NHS
East Kent
Hospitals University
NHS Foundation Trust

BOARD OF DIRECTORS MEETING – THURSDAY 7 FEBRUARY 2019

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place in the **Board Room, William Harvey Hospital, Kennington Road, Willesborough, Ashford, Kent, TN24 0LZ**, commencing at **9:45 a.m. to 12:30 p.m**.

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

People feel **cared** for as individuals

People feel **safe**, reassured and involved

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

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

AGENDA

18/				
OPENING MATTERS				
105	Chairman's welcome		**09:45**	Chair
106	Apologies for Absence			
107	Declaration of Interests			
108	Minutes of Previous Meeting held on 6 December 2018			
109	Matters Arising from the Minutes on 6 December 2018			
110	Chair's Report	**Discussion**	**10:00** **10 mins**	Chair
111	Chief Executive's Report	**Approval**	**10:10** **10 mins**	Chief Executive
PATIENTS: Providing high quality care to patients with great outcomes for their health and lives – getting the basics right every time and building healthcare that is best in class				
112	Freedom to Speak Up Guardians	**Discussion**	**10:20** **20 mins**	Chief Nurse and Director of Quality/ Freedom to Speak Up Guardians
113	Medical Director's Report	**Discussion**	**10:40** **10 mins**	Medical Director

We care

East Kent Hospitals University NHS Foundation Trust

114	Medical Director's Mortality Report	**Discussion**	**10:50** **10 mins**	Medical Director
115	Quality Committee - Chair Report	**Approval**	**11:00** **10 mins**	Chair Quality Committee – Barry Wilding
	TEA/COFFEE BREAK		**11:10** **10 mins**	

PROVISION: The provision of high quality care through the use of technology, research, education, innovation and intelligence.

116	Integrated Audit and Governance Committee (IAGC) – Chair Report - Revised Standing Financial Instructions - Revised Risk Management Strategy and Policy - Board Assurance Framework (BAF) - Annual Priorities 2018/19 - IAGC Terms of Reference	**Approval**	**11:20** **10 mins**	Chair Integrated Audit and Governance Committee – Barry Wilding
117	Finance and Performance Committee – Chair Report	**Approval**	**11:30** **10 mins**	Chair Finance and Performance Committee – Sunny Adeusi
118	Strategic Workforce Committee – Chair Report	**Approval**	**11:40** **5 mins**	Chair Strategic Workforce Committee – Jane Ollis
119	Charitable Funds Committee – Chair Report	**Approval**	**11:45** **5 mins**	Chair Charitable Funds Committee – Keith Palmer
120	Corporate Reporting		**11:50** **20 mins**	
	120.1 Integrated Performance Report	**Discussion**		Chief Executive / Executive Team
	120.2 Full Corporate/Highest Mitigated Strategic Risks Report	**Discussion**		Chief Nurse and Director of Quality/ Executive Team
121	Bribery Act Compliance	**Approval**	**12:10** **5 mins**	Director of Finance and Performance

We care

NHS
East Kent
Hospitals University
NHS Foundation Trust

CLOSING MATTERS

122	Any other business	
123	**QUESTIONS FROM THE PUBLIC**	**12:15** **15 mins**

Date of Next Meeting
Thursday 7 March 2019 in the Lecture Theatre, Queen Elizabeth the Queen Mother Hospital, Margate.

We care

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM JANUARY 2019

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) **(4)**	Appointed 1 April 2018
ADEUSI, SUNNY	Non Executive Director	None	1 November 2015 (Second term)
CAVE, PHILIP	Director of Finance and Performance Management	Wife works as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Group's (CCG's) of East Kent in their contracting **(5)** Non Executive Director of Beautiful Information Limited **(1)**	Appointed 9 October 2017
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)** Member of Health Advisory Board for OCS Group UK **(5)** Non Executive Director of Medway Community Healthcare **(1)**	6 January 2017 (First Term)
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)**	Appointed 1 September 2014
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) **(1)**	1 July 2017 (First term)

