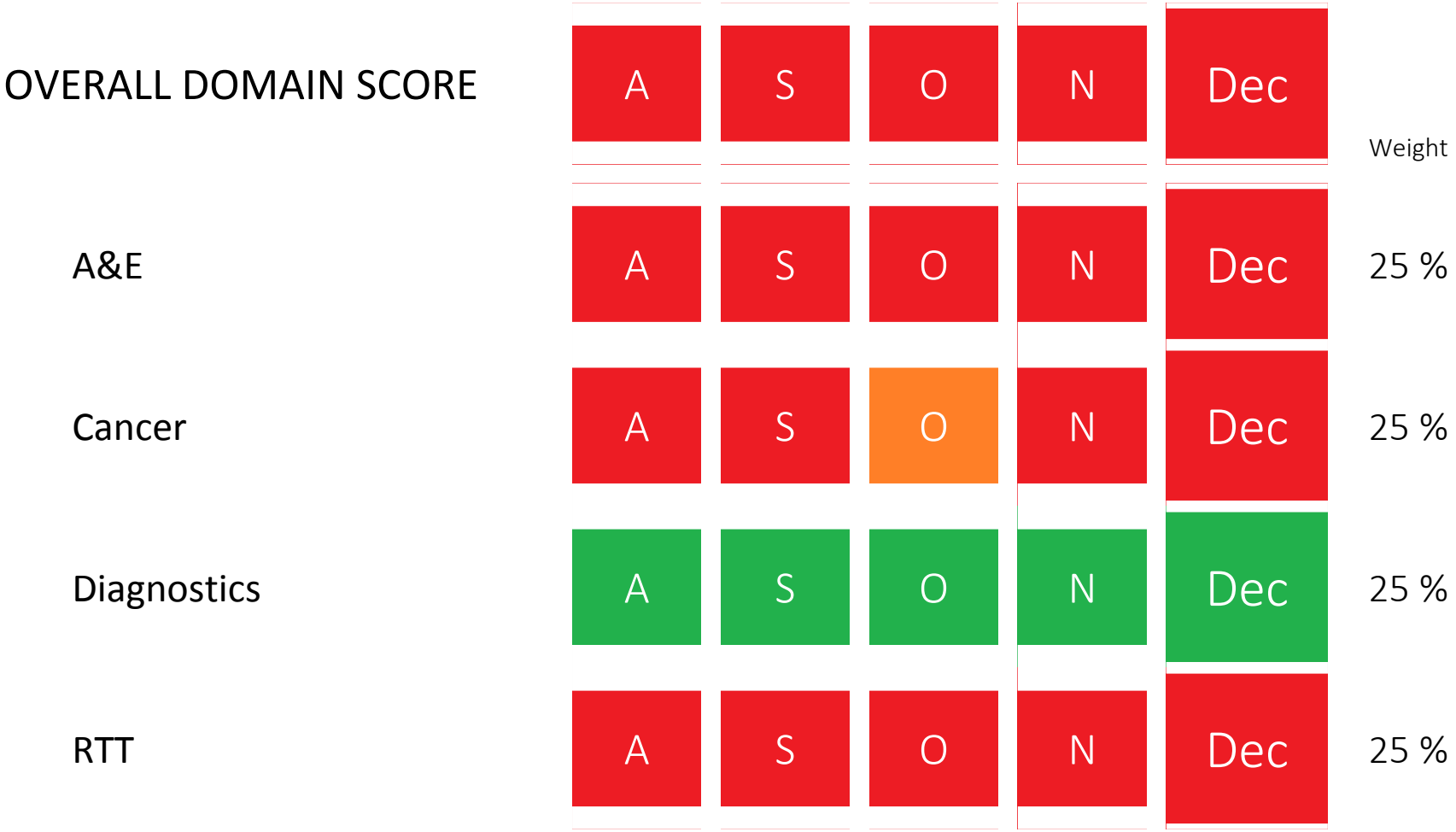
Responsive



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Responsive

		Aug	Sep	Oct	Nov	Dec	Green	Weight
A&E	ED - 4hr Compliance (%)	70.10	70.51	75.35	79.91	73.59	>= 95	100 %
Cancer	Cancer: 2ww (All) %	95.65	95.17	94.57	96.36	96.14	>= 93	10 %
	Cancer: 2ww (Breast) %	91.72	95.50	94.29	94.44	92.37	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	96.99	93.01	98.71	97.02	96.14	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	89.58	85.71	93.02	88.10	81.82	>= 94	5 %
	Cancer: 31d (Drug) %	95.52	97.01	100.00	100.00	92.00	>= 98	5 %
	Cancer: 62d (GP Ref) %	74.29	73.61	73.92	71.24	74.48	>= 85	50 %
	Cancer: 62d (Screening Ref) %	92.00	85.29	92.31	89.29	93.33	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	87.50	77.55	82.35	84.31	87.80	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.14	99.47	99.59	99.85	99.64	>= 99	100 %
	Audio: Complete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	
	Audio: Incomplete Path. 18wks (%)	100.00	100.00	100.00	100.00	100.00	>= 99	
RTT	RTT: Incompletes (%)	82.58	81.56	81.18	80.87	78.67	>= 92	100 %
	RTT: 52 Week Waits (Number)	31	51	64	67	80	< 1	

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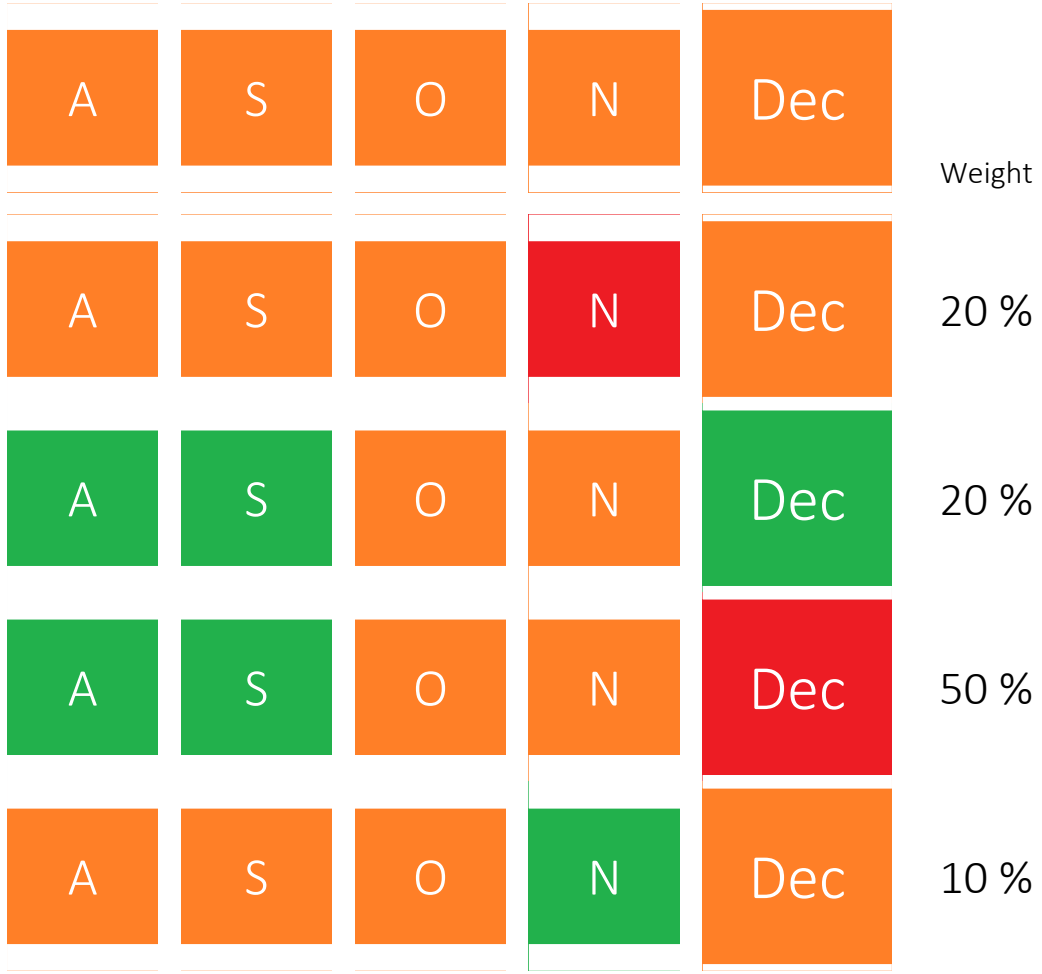
Safe



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Safe

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Incidents	Serious Incidents (STEIS)	4	7	7	4	5		
	Harm Free Care: New Harms (%)	98.5	98.6	97.7	97.7	97.4	>= 98	20 %
	Falls (per 1,000 bed days)	5.76	6.01	5.42	5.62	6.06	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.26	0.07	0.19	0.23	0.19	<= 0.15	10 %
	Clinical Incidents: Total (#)	1,283	1,281	1,366	1,308	1,364		
Infection	Cases of C.Diff (Cumulative)	15	19	22	23	25	<= Traj	40 %
	Cases of MRSA (per month)	0	0	1	1	0	< 1	40 %
Mortality	HSMR (Index)	83	83	83			< 90	35 %
	Crude Mortality EL (per 1,000)	0.4	1.4	0.5	0.1	0.9	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	34.2	34.4	36.6	35.0	45.7	< 27.1	10 %
	RAMI (Index)	83	82	93			< 87.45	30 %
Observations	Cannula: Daily Check (%)	73.5	70.8	68.7	69.7	70.3	>= 50	10 %
	Catheter: Daily Check (%)	46.0	42.8	41.1	41.6	40.4	>= 50	10 %
	Central Line: Daily Check (%)	64.6	64.1	64.0	63.9	62.1	>= 50	10 %
	VTE: Risk Assessment %	93.5	94.6	94.9	95.1	93.8	>= 95	20 %
	Obs. On Time - 8pm-8am (%)	91.8	92.1	92.2	92.2	92.5	>= 90	25 %
	Obs. On Time - 8am-8pm (%)	89.0	89.2	89.1	89.2	90.5	>= 90	25 %

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Well Led

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Well Led

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Culture	Staff FFT - Treatment (%)	70	70	70	70	70	>= 81.4	40 %
Data Quality & Assurance	Not Cached Up Clinics %	0.3	0.7	0.8	0.8	1.0	<= 0.1	25 %
	Uncoded Spells %	0.1	0.1	0.1	0.1	0.3	< 0.25	25 %
Finance	I&E £m	-1.9	-0.9	-0.2	-0.3	-2.0	>= Plan	30 %
	Cash Balance £m	4.1	6.6	10.1	1.4	8.3	>= Plan	20 %
	Total Cost £m	-50.2	-49.1	-49.6	-51.4	-51.1	>= Plan	20 %
	Forecast I&E £m	-19.0	-19.0	-19.0	-19.0	-30.0	>= Plan	20 %
	Normalised Forecast £m	-19.0	-19.0	-19.0	-19.0	-30.0	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	3	2	2	2	1	<= 3	20 %
	Formal Notices	0	0	1	0	0	< 1	15 %
Staffing	Sickness (%)	3.9	3.8	3.8	3.9	3.9	< 3.6	10 %
	Staff Turnover (%)	13.7	13.1	13.2	13.2	13.6	<= 10	15 %
	Vacancy (%)	12.3	12.2	12.2	11.4	11.8	<= 7	15 %
	Total Staff In Post (SiP)	6816	6846	6903	6946	6918		1 %
	Shifts Filled - Day (%)	96	95	105	97	98	>= 80	15 %
	Shifts Filled - Night (%)	105	103	117	103	107	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	12	12	13	12	12		
	Bank Filled Hours vs Total Agency Hours	58	57	54	54	55		1 %
	Agency %	6.5	6.4	6.6	6.6	6.0	<= 10	
Training	Appraisal Rate (%)	79.4	80.1	81.7	81.9	82.2	>= 85	50 %
	Statutory Training (%)	89	90	89	89	88	>= 85	50 %

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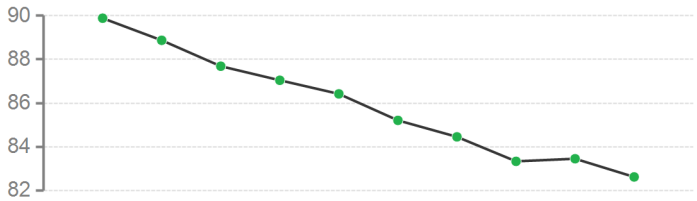
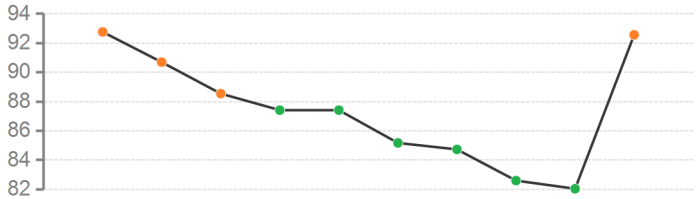
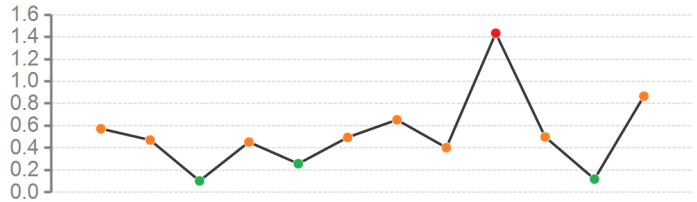
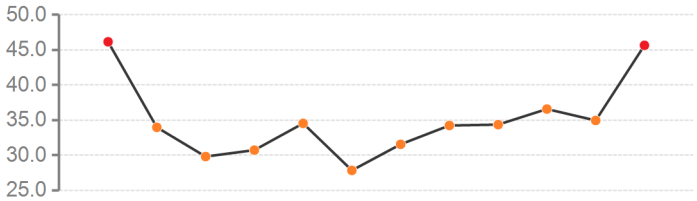
Strategic Theme: Patient Safety

Mortality

Dec	HSMR (Index)	86 (0.2%)		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)	87 (-0.1%)		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	Crude Mortality EL (per 1,000)	0.5 (31.0%)		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.
Dec	Crude Mortality NEL (per 1,000)	35.0 (14.1%)		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 in non-elective admissions has risen this period as expected. This is in association with a surge in predominantly acute respiratory illness.

As forewarned last month because the RAMI has been re-based there appears to have been a worsening index which still remains below the average and HSMR also remains below average.

The latest SHMI is from the July 2016 to July 2017 period and was 1.01 (0.90-1.12, 95% CI), this is as expected.

On CHKS data is available up until October 2017, in the period August to October 2017 overall crude mortality was 1.35% as compared with 1.33% in the corresponding months in 2016; the RAMI for the 2 periods was 87 and 99 respectively.