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM JANUARY 2019

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
MARTIN, LEE	Chief Operating Officer	None	Appointed August 2018
OLLIS, JANE	Non Executive Director	The Heating Hub **(1)** Board Member of the Kent Surrey Sussex Academic Health Science Network (AHSN) **(1)** Director of MindSpire **(1)** Non Executive Director of Community Energy South **(1)** Vice President of the British Red Cross in Kent **(4)**	8 May 2017 (First term)
PALMER, KEITH	Non Executive Director	Managing Director of Silverfox Consultancy Ltd **(1)** Sole shareholder of Silverfox Consultancy Ltd **(3)** Non Executive Director of EKMS **(1)** Non Executive Director of 2Gether Support Solutions **(1)**	1 January 2017 (First term)
REYNOLDS, SEAN	Non Executive Director	Trustee of Building Heroes **(1)**	20 August 2018 (First term)
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	Nil	Appointed January 2004
SMITH, SALLY	Chief Nurse and Director of Quality	Nil	Appointed 28 July 2015

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM JANUARY 2019

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SMITH, STEPHEN	Chair	Non Executive Director of NetScientific Plc **(1)** Chairman of Biotechspert Ltd **(1)** Non Executive Director of uMed Ltd **(1)** Non Executive Director of Draper and Dash **(1)** Chairman of Signum Health Ltd **(1)** Trustee of Pancreatic Cancer UK **(1)** Stephen Smith Ltd **(1)** Chair of Scientific Advisory Board **(4)** Pancreatic Cancer UK **(4)** Non Executive Director of Great Ormond Street Hospital **(1)** (overlap agreed by NHS Improvement until the end of May 2018) Trustee of Epilepsy Society **(4)**	1 March 2018
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)** Non Executive Director of Beautiful Information Limited **(1)**	Appointed June 2013
WILDING, BARRY	Senior Independent Director	Trustee of CXK, a Charity in Ashford inspiring people to thrive **(4 & 5)**	11 May 2015 (Second 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

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
Board of Directors
6 December 2018

UNCONFIRMED MINUTES OF THE NINETIETH MEETING OF THE BOARD OF DIRECTORS THURSDAY 6 DECEMBER 2018 AT 9.45 AM LECTURE THEATRE, EDUCATION CENTRE, QUEEN ELIZABETH THE QUEEN MOTHER HOSPITAL, ST PETERS ROAD, MARGATE

PRESENT:

Professor S Smith	Chair	StS
Ms S Acott	Chief Executive Officer	SAc
Mr S Adeusi	Non-Executive Director	SA
Mr P Cave	Director of Finance and Performance Management	PC
Ms W Cookson	Non-Executive Director	WC
Mr N Mansley	Non-Executive Director	NM
Mr L Martin	Chief Operating Officer	LM
Ms J Ollis	Non-Executive Director	JO
Mr K Palmer	Non-Executive Director	KP
Mr S Reynolds	Non-Executive Director	SRe
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 B Wilding	Non-Executive Director	BW

IN ATTENDANCE:

Ms A Ashman	Deputy Director of Human Resources (representing Ms S Le Blanc, Director of Human Resources)	AA
Dr T Doulton	Director of Research & Innovation (for Minute Number 133/18)	TD
Mrs A Fox	Trust Secretary	AF
Mrs D Otite	Programme Manager, Trust Secretariat (Minutes)	DO
Ms N Yost	Director of Communications and Engagement	NY

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs S Andrews
Mrs C Heggie
Mr J Ransley
Mr K Rogers
Mrs S Thomas
Mrs H Waymouth (Staff)
Mrs J Whorwell

MINUTE NO.		ACTION
124/18	**CHAIRMAN'S WELCOME** The Chair welcomed attendees to the meeting.	
125/18	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Ms S Le Blanc (SLB), Director of Human Resources.	

CHAIR'S INITIALS ……

126/18 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

127/18 **MINUTES OF THE PREVIOUS MEETING HELD ON 1 NOVEMBER 2018**

KP requested that on page 6, Board approval of the FPC report should be replaced by the QC report. Also, on page 7, Board approval of the FPC report should be replaced by the IAGC report. PS noted that the top line at page 6 should refer to 'investigated' rather than 'invested'.

The minutes of the Board Meeting held on 1 November 2018 were approved subject to the above changes.

128/18 **MATTERS ARISING FROM THE MINUTES ON 1 NOVEMBER 2018**

The Board **NOTED** the updates provided in the actions table and that all the actions from the previous meeting were closed.

129/18 **CHAIR'S REPORT**

The Chair reported that he had attended the Trust Awards Event and that it was an enjoyable evening aimed at rewarding and celebrating the work of staff and volunteers in delivering healthcare.

The Chair reported the appointment of an additional Deputy Medical Director who would assist the Medical Director's office. He added that it was an important and welcome change in a Trust of this size and complexity, as part of the roll-out of the Trust's clinically-led organisational structure.

SSm reported that the Trust was doing well on its trajectory towards the goal of over 75% of clinical staff having the flu vaccination. PS added that the Doctors had the highest uptake of 64.6%.

The Clinical Audit Awareness Week was held across the Trust during the last week in November. The Trust celebrated its volunteers who are a crucial part of the Trust's connection with the local communities and the organisational structure.

The Chair reported on the work of the Research Delivery Team. The Trust had recruited around 2,500 patients to clinical trials annually, and was keen to grow that number with the new medical school, because every NHS patient should be offered the opportunity to enter a clinical trial that would improve patient care.

The Chair reported on the Transformation through technology programme and that the recent PAS update had been successful.

The Chair had chaired a public meeting of the Council of Governors on 6 November. He emphasised that the Trust was trying to ensure that the Governors could play their full role in developing the activities and performance of the Trust through increased engagement by the Board in a two-way dialogue

The Board discussed and **NOTED** the Chair's report.

130/18 **CHIEF EXECUTIVE'S REPORT**

SAc updated the Board on the winter plan. Particularly in relation to the move of planned orthopaedic surgery from William Harvey Hospital (WHH) to Kent and Canterbury (K&C) which went live on 21 November 2018 and was going well. This required a huge amount of work from teams, particularly those transferring to K&C. As a result of the move, orthopaedic activity would be maintained in a more efficient way than the previous winter, freeing up capacity at the WHH to support winter medical and trauma activity.

The observation ward had been craned in and was currently being fitted out. It was envisaged this would be commissioned by 7 January 2019 to assist with winter planning. There was a similar installation at WHH that would be opened later in January 2019.

SAc reported that the number of super-stranded patients had not reduced. There was a plan to increase the intensive care capacity, which would support the flow of complex elective and emergency patients.

The Trust had taken part in the pre-consultation engagement that was being conducted before going to public consultation in 2019. There had been a lot of interest and attendance at the listening events, with two further to be conducted.

The plans around the stroke business case were being developed alongside Maidstone & Tunbridge Wells (MTW) and Darent Valley Hospitals. The Trust had held conversations around vascular services that would support stroke services through prevention work.

SA queried whether specialties that needed theatre space could move into the space freed up in WHH. SAc explained that Gynaecology would have priority for the freed up theatre capacity due to having the longest waiting list. The beds would support the emergency work in trauma and medical.

JO queried whether support was being received from partners to facilitate the safe discharge of patients. LM reported that the rapid response team were hitting their target of keeping 8 patients per ED each day out of hospital. The recruitment of the rapid transfer service was running approximately10 weeks behind. A lot of pathway work had been completed and there was a six-week programme of training for staff to follow those pathways.

NM questioned the likelihood of being able to use additional capacity for elective staff to catch up on financial slippage. SAc noted that the additional capacity had been included in the planning assumptions, so there would only be an additional advantage if it was more productive than planned. LM highlighted that to get back on plan, vacant theatres were being utilised and outpatient and day case activity was being pushed, but this could be thrown off by winter pressures.

The Chair asked whether anything could be done on outpatients that were not dependent on theatre time. LM noted that capacity had been increased for all

outpatient day cases and procedures, and further schemes were being considered. SA noted that there had been a comprehensive debrief around how to drive elective income and manage follow-ups for the remaining part of the year. LM highlighted that follow-ups were around 2,000 away from the end of year estimates. A lot of good work had been done in the virtual clinics.