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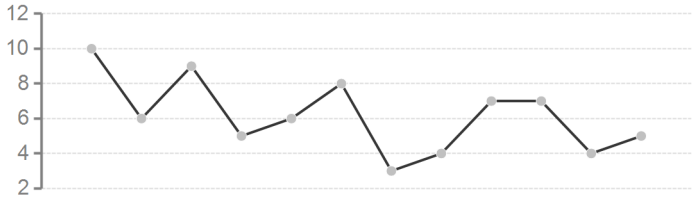
Strategic Theme: Patient Safety

Serious Incidents

Dec	Serious Incidents (STEIS)	74 (-8.6%)		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.

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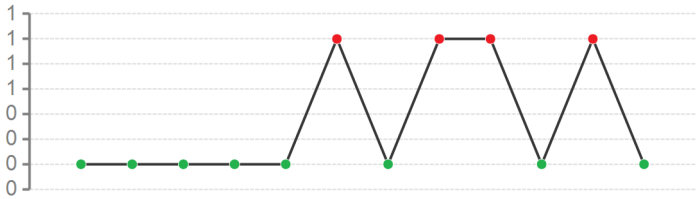
Strategic Theme: Patient Safety

Dec

Never Events (STEIS)

4
(33.3%)



Monthly number of Never Events. 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.

Comments:

Total open SIs on STEIS in December 2017: 58 (including 5 new)
SIs under investigation: 26
Breaches: 10
Non-breaches: 16
Waiting EKHUFT non-closure response: 8
Waiting CCG response: 24

Supporting Narrative:
The number of breached cases is 10; the number of older breaches is reducing. Breaches are mainly due to delays in report writing and gaps in and the rigour of the analysis. The Root Cause Analysis Panel and weekly corporate/divisional governance team meetings continue to support completion of and the quality of the investigations. The corporate team now attend many of the RCA meetings and are aligned to individual cases to support completion of the analysis and reports. Additionally the corporate team aim to link with the lead investigator early in the process.

Work continues on clearing the longest breached cases and most of these have been completed with further progress predicted. The Clinical Effectiveness Manager and Head of Patient Safety have been working with the divisions to progress completion of breached cases.

The five new SIs are:
- a Never Event (wrong implant of ophthalmology lens)
- screening issues (newborn hearing). This case has subsequently been downgraded in agreement with PHE.
- delayed treatment which meant the patient had a tracheostomy
- allegation of abuse - this is a managerial investigation
- suboptimal care of the deteriorating patient (this relates to three structured judgement reviews relating to fractured neck of femurs)

Never Events
During the last calendar year the trust has reported 4 Never Events. All have been associated with low or no harm and they have not been confined to one site or to one specialty. Specific action to be undertaken is to hold an Executive led Never Event Workshop to review the circumstances and establish the key learning which needs to be taken out to the organisation, a strategy for embedding that learning and a review process to check that the learning has been embedded.

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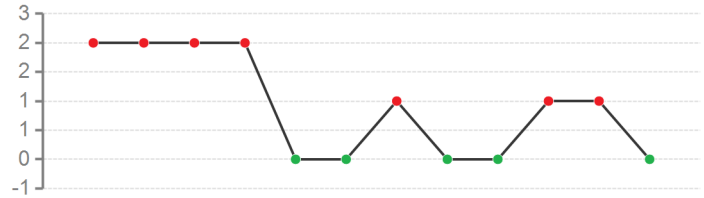
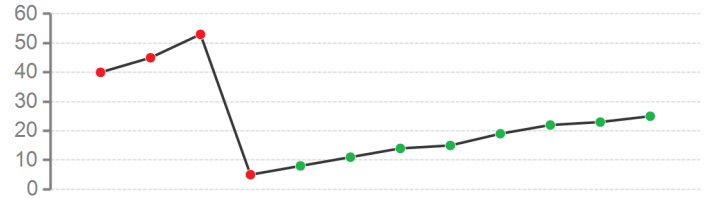
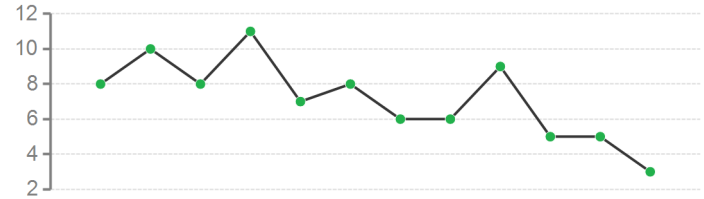
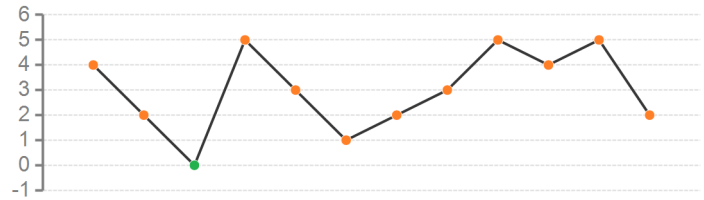
Strategic Theme: Patient Safety

Infection Control

Dec	Cases of MRSA (per month)	11 (266.7%)		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)	25 (8.7%)		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	86 (-1.1%)		The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	MSSA	36 (50.0%)		The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

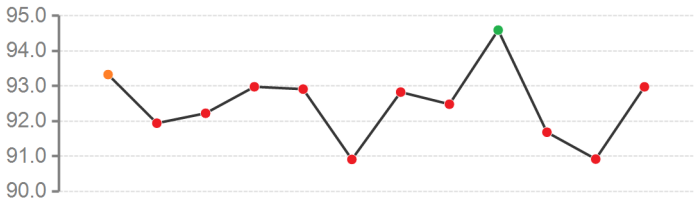
C.difficile
The year-to-date total is 28 cases against an annual limit of 46 cases (as of 19/01/2018). There is 1 case for Specialist Services, 20 cases for UC&LTC and 7 cases for the Surgical Division
MRSA
There continue to be 5 cases of Trust assigned MRSA bacteraemia this current year to date.
MSSA
Year to date there have been 30 cases of MSSA bacteraemia assigned to EKHUFT i.e. post 48 hour admission date.
E.coli
Year to date there continue to have been 58 cases of E.coli bacteraemia assigned to EKHUFT but the number of cases in East Kent has risen to 453.

The picture with Influenza has changed and in keeping with the rest of the country we have also experienced an influenza rate roughly double that of last year. Nationally for the 2nd week in January the rate was 151.2/1000 and 216 new acute respiratory outbreaks have been reported in the past 7 days (up to 18/01/2018), both Influenza A & B are co-circulating.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Patient Safety

Harm Free Care

Dec	Harm Free Care: New Harms (%)	98.6 (0.6%)		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.
Dec	Harm Free Care: All Harms (%)	92.5 (-0.2%)		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. The Safety Thermometer for Dec-17 shows an improvement in HFC to 92.98% (92.32% Nov-17). The most marked improvement is seen in the Surgical Services Division with a rise to 96.31% (87.43% Nov-17).

HFC was lower than the national average of 94.44% and the acute hospital only average of 94.32%. This reflects the high prevalence of patients admitted with urinary catheter related infections (1.98% against an acute hospital only average of 0.89%). Further work will be undertaken to explore admission source, and identify any themes, for patients admitted with a urinary catheter and UTI to understand why performance is significantly below the national average and to drive improvement priorities.

The total of Harm Free Care experienced in our care (New Harms only) at 97.46% remains similar to last month (97.72% Nov-17). This is similar to the national average of 97.94% and the acute hospital only average of 97.9%. However, there was a higher prevalence of catheters & New UTIs (1.19%) compared to the overall National Average (0.28%) and the Acute Hospital only average (0.35%). Development work led by the Infection Control team is underway to ensure improvement.

Rigorous work will continue to ensure validation is carried out correctly and focused work continues to be carried out to ensure harms are kept to a minimum and that patient safety remains a priority.

East Kent Hospitals University NHS
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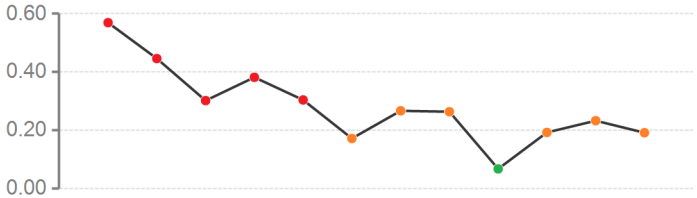
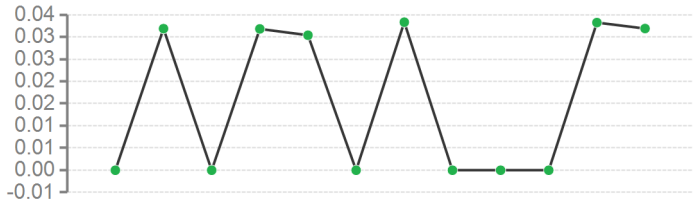
Strategic Theme: Patient Safety

Pressure Damage

Dec	Pressure Ulcers Cat 2 (per 1,000)	0.29 (-26.4%)		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)	0.02 (16.6%)		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 2017 a total of 33 category 2 pressure ulcers were reported. This is an increase of 15 from last month. This is likely to be due to the increased patient acuity that we are experiencing within the winter months. We are reporting a rate slightly over the 0.15 avoidable incidence/1000 bed days with a rate of 0.19/1000. This is an improvement on last month (0.23/1000). Although we reported significantly more category 2 pressure ulcers 6 were avoidable, a decrease of 1. These were avoidable due to lack of active mattress provision, heel offloading, a long period on an ED trolley and one incident involved a patient lying on their catheter tubing. There were 2 confirmed category 3 ulcers of which one was avoidable due to lack of documented interventions. There were no category 4 pressure ulcers. 11 unstageable ulcers were reported, an increase of 4 from last month. Three of these were avoidable. Reasons for the avoidable decision were: lack of heel offloading (x2) and lack of skin inspection under TED stockings. Actions: During December 2017 the screensaver raising awareness around medical devices was displayed again Trust-wide. Bespoke ward based teaching continued, focusing on areas of particular concern. The TVNs were invited to teach as part of the think glucose programme at QEQM and on the care certificate course trust-wide. Ward based active mattress and 'Heelpro' offloading boot training took place across the trust. The trust's 'Pressure Ulcer Patient Information' leaflet was sent to the virtual patient panel for comment and will be amended accordingly. Following discussion with the critical care outreach nurses the addition of pressure relief of medical devices is to be added to their NIV training course. The TV team are walking the floor of the EDs at least twice daily to ensure prevention strategies are in place especially during this period of winter pressure.

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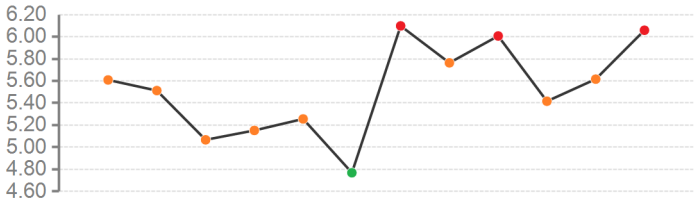
Strategic Theme: Patient Safety

Falls

Dec	Falls (per 1,000 bed days)	5.52 (-26.6%)		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 falls rate has increased in December. There were a total of 190 compared with 170 in November. 3 of these falls happened in non ward areas. 45 were at K&CH, 57 at QEQMH and 87 at WHH. Wards with the highest number of falls were CM1 (10), Oxford (12) and RSU (12) at WHH, Invicta at K&CH (11) and Deal at QEQMH (8). The sites have been under pressure in December with some staffing issues that has impacted on close observation of some high risk patients closely. Of significance is that there were 5 falls in the EDs (which is highly unusual). A patient on CL sustained a hip fracture but it is not possible to definitively state if this was the result of a medical collapse. A patient on Kent also sustained a hip fracture and preliminary opinion is that the fall was avoidable. A patient on Invicta fell 6 times and sustained a neck fracture. An RCA is being undertaken and it is likely the fall was avoidable and there is significant learning from it.
The recording of witnessed and unwitnessed falls continues to be worked up through the Datix reporting.
Actions:
1. Fall Stop programme continues at WHH on CL and CM1
2. Daily ward checks of Fall Stop AP to WHH wards to identify high risk patients and ensure risk assessments are completed and interventions are in place
3. 50% of staff on CL have now received the detailed Fall Stop training package
4. Weekly audits of risk assessment compliance on CL and CM1 demonstrates high compliance
5. Training dates set for 2018
6. Fall Stop AP is supporting Invicta at K&CH in light of the recent incident

Success:
CL ward had 17 falls in December 2016 and only 4 in December 2017, despite the seasonal pressures.

Plans:
1. Team are recruiting to the vacant band 6 post this month
2. Associate Practitioner to commence training in CDU at WHH
3. Associate Practitioner to support ED training at WHH

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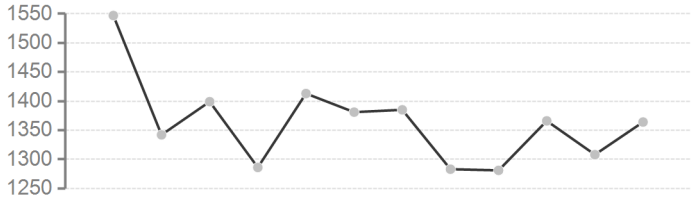
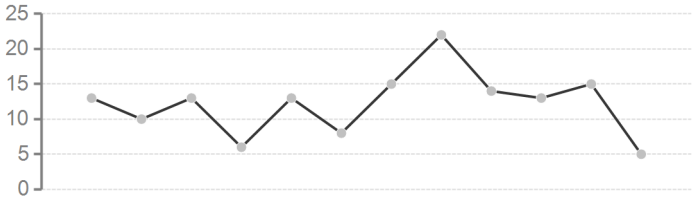
Strategic Theme: Patient Safety

Incidents

Dec	Clinical Incidents: Total (#)	16,355 (1.0%)		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 Incidents	147 (-3.9%)		The number of blood transfusion incidents 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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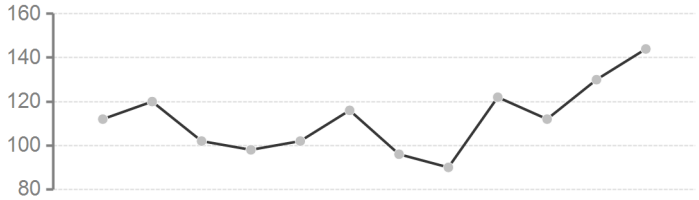
Strategic Theme: Patient Safety

Dec

Medicines Mgmt. Incidents

1,344
(0.8%)



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:

Clinical incidents overall summary
A total of 1356 clinical incidents have been logged as occurring in Dec-17 compared with 1304 recorded for Nov-17 and 1300 in Dec-16.
In Dec-17, three incidents have been graded as death and one incident has been graded as severe harm. In addition, 40 incidents have been escalated as a serious near miss, of which 11 are still under investigation. Comparison of moderate harm incidents reported: 27 in Dec-17, 11 in Nov-17 and 6 in Dec-16.
Over the last 12 months incident reporting continues to rise at WHH, and has remained constant at QEQM and K&CH.