SRe queried whether there would be a peak and de-surge and if resources could be organised to support that. LM said that the next big peak would be the first and second week in January 2019, and all work would be stopped apart from emergency work. The levelling out that used to take place in summer was not seen any more nationally.

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

131/18 **PATIENT EXPERIENCE STORY**

The Chair thanked Mrs Mitchell for sharing her story, which had supported improvement in the Trust.

Mrs Mitchell shared the story of her daughter born prematurely on 1 September 2014 at 34 weeks and how she had spent four weeks at the William Harvey in the Neonatal Intensive Care Unit (NICU) and the Special Care Baby Unit (SCBU). During this time, there was nowhere for Mrs Mitchell and her husband to stay at the hospital. Following this episode, Mrs Mitchell had become involved in the BLISS campaign to help keep families together and increase the amount of accommodation for parents in hospitals when children were in NICU/SCBU. In addition to the emotional burden, there were financial burdens in terms of travelling and parking costs.

The parking charges had now dramatically decreased for parents of babies in the special unit for longer than a week. There was a two bedroom apartment funded by the League of Friends that was available for the use of parents, which had been opened in the summer. There was a need for more accommodation for parents, considering there was room for 24 babies in the SCBU.

Mrs J Whorwell asked whether Mrs Mitchell had attended parent-craft classes. Mrs Mitchell said that she had not, because the class had started after her baby had been born. Mrs Whorwell commented that the NHS should educate women about the possibilities of premature birth, so that women were aware of what to do in the event.

Mrs Mitchell highlighted that while there had been support to get her home, she had not felt able to discuss the anxiety she had been experiencing once home with her baby. PS acknowledged that the NHS was not very good at understanding the post-traumatic stress part of recovering from being unwell and offering support. It was a programme of work for the Trust to consider taking forward.

The project to start a McDonald House had fallen through, but the Chair acknowledged that might be something the Trust could review in future. KP noted that it could be a project that the Charitable Funds Committee would be interested in.

SRe asked whether there was a national standard for parental accommodation. Mrs Mitchell understood that it varied across hospitals. Mrs Waymouth noted that there were not standards, but BLISS had made recommendations that units could audit themselves against. LM would gather information to feed into business plans.

The Chair noted the Trust was a substantial obstetrics hospital, and this issue should be higher up the agenda. The Board thanked Mrs Mitchell for her contribution.

ACTION: The Board would gather information relating to accommodation for parents at other hospitals to feed into the business planning process. **LM**

The Board discussed and **NOTED** the Patient Experience Story.

132/18 **MEDICAL REVALIDATION REPORT**

PS highlighted that the purpose of medical revalidation was to assure patients, the public and the Trust Board that doctors had the appropriate skills and competencies. PS confirmed that the revalidation process required all doctors to have an appraisal once per year and that the Trust was compliant with this.

SRe questioned whether the appraisal should be widened to include management competencies. PS commented that the appraisal covered all aspects of the doctor's role as well as a personal development plan. AA explained that it was important to ensure that the business skills were extracted from the appraisal and translated into action, as well as tied into other Trust systems.

LM noted that the appraisals were a different process to the work around operational development and leadership. AA highlighted that it was necessary to capture both personal development requirements as well as organisational development requirements.

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

133/18 **QUALITY COMMITTEE – CHAIR REPORT**

BW reported that the last Quality Committee (QC) had been much improved with a refreshed enthusiasm from the new Care Groups, but there was work underway to ensure that the reporting was standardised. LM confirmed that the standardised packs would be in place by end December 2018.

KP asked whether there was a problem with the Patient Experience Group (PEG). BW noted a wider problem around meetings dovetailing together.

SRe noted that the Finance and Performance Committee (FPC) and the QC were approaching the same issues from different angles, and sought clarity on how the governance would come together to ensure they were both properly informed. BW highlighted that the Trust was trying to manage such an immense number of risks that it was inevitable that something crystallised. It was right and proper that some issues were discussed more than once, but it was important that the Board held the overall discussions.