Blood transfusion (submitted by the Blood Transfusion Coordinator)
There were 5 Blood Transfusion related incidents for December 2017 (10 in November 2017 and 19 in December 2016). There are no clear themes amongst the incidents reported. All the incidents reported were low or no harm.

The incidents were a delay in administration on the ward, a collection error where the wrong unit was collected but returned to the laboratory, a wrong blood in tube, a unit given using an incorrect giving set and a suspected transfusion reaction; that upon investigation was found to be due to the underlying condition of the patient.

Reporting by site: 4 at QEQM and 1 at WHH.

Medicines management (submitted by the Medication Safety Officer)
The total number of medication related incidents occurring in December was 172, a 21% increase from the previous month. These included 119 no harm, 50 low harm and 3 moderate harm incidents. The moderate harm incidents involved omitted doses of sodium bicarbonate and digoxin to a patient with tachyarrhythmia, the commencement of a surgical procedure before refractory hypotension had been corrected and the omission isoprenaline to a patient in complete heart block.
The severity of medication related incidents in December shows that 69.1% of incidents reported were no harm incidents. This year to date the degree of harm related to no harm incidents is 69.3% and severe harm to death 0.1%. No incidents in December required RCA or were StEIS reportable incidents.
The incidents in December by medication error showed a further increase in the number of omitted dose errors reported to 31.5%. The data produced by the Medication Safety Thermometer in December, however, has shown that the percentage of patients with an omitted dose for the Trust has decreased to 20% from 36.7% in September. However due to the reconfiguration of some of the surgical wards these were not included in the audit for December.
Apart from the missed doses of medication the themes from the incident reporting include incidents concerning the discharge of patients either without medication or the wrong medication, three penicillin allergic patients given penicillin containing antibiotics, multiple reports of enoxaparin being prescribed with Direct Oral Anticoagulants and 6 incidents involving the prescribing and administration of Total Parenteral Nutrition.

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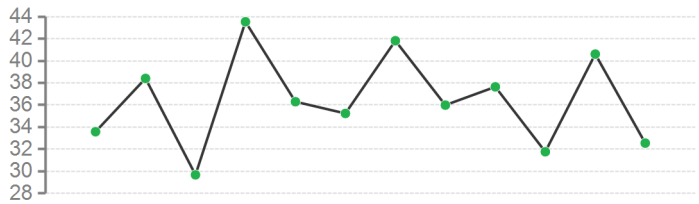
Strategic Theme: Patient Safety

Friends & Family Test

Dec	FFT: Response Rate (%)	36 (-3.5%)		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 (0.0%)		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.

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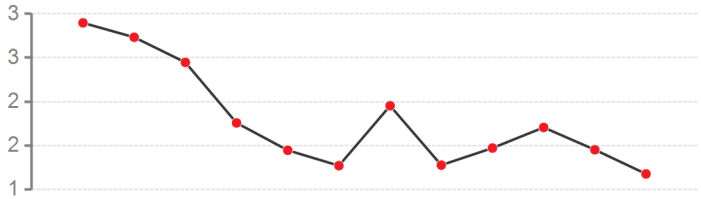
Strategic Theme: Patient Safety

Dec

FFT: Not Recommend (%)

1.8
(15.3%)



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:

A total of 7381 responses were received (33.4% eligible patients) during December. The response rate for the ED was 16.0% (15.8% Nov-17), inpatients was 32.6% (40.6% Nov-17), maternity; birth only 13.5% (19.4% Nov-17) and day cases 19.8% (21.7% Nov-17).

Recommendations by patients in December were similar to November with the total number of inpatients, including paediatrics, who would recommend our services 97.1% (96.8% in Nov-17), ED 79.6% (81.6% in Nov-17), maternity 100% (94.7% Nov-17), outpatients 92.9% (93.1% Nov-17) and day cases 95.0% (95.0% Nov-17).

90.5% of responders would recommend us to their friends and family and 6.1% would not. The Trust star rating in November is 4.55 (4.58 Nov-17).

Positive themes within FFT feedback include Staff attitude, Care, Cleaning and Competence across ED, inpatients, outpatients, maternity and day case. Negative themes within FFT feedback include:

- Patients who have experienced our EDs, outpatients and day case units feedback a poor experience of waiting times;
- Care, communication, staff attitude and environment within the EDs, inpatient areas and outpatients;
- There are no negatives themes for maternity antenatal, birth, postnatal community and postnatal

All areas receive their individual reports to display each month, containing the feedback left by our patients which assists staff in identifying areas for further improvement. This is monitored and actioned by the Divisional Governance teams.

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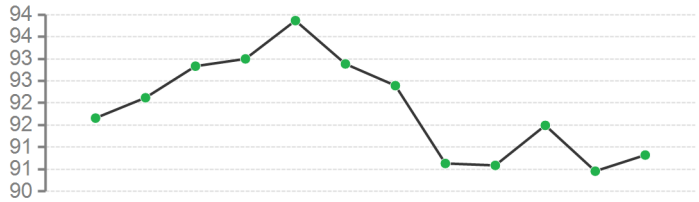
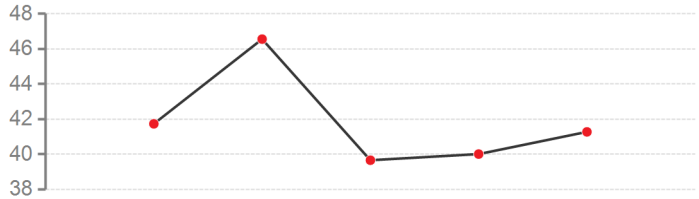
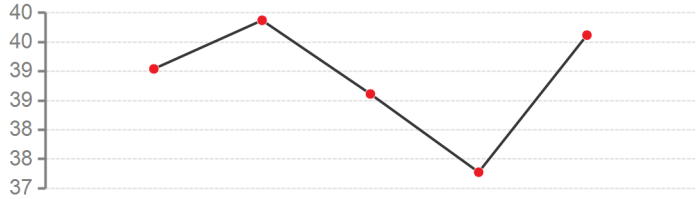
Strategic Theme: Patient Safety

Patient Experience 1

Dec	Overall Patient Experience %	92 (0.0%)		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	Privacy for discussions with Nurses %	41		Privacy for discussions Nurses
Dec	Aware of Nurse in each shift %	39		Aware of nurse in each shift

Comments:

This month overall patient experience, as a calculated average of the 5 key questions within the local inpatient survey, which enables our patients to record their experience in real-time, shows little change over the past few months.

New questions were added into the survey in August to enable close monitoring of three key areas where our performance in the 2016 national inpatient survey (published in May-17) was below the national average. Baseline performance in ensuring privacy when discussing patients' condition or treatment, ensuring patients are aware of which nurse is looking after them each shift and ensuring patients are able to discuss their worries and fears demonstrated significant opportunity for improvement.

This month a small improvement is seen across two but a fall in one of these three important elements of patient experience. An improvement plan has been implemented and progress is monitored through the Patient Experience Group.

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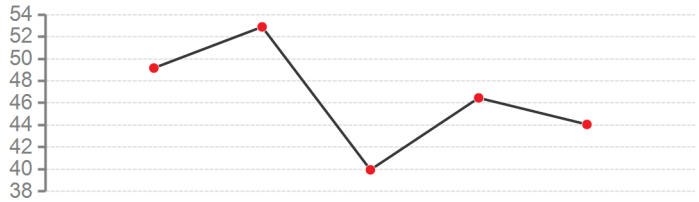
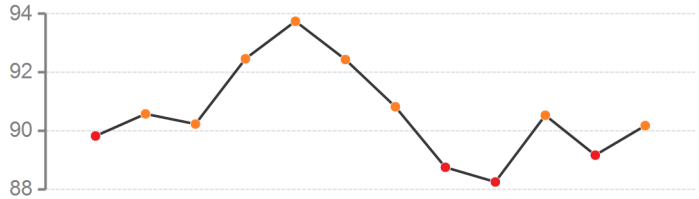
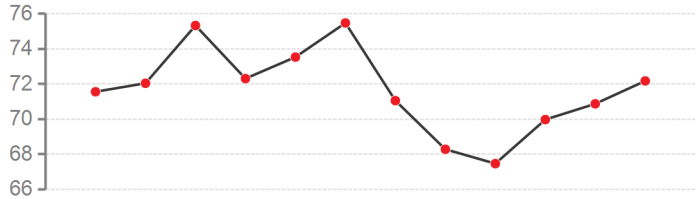
Strategic Theme: Patient Safety

Patient Experience 2

Dec	Discuss Worries with Nurses %	45		Discuss Worries with Nurses
Dec	Cleanliness? %	91 (-0.3%)		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 (-0.4%)		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:

Cleaning satisfaction, as rated by the survey, improved slightly in December. Auditing at ward level remains consistent at over 98%.

Hospital Food marginally improved again in December. We continue to work with Serco and Trust colleagues to amalgamate auditing resources so has to get a larger sample responses. We are aiming to deliver this in the new financial year.

Patient experience is additionally reported per ward within the heat map and focused work continues to promote this reporting. Several wards have not reported their performance (against the patient experience metrics) through the inpatient survey and FFT in December. Over the next quarter, the Divisional Heads of Nursing and Matrons will be working to ensure this is improved and sustained.

In quarter 3, greater focus is being placed on reviewing the results of ward and Trust surveys. The Complaints and Patient feedback steering group and Patient Experience Group will oversee this important work, to provide a Trust wide overview and ensure pace.

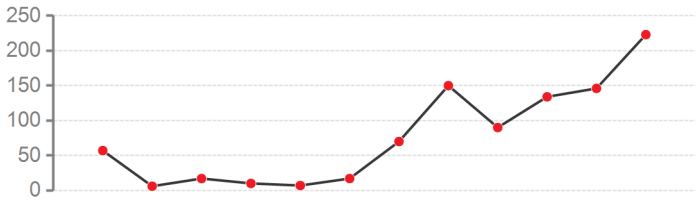
Strategic Theme: Patient Safety

Mixed Sex

Dec

Mixed Sex Breaches

927
(104.6%)



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:

Incidence of mixed sex accommodation breaches increased this month with 45 non-justifiable occurrences within the WHH CDU linked to flow and capacity issues.

There were 71mixed sex accommodation occurrences in total, affecting 309 patients. The remaining incidents occurred in the WHH CCU (21) and the QEQM Fordwich Stroke Unit (5), which were justifiable based on clinical need.

An NHSE and NHSI led Kent, Surrey and Sussex wide Task & Finish Group was established to ensure a consensus of the definitions and reporting arrangements of the national guidance, and this informed a local audit of providers of NHS funded care during September 2017. Revised guidance for reporting will be implemented from 1st Feb-18 and will include patients in critical care who are clinically ready for transfer to a ward.

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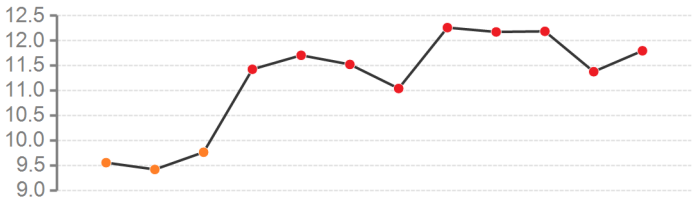
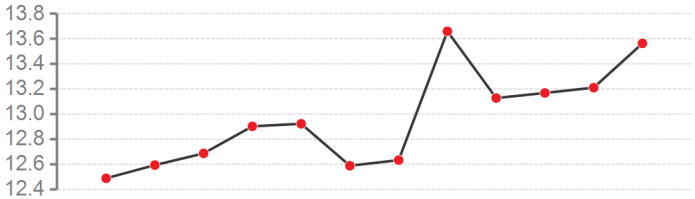
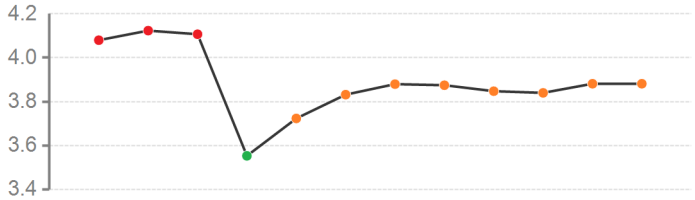
Strategic Theme: Human Resources

Gaps & Overtime

Dec	Vacancy (%)	11.2 (17.6%)		% 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 (%)	13.0 (8.8%)		% 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 (%)	4.0 (3.1%)		% 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

East Kent Hospitals University NHS
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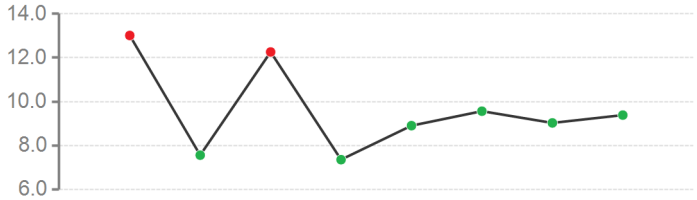
Strategic Theme: Human Resources

Dec

Overtime %

9.6
(49.4%)



% of Employee's that claim overtime.
Number indicates average of last 12 months data (as shown in graph).

Comments:

Gaps and Overtime
The vacancy rate remains steady at 11.2%, after three previous months above 12%. More work is being undertaken to target hard to fill vacancies, particularly within nursing and some Medical specialties.

The Turnover rate in month is 13.0%. Focus remains on hard to recruit roles to replace agency, but also to identify new ways and methods of attracting to hard to recruit roles. Exit data is reviewed to highlight any areas of concern.

The validated sickness absence position for November was 4.18% - which is an increase from 3.80% in October. The in month position for December is predicted at 4%. Divisions are working to develop sickness absence reduction plans, with a focus on long term sickness absence and an integrated approach to proactively managing absence with Occupational Health through case conferencing and regular contact.

Overtime as a % of wte remains steady at 9.6% for December.

All metrics are reviewed and challenged at a Divisional level in the monthly Executive Performance Reviews.