LM highlighted that the organisation was in transition. LM and SSm would be meeting to align the issues with the correct operational committees. The resource in risk had also been increased with the recruitment of a new Risk Manager for the Trust. The new Risk Manager was working with the Care Groups to refresh risk registers. BW highlighted that the governance could be implemented once the strategy and plan were in place. SA noted that the issues had to be triangulated.

The Chair explained that the Mid-Staffordshire Enquiry had highlighted that it was important to link finances to quality and safety. There was a direct line between a well-governed hospital and safe and high quality hospital. There were a range of measures in place in the Trust to ensure that the governance was substantially improved, with a view to improving the quality.

- **RESEARCH AND INNOVATION (R&I) ANNUAL REPORT**

TD reported that R&I were on the cusp of some great opportunities, which would include the new medical school, which was focused on the importance of research. The possibility of a joint research office between the Trust, university and NHS partners was being actively pursued, with the target of having a firm proposal by Easter. TD would be circulating a paper highlighting some of the commercial growth opportunities for the Trust, and what would be required to take advantage of those.

A major strategic ambition was to move towards more site-based working for the delivery teams. There were around 40 new studies that would open at the William Harvey site

JO congratulated TD on his consistent approach to growing R&I at the Trust. JO suggested that the R&I conference in 2019 focused on the impact of the Trust's research, and how it had translated into improving the quality of care. TD confirmed that an estimated 15 - 20% of consultants were involved in recruiting to research studies, and a goal for the Trust could be to increase this number.

TD added that there were longer term ambitions to tie in with the Trust's plans around Option 1 and Option 2, and would want to see investment in R&I structure and an innovation centre that would enable external partners to work with the Trust.

PS noted that the NHS was very poor at supporting research with time. The Chair noted that the Trust would want to improve its commitment and provide time for research, which would enable funding by the National Institute of Health Research.

ACTION: TD to circulate a paper highlighting some of the commercial growth opportunities for the Trust, and what would be required to take advantage of those. — TD

DECISION: The Board discussed and **APPROVED:**

i) the Quality Committee report; and
ii) the Research & Innovation Annual Report 2017/18

134/18 **NOMINATIONS AND REMUNERATION COMMITTEE – CHAIR REPORT**

WC reported that this was the first combined meeting of the Nominations and

Remuneration Committees and it went well.

DECISION: The Board discussed and **APPROVED**:

i) the Nominations and Remuneration Committee report; and
ii) the Terms of Reference for the Nominations and Remuneration Committee.

135/18 **FINANCE AND PERFORMANCE COMMITTEE – CHAIR REPORT**

SA highlighted that the Income & Expenditure (I&E) was £2.5m adverse to plan, largely due to a reduction in elective income. The focus would be on electives for the next few months to recover the position. The Chair asked whether there was a recovery plan in place. LM would circulate the productivity and recovery plans for each specialty. The risk was around winter knocking planned care off plan, but the goal was that the plans would deliver by the end of the year.

It was noted that there were measures in place to reduce agency and discretionary spend. There was work underway to increase theatre utilisation. WC raised concerns that agency and bank spend was continually increasing, and there did not appear to be any controls. LM highlighted the need to balance taking the control of agency staff usage, while allowing safe levels of staffing to be utilised. AA commented that there was evidence that the recruitment controls were being followed.

ACTION: LM to circulate the productivity and recovery plan that was presented to the FPC in November 2018. LM

DECISION: The Board discussed and **APPROVED** the Finance and Performance Committee report.

136/18 **CORPORATE REPORTING**

136.1/18 **INTEGRATED PERFORMANCE REPORT**

SAc presented the IPR, suggesting that the Board and executives highlight the elements they felt were genuinely necessary and helpful. SAc drew the Boards attention to the fact that the IPR was overly detailed, which could prevent the Board from focusing on the right things.

BW agreed that a review of the IPR would be welcome, suggesting that lead rather than lag indicators would enable the Board to look forward. SAc noted that some measures were too high level and did not help highlight the problem areas. SAc recommended that the IPR was re-crafted for the Trust. If there were fewer measures it would facilitate up to date information being provided.