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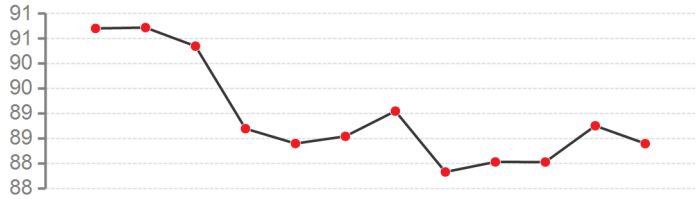
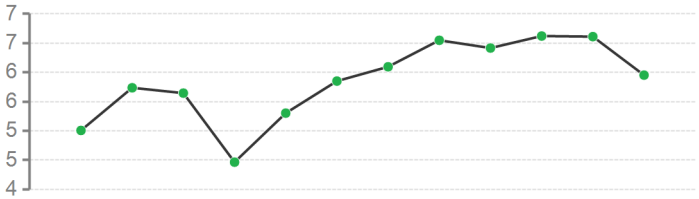
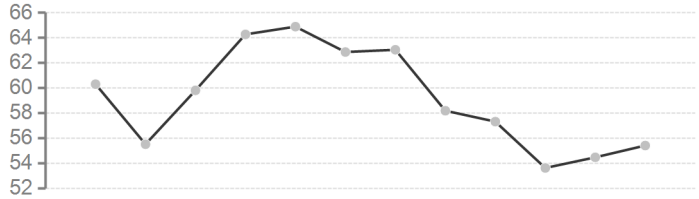
Strategic Theme: Human Resources

Temporary Staff

Dec	Employed vs Temporary Staff (%)	89.0 (-2.0%)		Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Agency %	5.9 (39.4%)		% of temporary (Agency and Bank) staff of the total WTE Number indicates average of last 12 months data (as shown in graph).
Dec	Bank Filled Hours vs Total Agency Hours	59 (22.1%)		% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff

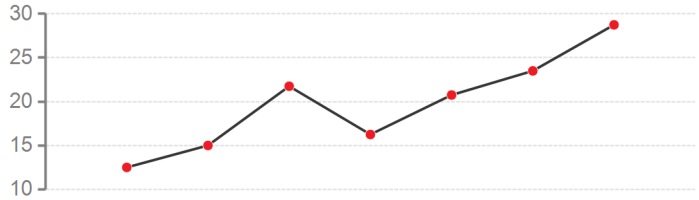
East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Dec

Local Induction Compliance %

19.8
(68.8%)



Local Induction Compliance rates (%) for temporary employee's to the Trust.
Number indicates average of last 12 months data (as shown in graph).

Comments:

Temporary Staff

Total staff in post (WTE) reduced from 6960 to 6918 in December, which left a vacancy factor of 796 wte across the Trust.

WTE agency decreased in December to 180 wte compared to 209 wte in November. Bank also reduced from 250 wte in November to 226 wte in December.

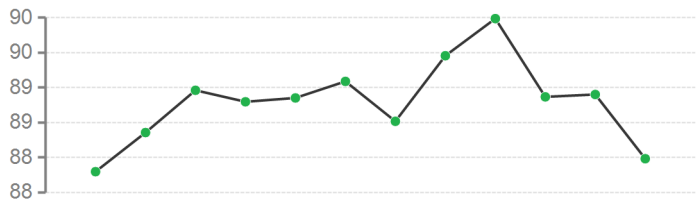
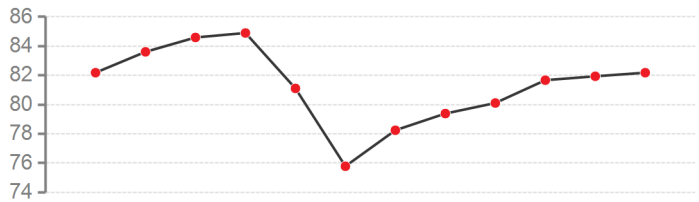
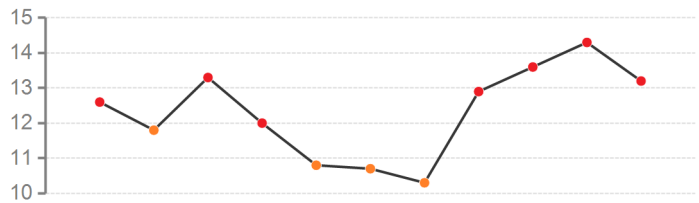
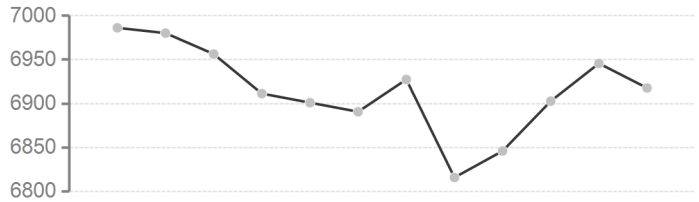
The average percentage of employed staff vs temporary staff over the last 12 months has reduced slightly from 89.1% to 89.0%.

Agency costs are monitored at EPR and weekly agency meetings, the focus remains on recruiting substantively to the reduce the use of agency. The Agency Taskforce review strategies for reducing agency costs. Divisions are all now monitoring Agency use on a post by post basis through the agency reduction plans in Aspyre with support from HR and Improvement Delivery Teams. These plans identify detailed and specific actions to eliminate where possible spend on agency.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Dec	Statutory Training (%)	89 (2.8%)		The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Appraisal Rate (%)	81.3 (1.8%)		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 (2.4%)		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	Total Staff In Post (SiP)	6918 (-0.4%)		Count of total staff in post (WTE)

Comments:

Workforce & Culture

Average Statutory training 12 month average remains at 89% but has reduced in month from 89% to 87% in December. This remains above the target of 85%. Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements. There remains an on-going issue with the recording of Information Governance, so this is being sent manually in some cases.

The Trust staff average appraisal rate increased slightly in November from to 81.3% to 82% but continues to be below the 90% target. The Surgical Services Division remain above the 90% target. Divisions are working on plans to complete outstanding appraisals as well as to avoid a further drop in appraisal rates for those due to be renewed in coming months.

The annual staff survey commenced on 9th October. EKHUFTs aim of achieving a response rate of over 50% across the organisation was achieved, with a 50.3% response rate.

The average time to recruit is 12 weeks, however a target has been set to reduce this to 8 weeks to ensure recruitment time meets the demands of our services.

Strategic Theme: Activity

East Kent Hospitals University NHS Foundation Trust

Activity vs. Internal Business Plan

Key Performance Indicators

Dec

	Dec-17				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	11,645	13,695	(-2,050)	-15%	129,613	132,921	(-3,308)	-2%	129,613	129,851	(-238)	0%	<=0%
Referral Non-Primary Care	10,933	12,519	(-1,586)	-13%	122,522	121,829	693	1%	122,522	126,835	(-4,313)	-3%	<=0%
OP New	16,604	18,273	(-1,669)	-9%	177,674	180,852	(-3,178)	-2%	177,674	183,716	(-6,042)	-3%	>=0%
OP Follow Up	35,782	38,693	(-2,911)	-8%	370,112	381,599	(-11,487)	-3%	370,112	369,521	591	0%	>=0%
Elective Daycase	5,559	5,836	(-277)	-5%	55,499	55,448	51	0%	55,499	59,578	(-4,079)	-7%	>=0%
Elective Inpatient	1,243	1,195	48	4%	11,429	11,870	(-441)	-4%	11,429	11,986	(-557)	-5%	>=0%
A&E	16,815	17,406	(-591)	-3%	157,288	161,041	(-3,753)	-2%	157,288	160,088	(-2,800)	-2%	>=0 & <5%
Non-Elective Inpatient	6,516	7,475	(-959)	-13%	60,207	64,911	(-4,704)	-7%	60,207	52,915	7,292	14%	>=0 & <5%
Chemotherapy	1,139	1,084	55	5%	10,799	11,791	(-992)	-8%	10,799	11,910	(-1,111)	-9%	>=0%
Critical Care	1,816	1,773	43	2%	16,398	16,071	327	2%	16,398	16,272	126	1%	>=0%
Dialysis	7,394	7,125	269	4%	62,546	62,434	112	0%	62,546	62,261	285	0%	>=0%
Maternity Pathway	1,006	1,089	(-83)	-8%	10,618	10,268	350	3%	10,618	10,598	20	0%	>=0%
Pre-Op Assessments	2,721	2,654	67	3%	26,548	28,812	(-2,264)	-8%	26,548	25,580	968	4%	>=0%
Diagnostic	342,859	363,516	(-20,657)	-6%	3,883,403	3,952,978	(-69,575)	-2%	3,883,403	3,887,616	(-4,213)	0%	<=0%
Other	4,683	4,835	(-152)	-3%	43,058	44,840	(-1,782)	-4%	43,058	38,892	4,166	11%	>=0%

The 2017/18 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2016/17 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals. The plan is capped at our total capacity and as such further activity (or demand reduction schemes would be required to achieve sustainable elective services. Further adjustments for patient safety/best practice issues such as reductions or increases in new to follow up rates have been applied. Finally EKHUFT have taken a view on the viability of CCG QIPP schemes achieving a reduction in demand in 2017/18. It should be noted that this does not reflect demand levels agreed within the 2017/18 contract. All trajectories to support attainment of the Sustainability and Transformation Funding have been based on this activity plan.

The capacity levels within the plans should be considered achievable although in many instances will stretch our services beyond their internal substantive capacity, efficiency programmes, workforce recruitments plans and it is anticipated therefore that substantial elements of the plan will continue to be delivered though additional waiting list payments. Within Orthopaedics projected demand exceeded our ability to deliver the operative demand and as such agreements have been made with our local CCGs for services to be directly commissioned with alternative providers.

December 2017

Elective Care

In December Primary Care referrals were 15% below expected levels; this increased the YTD variance to approximately -2,500. Referrals are comfortably within normal levels and at the same levels as those observed last year.

The Trust under achieved the new outpatient plan for December with appointments -9% (-1,669) under plan. This has increased the YTD variance to -2%. As with previous month the biggest drivers behind the under-performance are T&O, Physiotherapy, Ophthalmology and Cardiology. With the exception of T&O these specialties and seventeen further services are actively producing quantified recovery plans intended to respond to specialty level underperformance and deliver the full new outpatient plan. Reduction in primary care demand for Orthopaedics has rendered the specialty plan unachievable. Additional Locum capacity within the Neurology service has enabled them to recover their YTD underperformance and plans are in place to reduce waiting times to expected levels.

Expected reductions in capacity due to bank holidays and high annual leave throughout the festive period meant the Trust was unable to deliver capacity in line with demand, and as such both the waiting lists and backlogs increased in month.

As with new Outpatients the Trust was unable to deliver the follow up plan December, the YTD underperformance has remained at -3% (-11,487). There remain a number of large underperforming specialties, most notably Ophthalmology (-6,673), Physiotherapy (-4,433), Rheumatology (-3,100), Dermatology (-2,897) and Endocrinology (-2,122). The Physiotherapy service are reporting induction delays, a high vacancy rate and unusually high levels of maternity leave as the key drivers behind the underperformance, plans have been developed to recover the financial performance are now being realised.

A delay in the implementation of the CCG community contracts has resulted in long waiting times for Ophthalmology patients requiring follow up management. This has impacted on quality and patient safety. A recovery plan has now been implemented and the CCG has finalised contracts with community providers and the issue regarding the community clinical teams being requested to work outside NICE guidance in terms of the drug regime for wet Macular Degeneration (wAMD) has now been resolved. In order to address the immediate backlog of patients the following actions are being taken:

- Sub specialities such as Ophthalmology- therapeutics, diagnostics, Orthoptics general, refraction, contact lens and low vision have plans to validate and reduce the waiting times focusing on removing duplication of appointments
- The clinical lead is exploring the external medical workforce for short term options of recruitment until substantive appointments are made from phase 2 of the business case

- Investment of phase 2 of business case to engage clinical staff for 2018/19
- Review phase 3 of business case to ensure this is still in line with current growth with Business Planning 2018/19
- Transfer of Wet AMD follow ups to community (Dec 2017)
- Transferring of Wet AMD internal capacity to medical retina (Feb 2018)
- Commence with external insourcing to provide additional capacity (Feb 2018)
- Redesign of operational support to ensure targeted validation and booking of high risk areas. This will be further supported by a team of failsafe officers
- Redesign pathways to implement virtual clinics, linked to phase 2 of the Business case
- Implemented an urgent category process to ensure follow up patients receive their appointment within 8 weeks.
- Transfer of glaucoma stable patients to the community when CCG advise this pathway is in place (Feb 2018)
- Additional internal clinics continue to be undertaken (commenced)
- Change of job plans to facilitate additional clinic capacity (Jan 2018)

A more detailed report is being taken to the Board's Quality Committee and will be appended to the Quality Committee's Chair Report to the Board of Directors.

In December the Trust under-achieved the Daycase plan by -227 patients however the YTD performance remains at planned levels. The Orthopaedic service remains the largest risk to delivery of the plan. A number of unavoidable recruitment delays combined with significant unplanned leave is driving an underperformance in activity. In addition to this, the service continues to lose capacity to short notice cancellations for Trauma and DNA's. Changes to the waiting list initiative payment has limited the services ability to recover the position with additional sessions in month, as such they have now developed long term plans to address the underperformance, plans to increase day surgery rates over a 6 week winter period will improve this position across the year.

Elective Admissions are 4% behind the plan in the YTD, with large underperformances observed in Orthopaedics, Cardiology, Gynaecology, ENT and Paediatrics. The Trust secured additional theatre capacity to improve the position over the remainder of the year, although recovery plans would be dependent on access to acute beds in early December and from mid-February. There is a significant risk the required beds will be taken for non-elective acute medical patients over the winter months. General Surgery and Ambulatory care continue to perform well above planned levels.

Non Elective Care

The Trust sees non elective admissions to all of its 3 sites. These are typically some of the patients who attend the Trust Accident & Emergency departments, or are admitted directly through to the wards upon agreement with General Practitioners. These patients have an urgent clinical need that cannot wait for an elective pathway or outpatient appointment to be given, and so are monitored within the hospital site as diagnosis and treatment for their clinical condition is conducted. From the 19th June 2017, the Trust invoked a business continuity plan which resulted in acute medical patients no longer being admitted at the Kent & Canterbury site.

Accident & Emergency continues to track within 2% of expected activity levels.

In monitoring Non Elective care, metrics (detailed below) are reviewed to determine if patients are able to flow through the hospital without significant delays and bottlenecks.

The Bed Occupancy of the Trust continued to be at challenging levels through December with overall Trust wide bed occupancy around 95.1% (92.8 in November). At the Queen Elizabeth the Queen Mother Hospital site the bed occupancy position deteriorated and remained at 99.3% over December. The William Harvey Hospital position has also continued to show above-expected bed occupancy with an overall position of 96.8% for December. Bed occupancy positions are taken from midnight snapshots of Trust systems and compared against the number of available funded bed establishment.

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 continued to increase in comparison to November & October, with a monthly average of 85 medical outliers across the Trust, compared to an average of 70 and 65 previously. Individual site levels of medical outliers show a continuation of raised numbers over the month at the William Harvey Hospital site (30 at QEQMH, 50 at WHH).