SSm reported good performance on patient experience around mixed sex accommodation compliance. The complaints response time was red due to improvement work around long breached cases. The overall patient experience was amber, and SSm would be working with the relevant teams to identify the necessary improvements.

PS reported that VTE had reduced to 89% and was already beginning to recover to above 90%. The Trust was below trajectory for C. difficile, which was positive.

NM raised a question about electives and the impact on the bottom line if the target was being met.

The Chair requested that a recovery plan for elective activity was put in place with clear milestones, and took into account the bottom line and the quality of patients.

ACTION: LM and PC to prepare a recovery plan for electives and finances with clear milestones. **LM/PC**

SAc highlighted the need for the organisation to be clear about the most important issue for the recovery plan, whether it was finances or the absolute waiting list target. WC was not sure that enough time was spent on the enablers, such as theatre improvement and outpatient utilisation. WC noted that the lung and breast two week wait performance was poor, and asked whether it was linked to the former two items.

LM noted that a lot of the information that was being requested was in the pack, but this was being lost due to the density of the pack. The cancer waiting times were all improving. The Alliance had funded extra capacity for the five tumour streams that required it had been put in place, and two week waits had been achieved.

PS advised that two years of crude mortality data was required on the charts otherwise the trends could not be seen. It was noted that several NEDs would be keen to work with the executives on the packs, and this would be addressed offline.

LM highlighted that the programmes around the ED pathway were largely in place. For three weeks there had been no patients in the corridor, and the friends and family test had then increased by 8%. The blocking point for the whole pathway was currently the stranded patients. The pressure was on flow, so there was daily work with the community trust to try to rectify that. SAc highlighted that the stranded patients were at a higher level than last year. The biggest risk was service provision in the community.

SA queried at what stage advanced packages of care should be implemented to move patients home. SAc noted the risk was that supporting patients at home would be a long-term open-ended commitment. The finances from the dementia village would be transferred to other solutions, but it would likely be Spring 2019 before this was in place. The Chair highlighted the need for the Trust's views to be heard by the CCG and STP.

ACTION: The EMT to review the IPR report with a view to simplifying it. **SAc**

The Board discussed and **NOTED** the Integrated Performance Report.

136.2/18 **FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**

WC noted that a rewrite had been agreed upon after the CQC visit, of some risks that had been on the risk register for a long time without being mitigated. WC highlighted CRR 36 which was created in September 2016, where staff safeguarding training had been unsatisfactory for two years.

The Chair queried whether the safeguarding risk should be green. SSm confirmed that it should be green. AA noted that there was a requirement for staff to be trained within 12 months of starting employment, which had been achieved. LM

commented that there was more assurance that the care groups were taking ownership of issues. The Chair confirmed that there were no young people on the committees. SSm highlighted that a number of young people had been recruited as volunteers and the Trust was setting up a young person's council.

SRe highlighted that some of the risks had to be tolerated and others that had crystallised and were affecting the business had to be removed from the risk register. The Trust had to decide what it could and could not control to ensure that time, effort and resource was being employed in the right areas. There should be a hazard log to detect issues that were a few years away from impacting the Trust.

The Chair understood there would be a workshop on risk in the context of governance in the next three months.

KP highlighted that SRR 10, creating a five year plan with the CCG and STP, had been put back to August. PC noted that the latest guidance was for the financial plan to be developed in the summer. The Trust was developing its own three year plan. LS confirmed that the Trust was still waiting to hear the outcome of whether there would be extra funding in relation to SRR 4.

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

136.3/18 **CYBER UPDATE REPORT**

LS highlighted that cyber security was being managed through CRR 31 on the risk register. The Trust was compliant with all requirements for the cyber essential plus certificate.

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

137/18 **ANY OTHER BUSINESS**

No other business.

138/18 **QUESTIONS FROM THE PUBLIC**

Mrs Heggie noted that in the minutes the patient that she knew of that had entered hospital with sepsis had gone into the William Harvey.