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	6,750	8,145	-17%	-1,395
130 - Ophthalmology	12,244	13,619	-10%	-1,375
300 - General Medicine	1,038	1,621	-36%	-583
140 - Maxillo Facial	5,631	6,204	-9%	-573
107 - Vascular Surgery	1,666	2,145	-22%	-479
120 - Ear, Nose & Throat	8,541	8,978	-5%	-437
651 - Occupational Therapy	448	36	1135%	412
329 - TIA	1,089	516	111%	573
420 - Paediatrics	4,812	4,208	14%	604
320 - Cardiology	12,309	11,630	6%	679
Total	**129,613**	**132,921**	**-2%**	**-3,308**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	26,417	27,527	-4%	-1,110
110 - Trauma & Orthopaedics	13,991	14,863	-6%	-872
650 - Physiotherapy	10,405	10,994	-5%	-589
328 - Stroke Medicine	619	1,162	-47%	-543
400 - Neurology	1,563	1,948	-20%	-385
329 - TIA	642	1,002	-36%	-360
107 - Vascular Surgery	1,203	830	45%	373
300 - General Medicine	1,593	1,133	41%	460
800 - Clinical Oncology	8,599	8,046	7%	553
130 - Ophthalmology	9,367	7,109	32%	2,258
Total	**122,522**	**121,829**	**1%**	**693**

OP New

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	15,258	16,964	-10%	-1,706
320 - Cardiology	18,241	19,468	-6%	-1,227
650 - Physiotherapy	14,738	15,909	-7%	-1,171
328 - Stroke Medicine	558	1,125	-50%	-567
130 - Ophthalmology	16,380	16,932	-3%	-552
143 - Orthodontics	587	221	166%	366
300 - General Medicine	1,955	1,581	24%	374
100 - General Surgery	3,462	3,046	14%	416
420 - Paediatrics	6,384	5,922	8%	462
655 - Orthoptics	2,243	1,623	38%	620
Total	**177,674**	**180,852**	**-2%**	**-3,178**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	43,291	49,964	-13%	-6,673
650 - Physiotherapy	48,723	53,156	-8%	-4,433
410 - Rheumatology	10,756	13,856	-22%	-3,100
330 - Dermatology	15,655	18,552	-16%	-2,897
302 - Endocrinology	1,609	3,731	-57%	-2,122
110 - Trauma & Orthopaedics	25,995	28,058	-7%	-2,063
400 - Neurology	5,391	6,927	-22%	-1,536
800 - Clinical Oncology	32,296	30,442	6%	1,854
290 - Community Paediatrics	17,881	14,349	25%	3,532
320 - Cardiology	18,637	13,503	38%	5,134
Total	**370,112**	**381,599**	**-3%**	**-11,487**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	3,986	4,792	-17%	-806
410 - Rheumatology	982	1,364	-28%	-382
303 - Clinical Haematology	2,401	2,694	-11%	-293
330 - Dermatology	3,219	3,510	-8%	-291
120 - Ear, Nose & Throat	2,009	2,152	-7%	-143
430 - HCOOP	585	376	55%	209
320 - Cardiology	2,476	2,232	11%	244
502 - Gynaecology	1,749	1,437	22%	312
300 - General Medicine	15,591	15,189	3%	402
800 - Clinical Oncology	3,724	2,777	34%	947
Total	**55,499**	**55,448**	**0%**	**51**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	2,487	2,871	-13%	-384
320 - Cardiology	235	549	-57%	-314
502 - Gynaecology	1,005	1,228	-18%	-223
120 - Ear, Nose & Throat	550	685	-20%	-135
420 - Paediatrics	143	229	-38%	-86
103 - Breast Surgery	315	395	-20%	-80
430 - HCOOP	129	54	141%	75
104 - Colorectal Surgery	397	310	28%	87
503 - Gynaecology Oncology	201	81	147%	120
300 - General Medicine	1,464	751	95%	713
Total	**11,429**	**11,870**	**-4%**	**-441**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
180 - Accident & Emergency	2,878	5,300	-46%	-2,422
430 - HCOOP	8,014	9,422	-15%	-1,408
300 - General Medicine	18,894	20,016	-6%	-1,122
420 - Paediatrics	6,817	7,267	-6%	-450
101 - Urology	2,863	3,187	-10%	-324
100 - General Surgery	4,452	4,703	-5%	-251
422 - Neonatology	423	255	66%	168
320 - Cardiology	1,599	1,413	13%	186
501 - Obstetrics	3,665	3,434	7%	231
110 - Trauma & Orthopaedics	3,168	2,800	13%	368
Total	**60,207**	**64,911**	**-7%**	**-4,704**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	3883389	3952978	-2%	-69,589
A&E	157288	161041	-2%	-3,753
Pre-Op	26548	28812	-8%	-2,264
Other	43058	44840	-4%	-1,782
Chemotherapy	10799	11791	-8%	-992
Maternity Pathway	10618	10268	3%	350
Critical Care	16398	16071	2%	327
Dialysis	62546	62434	0%	112

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

4 Hour Emergency Access Standard

Key Performance Indicators

73.59%

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Green
4 Hour Compliance	70.57%	75.94%	80.16%	76.93%	76.78%	78.15%	71.18%	70.10%	70.51%	75.34%	79.91%	73.59%	95%
12 Hour Trolley Waits	2	0	0	0	0	1	1	2	0	0	0	2	0
Left without being seen	4.87%	3.53%	3.08%	3.82%	3.57%	3.62%	5.05%	4.51%	4.48%	3.44%	2.65%	3.34%	<5%
Unplanned Reattenders	8.20%	8.62%	9.11%	8.48%	9.04%	9.45%	10.00%	9.22%	8.75%	8.68%	8.32%	9.03%	<5%
Time to initial assessment (15 mins)	76.1%	76.4%	77.8%	77.9%	93.8%	93.9%	92.4%	92.3%	93.4%	90.6%	91.1%	88.6%	90%
% Time to Treatment (60 Mins)	39.8%	40.8%	40.7%	39.4%	51.1%	51.6%	46.7%	46.1%	45.9%	47.8%	54.6%	53.3%	50%

2017/18 Trajectory (NHSI Return 7th June 2017)

-16.41 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
Trajectory	75.0%	75.0%	80.0%	83.0%	87.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	95.0%	
Performance	76.9%	76.8%	78.2%	71.2%	70.1%	70.5%	75.3%	79.9%	73.6%				

The Emergency Access Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against the 4 Hour Standard.

Summary Performance

December performance for the 4 hour target was 73.6%, against the NHS Improvement trajectory of 90.0%.This is a decreased performance compared to the previous month. There were two 12 Hour Trolley Waits for December compared to zero for the previous three months. The number of patients who left the department without being seen remained compliant, but increased from last month to 3.34%. Unplanned reattendances increased further to 9.03%.

The priority and focus for December has been to maintain safe patient care; improving performance and patient flow across the whole emergency patient pathway. There has been an increase in activity, with high numbers of medically unwell patients attending ED by ambulance. Patient acuity has been high with notable respiratory illness. The increase in acuity has put increasing pressure on the staff in ED to maintain safe patient care and in order to mitigate this risk additional consultant acute physician hours have been allocated to ED and also ambulatory care and the Acute Medical Unit. Additional Consultant Physician sessions have also been implemented to ensure that, where possible, patients on the medical wards, including patients in winter escalation beds or outliers have been reviewed 7 days per week.

It is also a priority to work with SECAMB colleagues in order to minimise the number of handover delays. This has proven to be challenging when high numbers of ambulance arrive within an hour, including GP expected medical patients arriving in the early evening.

The WHH ED's Rapid Assessment and Treatment area has been opened with a new patient flow to enable ambulance and walking patients to be assessed on arrival and steamed to the most appropriate area of the department. A dedicated seated observation area for patients, who may require a longer period of assessment or treatment, has been completed and is temporarily in use as an assessment area until the furniture arrives.

The QEQMH improvement works have all been completed with new waiting room chairs arriving in January. Due to the number of majors patients attending in the evenings and at weekends, the minor injuries service has been relocating into Monkton Suite, which has been successful in helping to maintain patient flow.

Medical staffing vacancies at Speciality Doctor (middle grade level) continue to improve as new substantive doctors are coming into post. Nursing vacancies are increasing due to the pressure of work within the department, however, a robust workforce plan is being developed, which includes a skills escalator for nursing career development.

The 2020 improvement programme continues with a site focus on patient flow. Identifying a golden patient from each ward to support early morning discharge, together with increased use of the Discharge Lounge is on-going. A priority is to focus on improving the bed allocation process to reduce any unnecessary time delays from when a bed is allocated to a new patient arriving on the ward.

The GP in ED service continues to become integrated within the departments.

Risks to delivery of the standard:

- Overcrowding in ED due to poor patient flow and lack of timely bed availability.
- High patient acuity
- Continued high levels of activity, particularly in the evenings.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

Cancer Compliance

Key Performance Indicators

74.48 %

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Green
62 day Treatments	60.61%	70.45%	77.30%	72.40%	70.19%	75.18%	73.80%	74.29%	73.61%	73.92%	71.24%	74.48%	>=85%
>104 day breaches	40	40	40	38	32	46	42	30	25	28	27	23	0
Demand: 2ww Refs	3,100	2,920	3,609	2,625	3,296	3,630	3,329	3,475	3,174	3,399	3,341	2,716	2990 - 3305
2ww Compliance	95.82%	96.08%	97.41%	93.59%	95.67%	96.78%	94.86%	95.65%	95.17%	94.57%	96.36%	96.14%	>=93%
Symptomatic Breast	97.27%	94.81%	93.57%	90.91%	90.71%	89.87%	83.97%	91.72%	95.50%	94.29%	94.44%	92.37%	>=93%
31 Day First Treatment	93.63%	96.96%	97.42%	95.68%	94.81%	95.99%	93.92%	96.99%	93.01%	98.71%	97.02%	96.14%	>=96%
31 Day Subsequent Surgery	82.22%	94.12%	90.24%	89.29%	92.00%	85.96%	87.04%	89.58%	85.71%	93.02%	88.10%	81.82%	>=94%
31 Day Subsequent Drug	96.94%	95.77%	97.50%	97.06%	95.24%	97.53%	98.41%	95.52%	97.01%	100.00%	100.00%	92.00%	>=98%
62 Day Screening	91.67%	76.47%	89.23%	92.00%	95.00%	95.83%	92.73%	92.00%	85.29%	92.31%	89.29%	93.33%	>=90%
62 Day Upgrades	75.68%	92.59%	69.77%	66.67%	80.56%	76.19%	86.84%	87.50%	77.55%	82.35%	84.31%	87.80%	>=85%

2017/2018 Trajectory

-11.52 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	71.60%	66.60%	76.80%	80.90%	83.40%	85.90%	85.60%	85.80%	86.00%	86.00%	85.50%	87.00%	Sep
Performance	72.40%	70.19%	75.18%	73.80%	74.29%	73.61%	73.92%	71.24%	74.48%				Sep

The 62 Day Cancer Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance. A Cancer Recovery Plan is in place with an aim to improve performance and ensure that the cancer standards are sustainably delivered across all tumour sites.

Summary Performance

December performance is currently 74.48% against the improvement trajectory of 86%, validation continues until the beginning of February in line with the national time table. The total number of patients on an active cancer pathway is 2,318. There are currently 23 patients waiting 104 days or more for treatment, a significant reduction over the past year.

Our overall PTL size has been decreasing over the past six months from approximately 3,100 to circa 2,300 in the previous three months. There is also a decrease in the total number of patients over 62 days on the PTL (both diagnosed and undiagnosed) which has been an average of 180 over the past year, but is currently 160

Risks to delivery of the standard:

- Key areas of concern for the Trust are Urology, Lung, and adequate surgical theatre capacity.

Actions taken to mitigate risk and improve performance:

- Daily cancer huddle meetings have been implemented for Lung, Lower GI, Urology and Head and Neck with the focus on patients between day 40 upwards, to ensure all breaches are prevented as far as possible. We have seen a significant reduction in patients over 62 days and 104 days since this has been implemented and have prevented breaches since this process has been implemented.

	July Average	August Average	September Average	October Average	November Average
Over 62 days	180	155	158	140	135
Over 104 days	43	38	29	22	26

- A webpage style PTL has been implemented with all tumour sites. This refreshes data every 30 minutes from Infloflex providing a real time position and validation for each tumour site. This has seen significant improvements within tumour sites in terms of actions being completed and patients being pushed through their pathways.
- We had a successful visit from NHSI and IST at the end of October, with the focus on Urology. Key actions have been taken from this meeting including demand and capacity modelling for diagnostics and urology.

- In October we saw significant improvements in key target areas – in particular 31 day first treatment where we only had 2 breaches for the whole of October which illustrates our capacity to treat these patients is right.
- Our 62 day upgrade performance also improved to 81%.
- We have been successful in gaining funding from NHSI to support improvement in our 62 day performance. We have been given £48K which was utilised for additional cancer pathway trackers and a pathway tracker for pathology. This has been very successful and we are looking to make this role substantive. Last month and additional £145k was agreed to be spent on radiology reporting to improve this turnaround time.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

18 Week Referral to Treatment Standard

Key Performance Indicators

78.67 %

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Green
Performance	83.79%	84.35%	85.40%	84.85%	85.82%	85.07%	83.61%	82.58%	81.56%	81.18%	80.87%	78.67%	>=92%
52w+	18	24	28	29	36	30	30	31	51	64	67	80	0
Waiting list Size	45,682	45,449	46,483	47,649	49,241	50,377	53,801	54,519	54,749	54,783	54,777	54,383	<38,938
Backlog Size	7,407	7,111	6,785	7,218	6,980	7,519	8,816	9,497	10,096	10,312	10,481	11,599	<2,178
Demand: PC Referrals	15,063	14,909	17,861	13,817	16,462	16,946	15,779	15,534	15,172	16,529	16,026	12,428	<15,484
Demand: Additions to IP WL	3,359	3,096	3,613	2,720	3,134	3,496	3,224	3,143	3,228	3,551	3,824	2,885	<3,076
Pathway 1st OPA													>=92%
Pathway Decision to Treat													>=92%

2017/2018 Trajectory

-6.28 %

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	84.13%	83.46%	84.20%	84.44%	83.91%	84.45%	84.75%	85.71%	84.95%	85.18%	86.00%	86.93%	87%
Performance	84.85%	85.82%	85.07%	83.61%	82.58%	81.56%	81.18%	80.87%	78.67%				Sept

The Referral to Treatment Waiting Time Standard is subject to a Contract Performance Notice due to the Trust being unable to achieve compliance against this standard. An RTT Recovery Plan has been developed jointly with local CCGs in order to address both short term backlog clearance and longer term increases in recurrent demand. The aim of the plan is to improve performance and ensure that the RTT Standards are sustainably delivered throughout the Trust.

Summary Performance

December performance decreased to 78.67%. Expected reductions in capacity due to bank holidays and high annual leave throughout the festive period meant the Trust was unable to deliver capacity in line with demand, and as such both the waiting lists and backlogs increased in month. The Trust had planned to reduce elective activity to increase capacity for emergency acute medicine. This was a national requirement. The 2% reduction in performance is similar to that observed in previous years. On the 21st of December two elective orthopaedic wards were transferred to medicine in accordance to the planned winter plan to support the sickest patients attending our hospitals. This has resulted in a reduction in the admission of elective Orthopaedic inpatients.