Mrs Heggie highlighted that the volunteers being recruited should not affect paid posts. The jobs that were being considered including taking blood and delivering drugs, were not jobs that should go to volunteers.

Mrs Heggie stated the orthopaedic staff were concerned that the new theatres were too small. SAc confirmed that staff were managing with the theatres.

It was noted that the discharge issues largely related to community capacity over which the Trust had limited capacity.

Mrs Heggie queried whether the ophthalmology outpatient delays were a knock-on effect of the initial procedures being undertaken off site, and the follow-up falling to the Trust. LM highlighted that staff were doing initial procedures and follow-up was falling to the community. A lot of capacity had gone in, and patients were being

seen in the evening and over weekends. Upskilling staff in communities was part of the action plan.

Mrs Heggie asked whether disciplinary investigations were carried out with doctors in the same way as other staff. PS confirmed that was the case. AA noted that disciplinary was a confidential process, and there was no distinction for grades of staff.

Mrs Heggie queried whether specific activities that had to be undertaken as part of FSM could be explained. PC highlighted that the item was a three-year financial recovery plan was required.

Mrs Heggie raised the issue of drug prescribing, and that the Trust was aspiring to have a culture where all grades of staff could raise concerns.

Mrs Heggie noted that if the public were to attend Committees it should be people with some knowledge to understand proceedings. SSm agreed that that was the case.

Mrs Heggie queried whether 2gether Support Solutions Limited (2gether) had its own budget. PC confirmed that 2gether was its own company and filed its own accounts, but there would be flows of money between the Trust and 2gether.

Mrs Whorwell queried whether the Trust had safeguarding training with other public sector organisations. SSm confirmed that the Kent & Medway-wide safeguarding boards had multi-agency training. The Trust had both e-learning and face-to-face training. There was also collaboration on cases.

Mrs Whorwell asked who would inform patients about the possibility of patient trials. SAc noted that clinicians would direct patients to trials, but there were plans to market trials to patients. NY noted there was a lot of promotion around research.

The Chair closed the meeting at 12.59 pm.

Date of next meeting in public: Thursday 7 February 2019 in the Board Room, William Harvey Hospital, Ashford.

Signature _____

Date _____

CHAIR'S INITIALS ……

OPEN ACTIONS 18/109

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**OPEN ACTIONS FROM THE PREVIOUS BOARD**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**PROGRAMME MANAGER, TRUST SECRETARIAT**
PURPOSE:	**DISCUSSION**
APPENDICES	**APPENDIX 1 – ACTION POINTS FROM THE PUBLIC MEETING OF THE BoDs 6 HELD ON DECEMBER 2018**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Board may lose sight of progress of key actions if the action list is not properly updated and maintained. The Trust Secretariat ensures there is an efficient process for maintaining the action list.
LINKS TO STRATEGIC OBJECTIVES:	**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	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to:

a) Note the progress updates on open actions; and
b) Approve the closure of the following actions:
   - B/016/18 - Circulate a paper highlighting some of the commercial growth opportunities for the Trust.
   - B/016/18 - Circulate the productivity and recovery plan that was presented to the FPC in November 2018.
   - B/017/18 - Prepare a recovery plan for electives and finances.

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 7 FEBRUARY 2019

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 6 DECEMBER 2018

ACTION NUMBER	DATE OF MEETING	MINUTE NUMBER	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
B/015/18	06.12.18	131/18 Patient Experience Story	Gather information relating to accommodation for parents at other hospitals to feed into the business planning process.	LM	March 2019	The Board will be provided with a verbal update of progress at the February Board meeting.
B/016/18	06.12.18	133/18 Quality Committee – Chair Report	Circulate a paper highlighting some of the commercial growth opportunities for the Trust, and what would be required to take advantage of those.	TD	February 2019	The paper has by circulated by email to a number of the Executives in mid-December 2018. **Action closed.**
B/016/18	06.12.18	135/18 Finance and Performance Committee – Chair Report	LM to circulate the productivity and recovery plan that was presented to the FPC in November 2018.	LM	December 2019	The Productivity and recovery plan was circulated to the Board of Directors in December 2018. **Action closed.**
B/017/18	06.12.18	136.1/18 Integrated Performance Report	Prepare a recovery plan for electives and finances with clear milestones.	LM/PC	February 2019	The Recovery plan was reviewed in detail at the Finance & Performance Committee (FPC) in January 2019. It forms part of the FPC Chair's report. **Action closed.**
B/018/18	06.12.18		The EMT to review the IPR report with a view to simplifying it.	SAc	February 2019	The Board will be provided with a verbal update of progress at the February Board meeting.