The number of patients waiting over 52 weeks for first treatment has increased to 80. **This is above the trajectory submitted to NHSI, General Surgery (32), Gynaecology (34), ENT (5), Urology (3), Orthopaedics (1), MFU (1), General Medicine (1), Dermatology (1) and Other Specs (2).** This is due to the following reasons:

1. Due to slippage of additional capacity schemes that were due to commence in September, it has not been possible to resolve the capacity issues highlighted in Gynaecology and General Surgery in particular. Schemes are now confirmed for the end of October (and beginning of December (gynaecology and general surgery). However, with the pressure on emergency pathways the majority of this capacity will be based on day case admission only.

2. As a result of winter bed pressures and the requirement to review elective activity it will be necessary to review patients on elective pathways to mitigate the risk for 52 week breaches in these and other specialities.

Risks to delivery of the standard:

- Continued Increase in Orthopaedic & General Surgery waiting list additions.
- Higher than planned demand within business plan resulting in no flexibility within capacity in key specialities such as Orthopaedics, Dermatology, Maxillo Facial and Gynaecology.
- Recruitment constraints in services such as Neurology and Dermatology, leading to long outpatient waits.
- Change in payment for waiting list initiatives, has led to a significant reduction in medical staff providing additional capacity outside agreed job plans.
- General Surgery capacity for patients presenting with high BMI for benign disease (single handed surgeon) creating 52 week waits.
- ENT surgical demand remains in excess of capacity in key subspecialties resulting in 52 week waits.
- Winter pressures, reduction in bed and theatre capacity as stipulated by NHSI to admit and treat our sickest patients
- Waiting time from referral to first outpatients in some key specialities
- High wait times in the awaiting decision to treat in General Surgery

Actions taken to mitigate risk and improve performance:

- The new Interactive Patient Tracking Technology has been implemented which allows real time recording of patient pathways and supports the operational teams in delivery.
- Continued sourcing of outpatient internal capacity is being established for Orthopaedics, ENT, General Surgery, Maxillo Facial and Gynaecology.
- Saturday working in new consultants contracts across the trust to improve utilisation of theatres and increase capacity.
- Improve Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots, a baseline has been produced and the effectiveness in reducing waste has commenced.
- The Trust has established long term solutions to begin to sustainably address the imbalance in capacity and demand in December, through a number of schemes, including; increasing theatre utilisation to 50 weeks per year, develop local anaesthetic cataract surgery in Buckland Hospital, Dover releasing 5 theatre sessions per week at acute hospitals William Harvey and Queen Elizabeth the Queen Mother Hospitals.
- Tendered for insourcing providers for Ophthalmology and Orthopaedic day case capacity to commence in February
- Business Planning for 18/19 to reduce the waiting list size utilising the capacity that is available
- Production plans in each speciality linked to reducing waiting times

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.6%

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Green
Performance	99.65%	99.67%	99.78%	99.06%	99.36%	99.46%	99.20%	99.14%	99.47%	99.59%	99.85%	99.64%	>=99%
Waiting list Size	14,171	14,048	15,580	14,882	14,480	14,709	14,822	14,011	14,827	15,419	14,321	14,345	<14,000
Waiting > 6 Week Breaches	49	46	35	140	92	80	119	120	79	63	22	52	<60
Average Wait													<4

2017/18 Trajectory

0.54%

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Green
STF Trajectory	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	Apr
Performance	99.06%	99.36%	99.46%	99.20%	99.14%	99.47%	99.60%	99.85%	99.64%				Apr

Summary Performance

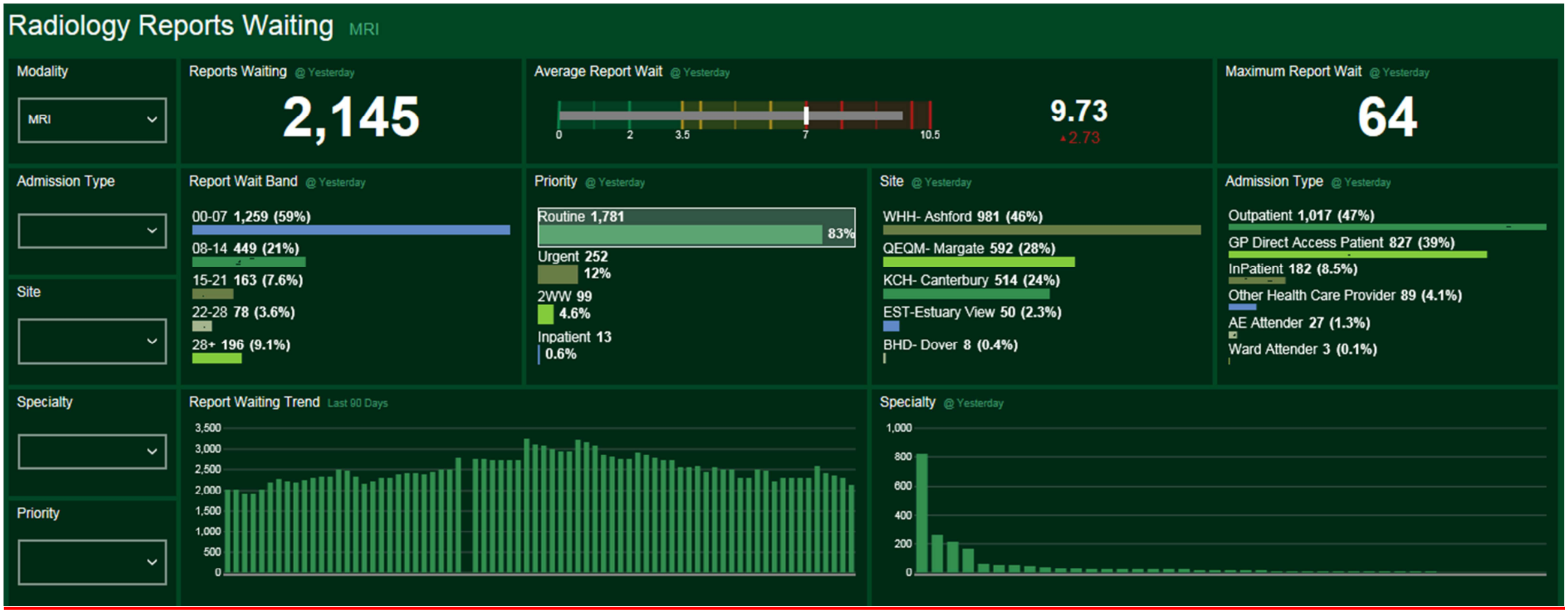
The standard has been met for December 2017 with a compliance of 99.64%. As at the end of the month there were 582patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 39, 24 in Computed Tomography, 8 in Non-Obstetric ultrasound, 5 in MRI, 2 in DEXA
- Cardiology: 6
- Urodynamics: 7

Risks to delivery of the standard:

- Of the 58 breaches in total (12 in Echocardiography, 39 Radiology, 7 Urodynamics in Gynaecology). The number of patients waiting has decreased slightly by 29. Focussed daily oversight is required in order to maximise each patient and equipment on all sites to continue to deliver the standard.
- The backlogging of examinations on to the RIS and completing the unspecified images on PACS in radiology due to the November GE / IT/ server issues, which caused a major outage for 7 days has been completed. The knock on reporting backlog has improved for MRI since December but deteriorated slightly for CT.
- Current wait time for Cancer referrals is 3-5 days for CT and 11-12 days for MRI.
- CT backlog reports are 1,621 (previous report 1,529) and MRI is 2,819 (previous 3,225) CT has grown in month as a result of the reduction in locum capacity, some progress had been made in MRI in the main due to third party capacity as of 18/01/18. Reporting in a timely way for each patient within all modalities remains a concern for the Division; patients are still waiting a long time for a report and a clinical outcome.
- Some improvements in sickness positively impacted this month going forward, however the Nuclear Medicine services remains a risk due to on-going sickness and maintaining high professional standards (MHPS) investigations.
- Increasing third party provider support for MRI backlog in particular.
- Workforce resilience: It is additionally acknowledged the reliability and clinical skill mix of locums restricts service improvement and backlog reductions.

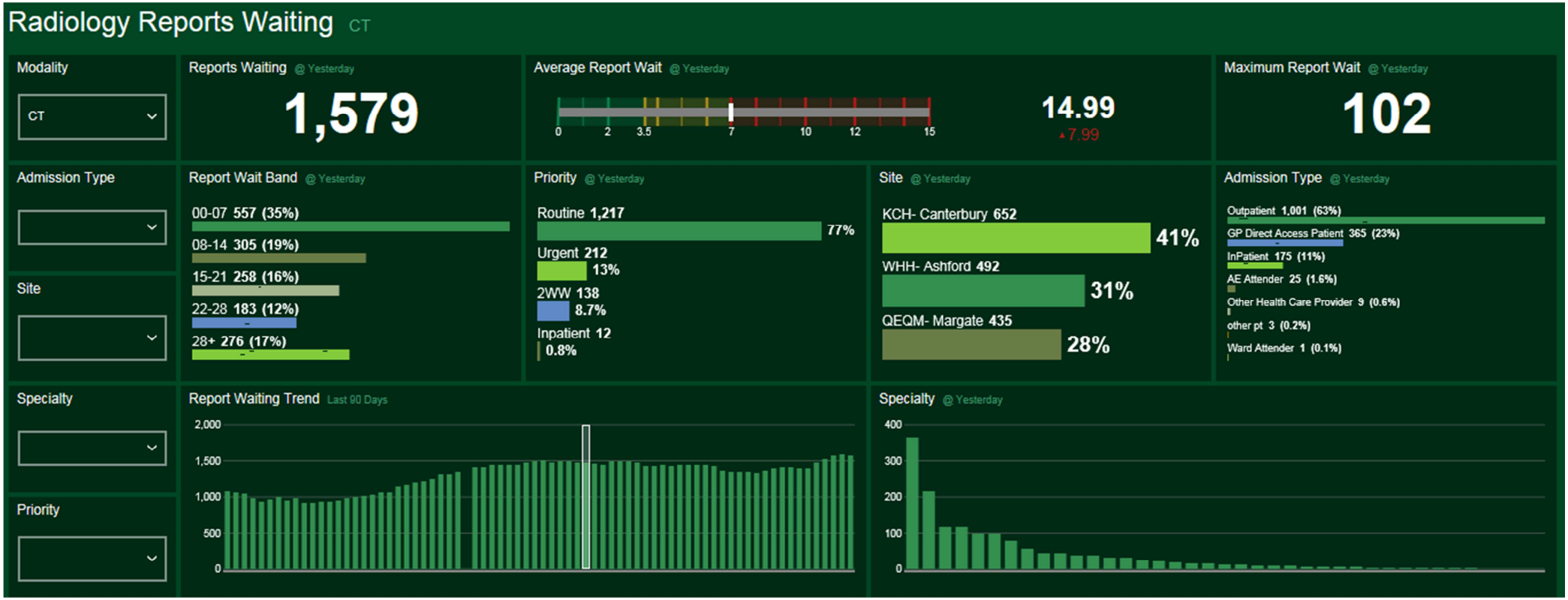
Reporting backlogs:



Total MRI backlog reporting position as of 18/01/18: (N.B. this data excludes written exams sent to third party reporters ~ 600 exams)

MRI has improved its large number of reports outstanding by ~470 examinations overall compared to December (3,215).

Whilst numbers waiting over 2 weeks have improved there is still a significant number waiting over 28 days.



The total CT backlog reporting position as of 18/01/18:

For CT, the total waiting for a report has increased by 99 examinations overall compared to December (1,480).

There is a higher percentage waiting over 2 weeks for a report than MRI that competes with pressure for 2WW and A/E-Inpatient urgent imaging reports.

Actions taken to mitigate risk and sustain performance:

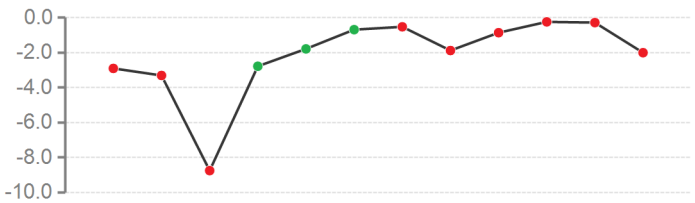
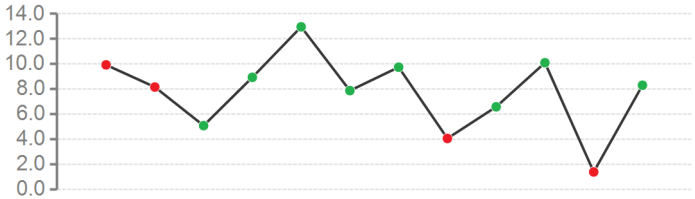
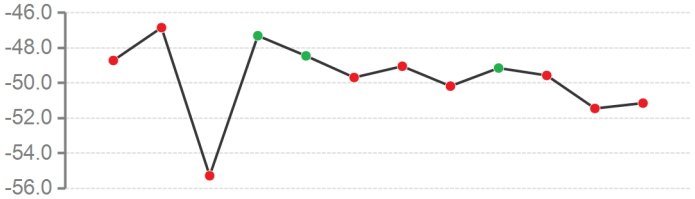
- We are working closely with GE and IT to monitor resilience of the system; some planned downtime is required to make this happen but this will be planned in collaboration with all parties.

- We continue to actively recruit substantive and interim /fixed locums to support the demand and address the reporting concerns.
- Outsourcing Cardiology CT in month with plan to bring back in house in March 2018.
- New MRI's are commissioned and fully functional at KCH are enabling us to review some mobile use week on week; however to bring the workload to realistic levels of 2 weeks we continue to need additional vans supporting service delivery.
- Additional lists being undertaken by locums include both extended days during the week and Saturday lists.
- Working with third party reporting providers to increase capacity.
- We have made a request to Commissioners to close Direct Access MRI slots to reduce demand, free up capacity and or reduce financial burden of buying in Vans and outsourcing the reporting which is no longer cost effective. This has been agreed for South Kent and Thanet but not yet for Canterbury and Ashford areas and no formal agreement is yet in place for either commissioner.
- The Division have received £125k from Central Cancer funding to support delivery of 2 WW position and bring this to within 7 days the department – but have been unable to source a locum to increase specific capacity.
- All our equipment is monitored closely and regularly serviced to ensure we maximise capacity and reduce down time.
- Daily oversight continues.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Finance

Finance

Dec	I&E £m	-42.4 (623.0%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £6.3m deficit adjusted for "extra" CIPS
Dec	Cash Balance £m	8.3 (499.1%)		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	-51.1 (-0.6%)		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	-30.0 (58.2%)		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

-30.0 (58.2%)

This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments:

The Trust's I&E deficit in December (month 9) was £3m (consolidated position excluding Sustainability and Transformation Funds, including Spencer Wing, and after technical adjustments) against a planned deficit of £2.9m.

The year to date I&E deficit is £17.1m which is on plan

The Trust has had to worsen its Forecast in Month 9 by £11m to recognised the expected impact of additional A&E pressures and winter costs which will deliver a £30m deficit for the full year.

Trust unconsolidated pay costs in the month of £29.1m were £1.2m better than November (of which approximately half was due to the non recurrence of catch up charges seen in November) but was £0.5m worse than plan. Permanent staff costs were £0.4M lower than November with overtime at similar levels to last month. Bank usage reduced by £0.1m and agency/locum staff reduced £0.7m. All Temporary staff (agency, bank, locum, overtime) reduced by £0.8m to £3.5m in month. Waiting list payments also reduced by £0.1m to £0.2m in month but were still higher than plan in month by £0.1m. Pay is now £2.1m worse than plan year to date. The main driver for the pay overspend in month is the inability to close beds due to patient flow pressures which had been expected as part of a CIP built into the budget, this is likely to continue. The reduction in spend in month is driven by both lower levels of available labour during the Christmas period and the fact November included some one off catch up Agency/Locum costs.

Clinical income was £0.7m (1.6%) ahead of plan in month. This is driven by strong non-elective activity, non planned Health and Social Village bed income and NHSE income reductions which they have not been able to deliver. This is offset by low elective activity. Clinical income is £1.9m better than plan year to date. Other income is £0.3m better than plan in month driven by recognition of centrally funded one off A&E recovery income (per NHSi instructions). Year to date other income is £0.5m behind plan as lost STF income is offset by over recovery of R&D and Education income.

Against the £32m CIPS target, including income, £21.7m is reported year to date against a target of £22m, £0.3m behind plan. Of the reported position 15% is non recurrent.

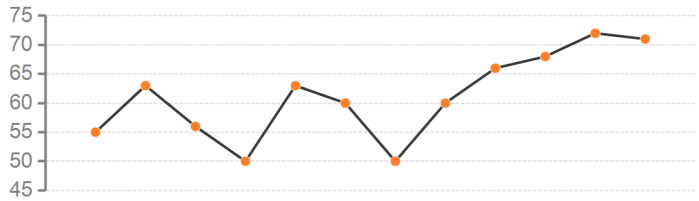
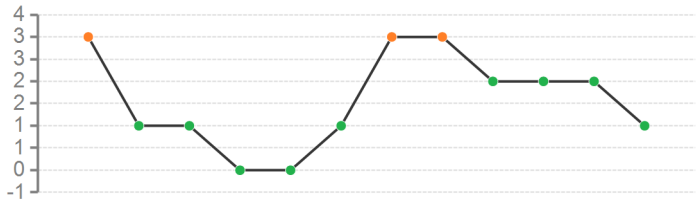
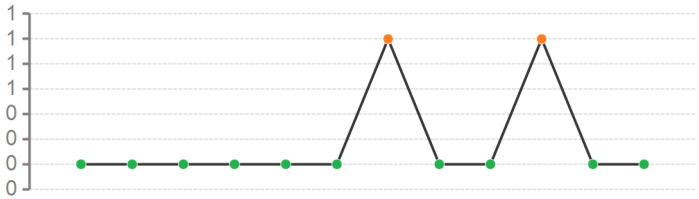
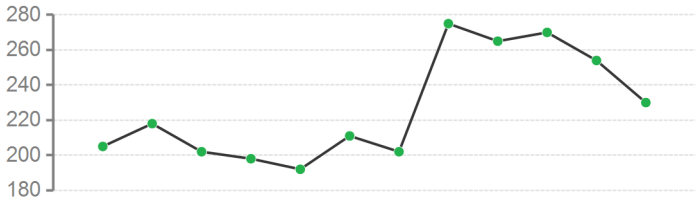
The cash balance as at the end of December was £8.3m, £6.3m above plan. The trusts total cash borrowing is now £29.6m.

As the expenditure risks are now recognised as crystallising in the revised Trust forecast the risks remaining have been estimated at £4m driven by Commissioner challenges the result of which is still to be agreed.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

Dec	Representation at H&S	734 (17.8%)		% 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)	19 (18.8%)		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	2 (100.0%)		Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).
Dec	Health & Safety Training	2722 (116.7%)		H&S Training includes all H&S and risk avoidance training including manual handling

Comments:

Representation at H&S committee's decreased fractionally in December due to the Christmas holiday period. The direction of travel for this metric is green reflecting the improvement made in terms of Divisional commitment to attending key H&S meetings.

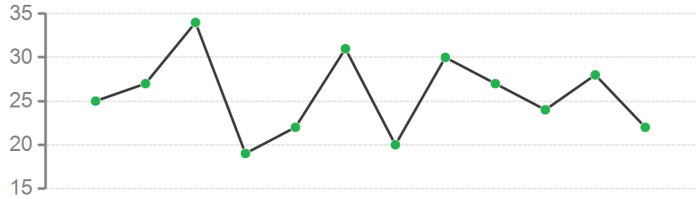
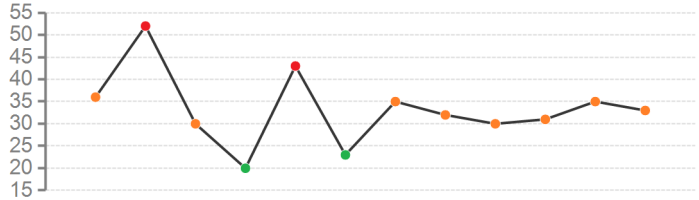
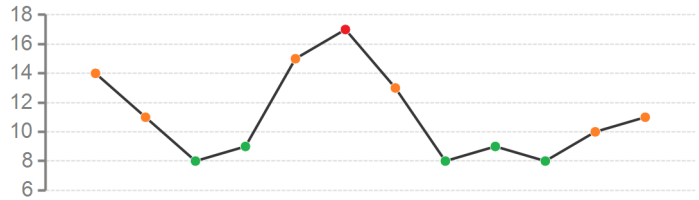
There was 1 RIDDOR in December - relating to a staff member who slipped on ice in one of the car parks. Gritting had been undertaken.

Staff training on H&S has declined in Q3 but remains very high over all. The overall program of training is cyclical, reflecting the availability of staff and as such tends to tail off in Q3 and Q4.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

Dec	Accidents	309 (-14.6%)		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	129 (0.8%)		Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Dec	Violence & Aggression	400 (2.3%)		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	133 (-28.9%)		Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Comments:

The number of accidents decreased in December, this maintains a green rating against this metric and year to date green.

The number of Fire incidents decreased in December returning this metric to Amber.

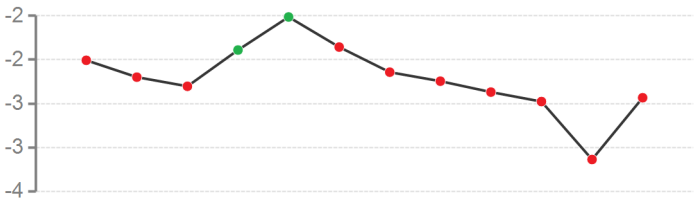
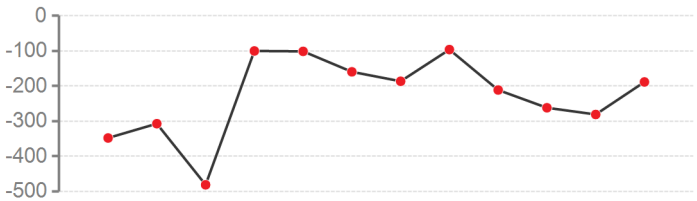
The number of Violent & Aggressive incidents captured on Datix has remained steady for the last 6 months with minimal changes. The Trust continues to deploy its Conflict Resolution Training along with other initiatives to support staff.

The number of sharps incidents remained low this month although increasing slightly from November.

East Kent Hospitals University NHS
NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

Dec	Payroll Pay £m	-26.4 (-1.7%)		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	-2.4 (-22.4%)		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	-188 (-33.0%)		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	-808 (34.0%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Comments:

Pay performance is adverse to plan ytd by £2.1m (0.8%).

Trust unconsolidated pay costs in the month of £29.1m were £1.2m better than November (of which approximately half was due to the non recurrence of catch up charges seen in November) but was £0.5m worse than plan.

Permanent staff costs were £0.4M lower than November with overtime at similar levels to last month. Bank usage reduced by £0.1m and agency/locum staff reduced £0.7m. All Temporary staff (agency, bank, locum, overtime) reduced by £0.8m to £3.5m in month. Waiting list payments also reduced by £0.1m to £0.2m in month but were still higher than plan in month by £0.1m. Pay is now £2.1m worse than plan year to date. The main driver for the pay overspend against plan in month is the inability to close beds due to patient flow pressures which had been expected as part of a CIP built into the budget, this is likely to continue.

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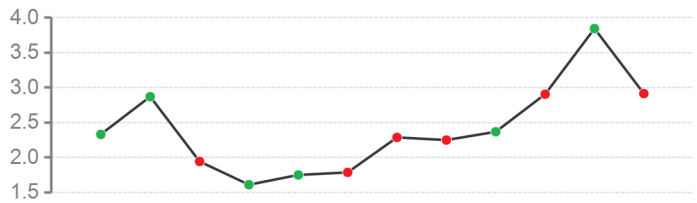
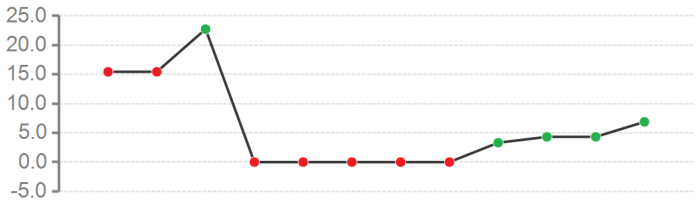
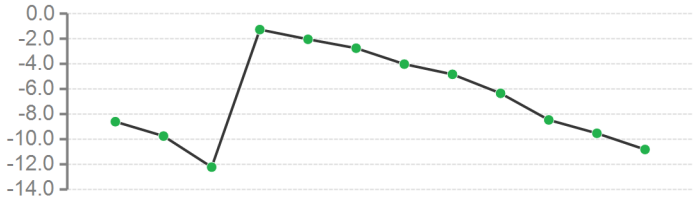
Strategic Theme: Use of Resources

Balance Sheet

Dec	CIPS £m	40.5 (-24.2%)		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	12.7 (-13.1%)		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Dec	Capital position £m	-111.9 (13.5%)		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:

The cash balance as at the end of December was £8.3m, £6.3m above plan. A further £2.6m was drawn down in December but under the terms of the loans it is expected £0.8m will be repaid in January. The Trust is currently borrowing a total of £29.6m of cash.

Total invoiced debtors have decreased from the opening position of £19.2m by £12.8m to £6.4m. The significant reduction is primarily due to credits and re-invoices in respect of the 2016/17 final position for the EK CCGS.

Invoiced creditors have increased by £4.8m from the opening position to £35.9m. 50.4% relates to current invoices (M8 50.3%) with 10.2% or £3.6m (M8 £3.3m) over 90 days.

East Kent Hospitals University NHS
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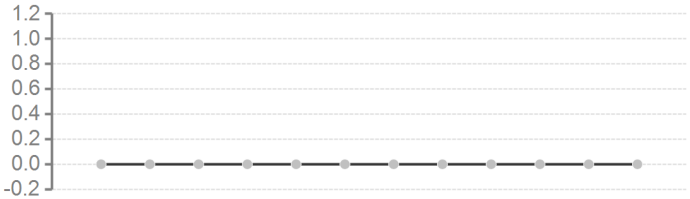
Strategic Theme: Use of Resources

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: A full programme of CIPS valued at £32m for 2017/18 is being rolled out. The CIPs Plan is net of the cost of delivery. CIPs achieved in M09 were £2.9m (a decrease of £0.9m in month due to a number of non recurrent items recognised in M8) against a plan of £3.5m. Achievement for the Year to Date is £21.7m against plan of £21.9m. The major areas of CIP achievement in M09 were Divisional schemes £1.1m, Medicines Optimisation £0.1m and Workforce £0.6m offset by shortfalls in Patient Flow £(0.1m) and agency £(0.2m). CIPs in December amounted to £2.7m recurrent and £0.3m on a non-recurrent basis. Year to date £18.4m recurrent and £3.3m non-recurrently.

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Strategic Theme: Improvement Journey

		Aug	Sep	Oct	Nov	Dec	
MD01 - End Of Life	Lost Days (Fast Track)	10	17	13	15	14	
MD02 - Emergency Pathway	ED - 4hr Compliance (%)	70.10	70.51	75.35	79.91	73.59	>= 95
	ED - 1hr Clinician Seen (%)	47	47	48	55	53	>= 55
MD04 - Flow	IP - Discharges Before Midday (%)	13	12	12	13	12	>= 35
	Medical Outliers	59	73	69	73	87	
	Lost Days (Non-EKHUFT)	54	61	56	61	61	
	DToCs (Average per Day)	43	50	55	55	49	< 35
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	74.29	73.61	73.92	71.24	74.48	>= 85
MD07 - Maternity	Midwife:Birth Ratio (%)	31	30	29	30	28	< 28
	Staff Turnover (Midwifery)	14	13	13	13	13	<= 10
	Vacancy (Midwifery) %	8	6	5	6	7	<= 7
MD08 - Recruitment & Staffing	Staff Turnover (%)	13.7	13.1	13.2	13.2	13.6	<= 10
	Vacancy (%)	12.3	12.2	12.2	11.4	11.8	<= 7
	Staff Turnover (Nursing)	14	13	13	13	14	<= 10
	Vacancy (Nursing) %	13	12	13	9	10	<= 7
	Vacancy (Medical) %	21	19	16	13	13	<= 7
MD09 - Workforce Compliance	Appraisal Rate (%)	79.4	80.1	81.7	81.9	82.2	>= 90
	Statutory Training (%)	89	90	89	89	88	>= 85
KF01 - Complaints	Complaint Response in Timescales %	83	77	80	87	79	>= 85
	Complaint Response within 30 days %	49	24	2	6	7	>= 85

KF02 - Workforce & Culture	Staff FFT - Work (%)	49	49	49	49	49	>= 60
	Staff FFT - Treatment (%)	70	70	70	70	70	>= 81.4
KF09 - Medicines Management	Pharm: Fridges Locked (%)	82	77	78		94	>=95
	Pharm: Fridge Temps (%)	80	78	84		86	>= 100
	Pharm: Drug Trolleys Locked (%)	100	97	99		100	>= 90
	Pharm: Resus. Trolley Check (%)	80	87	79		83	>= 90
	Pharm: Drug Cupboards Locked (%)	79	75	74	0	83	>= 90

East Kent Hospitals University NHS
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Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 1hr Clinician Seen (%)	% of A&E attendances seen within 1 hour by a clinician	>= 55	
	ED - 4hr Compliance (%)	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge.	>= 95	100 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	<= 92	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 35	30 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Lost Days (Fast Track)	Beddays lost due to delayed discharge (Fast Track)		
	Lost Days (Non-EKHUFT)	Beddays lost due to delayed discharge (Non-EKHUFT)		
	Medical Outliers	Number of patients recorded as being under a Medical specialty but was discharged from a Surgical Ward (Patients admitted to a ward which is not related to their clinical reason, mainly due to capacity reasons)		
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %
Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %

Clinical Outcomes	Cleanliness Audits (%)	Cleaning Schedule Audits	>= 98	5 %
	Clinical Audit Prog. Audit	Agreed Clinical Audit programme meets national programme requirements	>= 3	5 %
	Clinical Audit Review	Review of the Clinical Audit Programme	>= 3	5 %
	FNoF (36h) (%)	% Fragility hip fractures operated on within 36 hours (Time to Surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an Inpatient, to the start of anaesthesia). Data taken from the National Hip Fracture Database. Reporting one month in arrears to ensure upload completeness to the National Hip Fracture Database.	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90	5 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>=95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Policies in Date (%)	All documents that are marked as policies are in date on the SharePoint system	>= 95	10 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 60	50 %
Data Quality & Assurance	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings.	<= 0.1	25 %

Data Quality & Assurance	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code %	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	< 7	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £6.3m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %
	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %

Health & Safety	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	< 1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	Representation at H&S	% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 76	20 %
	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 25	10 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.	< 1	
	Blood Transfusion Incidents	The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Falls (per 1,000 bed days)	Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 94	10 %
	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.	>= 98	20 %
	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		

Incidents	Never Events (STEIS)	Monthly number of Never Events. Uses validated data from STEIS. Arrow indicatessum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.	< 1	30 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls	>= 1	0 %
	Pressure Ulcers Cat 2 (per 1,000)	Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 0.15	10 %
	Pressure Ulcers Cat 3/4 (per 1,000)	Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	C. Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	< 1	
	Cases of C.Diff (Cumulative)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month.	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	E. Coli	The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 44	10 %
	E. Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	< 44	
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	

Infection	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	< 1	
	MSSA	The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	
	MSSA (per 100,000 population)	The total number of MSSA bacteraemia per 100,000 population.	< 12	
Initiatives	Antimicrobial Resistance & Stewardship CQUIN Delivered %	CQUIN made up of two parts – reducing antibiotic consumption in named antibiotics and review of patients on antibiotics after 48/72 hours	>= 100	20 %
	End of Life Pathway CQUIN Delivered %	CQUIN linked to current improvement work and multi-agency policy	>= 100	20 %
	Patient Flow CQUIN Delivered %	CQUIN linked to SAFER project	>= 100	20 %
	Sepsis CQUIN Delivered %	CQUIN including acute wards and with antibiotic review at 72 hours	>= 100	20 %
	Staff Health & Wellbeing CQUIN Delivered %	CQUIN made up of three parts – staff access to healthy activities, health food options on site and flu vaccine uptake	>= 100	20 %
Mortality	Crude Mortality EL (per 1,000)	The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.	< 90	35 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	< 87.45	30 %
	SHMI	Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data.	< 0.95	15 %

Observations	Cannula: Daily Check (%)	The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-8pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 8pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant.	>= 95	20 %
Patient Experience	Aware of Nurse in each shift %	Aware of nurse in each shift	>= 89	4 %
	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	
	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	
	Cleanliness? %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	5 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	Discuss Worries with Doctors %	Discuss Worries with Doctors	>= 89	
	Discuss Worries with domestic %	Discuss Worries with domestic	>= 89	

Patient Experience	Discuss Worries with Nurses %	Discuss Worries with Nurses	>= 89	4 %
	Discuss Worries with support %	Discuss Worries with support	>= 89	
	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 %
	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 %
	Privacy for discussions with Doctors %	Privacy for discussions Doctors	>= 89	
	Privacy for discussions with Nurses %	Privacy for discussions Nurses	>= 89	2 %
	Privacy for discussions with Support %	Privacy for discussions Support	>= 89	
	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	
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 %

Productivity	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 80	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: 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	1:1 Care in labour	The number of women in labour 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.	>= 99	
	Agency %	% of temporary (Agency and Bank) staff of the total WTE Number indicates average of last 12 months data (as shown in graph).	<= 10	
	Agency & Locum Spend	Total agency spend including NHSP spend		
	Agency Filled Hours vs Total Agency Hours	% hours worked which were filled by the NHSP against the total number of hours worked by agency staff		
	Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	
	Agency Staff WTE (Bank)	WTE Count of Bank Hours worked		
	Agency Staff WTE (NHSP)	WTE Count of NHSP Hours worked		
	Bank Filled Hours vs Total Agency Hours	% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff		1 %
	Bank Hours vs Total Agency Hours	% hours worked by Bank (Staffflow) against the total number of hours worked by agency staff		

Staffing

Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available.		
Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
Employed vs Temporary Staff (%)	Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 92.1	1 %
Local Induction Compliance %	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	
Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	< 28	2 %
NHSP Hours vs Total Agency Hours	% hours worked by NHSP against the total number of hours worked by agency staff		
Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	
Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
Roster Effectiveness (%)	The time ward staff attribute to clinical duties as a % of the ward duty roster. Data source - eRoster.		15 %
Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA)	>= 80	15 %
Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA)	>= 80	15 %
Sickness (%)	% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 3.6	10 %
Stability Index (excl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		
Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		
Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	15 %

Staffing	Staff Turnover (Midwifery)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Midwives. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
	Staff Turnover (Nursing)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Nurses. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Temp Staff (WTE)	WTE Count of Temporary Staff Used	< 182	
	Time to Recruit	Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
	Total Staff Headcount	Headcount of total staff in post		
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Total Staff In Post (SiP)	Count of total staff in post (WTE)		1 %
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %
	Vacancy (%)	% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	15 %
	Vacancy (Medical) %	% Vacant positions against Whole Time Equivalent (WTE) for Medical Staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
	Vacancy (Midwifery) %	% Vacant positions against Whole Time Equivalent (WTE) for Midwives. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
	Vacancy (Nursing) %	% Vacant positions against Whole Time Equivalent (WTE) for Nurses. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 90	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	

Training	Statutory Training (%)	The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.	< 0	
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	< 0	
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	< 0	
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		
	Independent Sector £k	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	

Data Assurance Stars


Not captured on an electronic system, no assurance process, data is not robust


Data is either not captured on an electronic system or via a manual feeder sheet, does not follow an assured process, or not validated/reconciled


Data captured on electronic system with direct feed, data has an assured process, data is validated/reconciled

East Kent Hospitals University NHS
NHS Foundation Trust

Human Resources Heatmap

	Clinical	Corporate	Finance & Perform	HR	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term
Agency %	1.4	0.6	1.4	0.5	2.6	2.3	5.1	4.1	10.0
Appraisal Rate (%)	81.3	56.4	85.7	89.8	51.8	82.0	87.4	92.4	74.9
Employed vs Temporary Staff (%)	86.4	82.1	87.1	92.3	90.1	92.3	88.0	90.8	84.8
Sickness (%)	4.0	2.9	2.0	3.9	2.7	4.1	3.7	4.0	3.9
Staff Turnover (%)	15.4	18.8	11.0	14.1	14.5	12.4	6.7	12.4	15.3
Statutory Training (%)	91	86	96	95	87	88	95	86	85
Total Staff In Post (SiP)	1428	72	126	125	119	1341	329	1738	1640
Vacancy (%)	13.6	20.0	12.9	9.9	9.9	7.7	12.0	9.6	15.3

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East Kent Hospitals University NHS
NHS Foundation Trust

Patient Safety Heatmap - DECEMBER 2017

KEY

	data not yet available
NULL	null return, data not received
N/A	metric is not applicable

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Aware of Nurse in each shift %	Privacy for discussions with	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
KCH - Kent & Canterbury																	
Specialist																	
KBRA - BRABOURNE (KCH)	100.0	0	0	0	0	0	34	NULL	NULL	NULL	55	100	0.0	92.3	80	100	15
MARL - MARLOWE WARD	100.0	3	4	0	0	0	165	33	50	33	54	100	0.0	90.6	95	96	8
Surgical																	
CLKE - CLARKE WARD	96.6	4	2	0	0	1	1	33	33	50	36	99	0.0	80.1	88	97	6
KENT - KENT WARD	100.0	6	5	0	0	0	0	33	50	50	29	100	0.0	93.1	100	90	10
KITU - KCH ITU	100.0	0	0	0	0	0	53	N/A	N/A	N/A	N/A	N/A	N/A	91.0	91	100	30
Urgent Care																	
HARB - HARBLEDOWN WARD	100.0	3	6	0	0	0	5	100	100	100	6	100	0.0	102.1	88	112	6
INV - INVICTA WARD	90.5	1	11	0	0	0	1	50	100	100	19	100	0.0	82.8	96	138	6
KING - KINGSTON WARD	100.0	1	3	0	0	0	0	50	50	50	30	100	0.0	82.0	97	135	6
KNRU - EAST KENT NEURO REHAB UNIT	100.0	1	3	0	0	1	0	100	33	50	36	100	0.0	97.5	99	131	6
MTMC - MOUNT/MCMASTER WARD	100.0	0	5	0	0	0	0	NULL	NULL	NULL	0	NULL	NULL	80.8	88	131	5
TREB - TREBLE WARD	88.2	0	6	0	0	0	0	50	50	50	34	100	0.0	85.3	90	96	7
QEH - Queen Elizabeth Queen Mother																	
Specialist																	
BIR - BIRCHINGTON WARD	100.0	1	2	0	0	0	1	33	100	33	0	NULL	NULL	96.8	91	101	6
KIN - KINGSGATE WARD	100.0	0	0	0	0	1	0	N/A	N/A	N/A	N/A	N/A	N/A	81.8	93	86	24
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	88.4	82	100	14
RAI - RAINBOW WARD	100.0	0	0	0	0	0	1	N/A	N/A	N/A	26	99	0.0	91.8	108	114	9
Surgical																	
BIS - BISHOPSTONE WARD	100.0	1	2	0	0	1	0	50	50	50	75	98	0.0	67.0	94	99	6
CSF - CHEERFUL SPARROWS FEMALE	100.0	1	1	0	0	0	0	33	33	50	64	96	3.6	81.3	94	100	7
CSM - CHEERFUL SPARROWS MALE	100.0	1	2	0	0	1	2	33	33	33	34	92	2.6	96.9	102	106	8
QITU - QEH ITU	87.5	0	0	0	0	0	95	N/A	N/A	N/A	N/A	N/A	N/A	92.8	97	115	25
QX - QUEX WARD	100.0	0	1	0	0	0	78	50	50	50	75	100	0.0	93.3	75	72	4
SB - SEA BATHING WARD	90.9	0	0	0	0	0	0	100	50	50	58	100	0.0	91.1	111	108	7

Apdx.

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	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	Aware of Nurse in each shift %	Privacy for discussions with Nurses %	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
Urgent Care																	
DEAL - DEAL WARD	96.4	1	8	0	0	0	0	50	50	50	4	100	0.0	93.2	94	117	5
FRD - FORDWICH WARD STROKE UNIT	90.9	0	6	0	0	0	1	100	100	100	27	100	0.0	76.2	102	124	8
MW - MINSTER WARD	95.5	2	7	0	0	1	24	50	33	50	66	95	0.0	86.5	110	112	7
QCCU - QEH CCU	100.0	0	0	0	0	0	0	NULL	NULL	NULL	103	100	0.0	86.4	87	86	7
QCDU - QEH CDU	95.8	0	0	2	0	0	8	NULL	NULL	NULL	24	92	6.3	99.3	118	161	11
SAN - SANDWICH BAY WARD	100.0	2	5	0	0	0	1	50	50	100	83	100	0.0	101.5	131	143	7
SAU - ST AUGUSTINES WARD	96.4	1	2	0	0	0	0	NULL	NULL	NULL	45	92	0.0	84.7	135	121	6
STM - ST MARGARETS WARD	100.0	0	6	0	0	3	0	33	50	50	0	NULL	NULL	87.6	151	188	8
WHH - William Harvey																	
Specialist																	
FF - FOLKESTONE	100.0	0	0	0	0	2	0	50	50	50	N/A	N/A	N/A	84.3	85	84	17
KEN - KENNINGTON WARD	100.0	0	1	0	0	0	0	33	50	50	0	NULL	NULL	77.5	91	126	8
PAD - PADUA	100.0	0	1	0	0	0	0	N/A	N/A	N/A	7	97	0.0	91.8	102	96	8
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	133	N/A	N/A	N/A	N/A	N/A	N/A	100.4	77	88	16
Surgical																	
ITU - WHH ITU	100.0	0	0	6	0	0	23	N/A	N/A	N/A	N/A	N/A	N/A	92.3	123	130	31
KA2 - KINGS A2	100.0	1	2	0	0	0	148	33	33	50	22	100	0.0	87.4	100	123	6
KB - KINGS B	100.0	0	2	0	1	1	173	33	33	50	38	89	2.2	92.4	104	105	6
KC - KINGS C1	96.2	3	3	0	0	0	0	50	50	50	85	97	2.6	89.0	105	100	6
KC2 - KINGS C2	100.0	2	6	0	0	0	82	33	50	50	31	100	0.0	82.8	84	96	6
KDF - KINGS D FEMALE	94.4	2	1	0	0	0	302	50	33	50	47	100	0.0	97.0	N/A	N/A	N/A
KDM - KINGS D MALE	95.0	8	6	0	0	1	0	33	33	33	46	100	0.0	N/A	105	108	7
RW - ROTARY WARD	100.0	3	3	0	0	1	51	33	50	33	45	100	0.0	90.7	92	98	8
Urgent Care																	
CCU - CCU	100.0	0	0	0	0	0	0	33	50	50	71	100	0.0	83.4	N/A	N/A	N/A
CJ2 - CAMBRIDGE J2	100.0	0	0	0	1	0	0	33	33	33	85	95	2.6	77.3	101	112	6
CK - CAMBRIDGE K	95.8	0	0	0	0	0	0	50	50	50	35	97	0.0	80.2	101	105	7
CL - CAMBRIDGE L REHABILITATION	100.0	3	4	0	0	1	0	33	33	33	81	96	4.2	90.5	94	126	6
CM1 - CAMBRIDGE M1 SHORT STAY	83.3	3	10	0	0	1	0	50	50	50	18	100	0.0	78.1	N/A	N/A	N/A
CM2 - CAMBRIDGE M2	100.0	0	1	0	0	1	0	50	50	50	66	97	0.0	101.2	112	122	7

Apdx.

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	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	Aware of Nurse in each shift %	Privacy for discussions with Nurses %	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
OXF - OXFORD	92.3	1	12	0	0	2	0	50	50	100	17	100	0.0	94.8	110	142	8
RST1 - RICHARD STEVENS 1 STROKE UNIT	100.0	3	12	0	0	2	0	50	50	50	12	100	0.0	83.4	117	132	9
WCDM - WHH CDU MIXED	88.2	0	0	3	0	0	0	33	25	25	18	75	14.3	82.6	100	92	12