CHAIR'S REPORT **18/110**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**CHAIR'S REPORT**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**PROGRAMME MANAGER, TRUST SECRETARIAT**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Introduction

The purpose of this report is to:

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

Key Events

- **HFMA Annual Chairs' Conference (Delivering strong governance through collaboration)**

  I attended the HFMA Annual Chairs' Conference in January 2019. The conference was a networking opportunity exclusively for Chairs working in the NHS, for arms-length bodies and the voluntary sector within the health and social care sectors.

  At the conference, we heard from Chairs working for the NHS regulators (Care Quality Commission (CQC), NHS Improvement (NHSI) and Clinical Commissioning Group (CCG)), alongside sessions focusing on leadership, diversity and the changing role of the Chair in times of significant change and uncertainty.

  This event was a great opportunity for me to network with peers and take away valuable learning which I can implement in my role as Chair.

- **Frimley Park Hospital Visit**

  I, along with the Chief Executive Officer (CEO) and Sean Reynolds, Non-Executive Director (NED) recently visited Mr Pradeep Patel (Chair) and Mr Neil Jardis (CEO) of Frimley Park Hospital (which received an outstanding rating from the CQC). We spent a very interesting morning discussing a variety of topics relating to the functioning of the Board to the Transformation Programme that they undertook when they acquired Wexham Park Hospitals and the kind of challenges they face in running a separate site organisation. We were most grateful for the hospitality shown to us and intend to maintain a dialogue with the Trust.

- **2gether Support Solutions – Deed of Variation**

  The Trust Board authorised the establishment of a subsidiary company, 2gether Support Solutions Limited (2gether), as an Operated Healthcare Facility (OHF) at the Extra-Ordinary Board meeting on 27 September 2018. However, following the detailed work by the Trust and 2gether to transact the contract model in the month 7 ledger, some issues

came to light that required a deed of variation to address.

The Board agreed at the Extra-Ordinary meeting that the Chief Executive Officer (CEO) and I have delegated authority to authorise changes to the contract. Further contract variations permitted by the Operated Healthcare Agreement will be authorised in line with the Standing Financial Instructions Scheme of Delegation and reported to the Finance and Performance Committee and Trust Board for a 6 month period whilst the contract matures.

In line with the delegated authority, the CEO and I have authorised the deed of variation on behalf of the Trust.

- **Sean Reynolds, Non-Executive Director, Board member makes New Year's Honours list**

  One of our Non-Executive Directors, Air Marshal Sean Keith Paul Reynolds, CBE DFC was honoured by Her Majesty the Queen in the annual New Year Honours list 2019. He was appointed to the Military Division's most honourable Order of the Bath as a CB – Companion.

- **Research Grant received for Haemophilia Centre**

  The Haemophilia Centre at Kent and Canterbury Hospital (K&CH) has been awarded a prestigious £250,000 grant to lead a research 'first' into haemophilia.

  The study, beginning in April 2019, will be the first ever randomised clinical trial of its type for physiotherapy intervention in children with haemophilia. Haemophilia is a rare inherited blood disorder which affects males. The study will take the first steps towards establishing links between exercise, weak muscles and joint damage caused by bleeding in children with the condition.

  The grant was awarded by the National Institute of Health Research (NIHR). Funders said the involvement of patients and public in the research was exceptional and considered the research would provide robust evidence and was likely to have a marked impact on reducing future health care costs.

  The Haemophilia Centre at K&C treats more than 500 patients from across Kent.

  The study will also involve teams from the University of Kent, The Royal London Hospital, Great Ormond Street Hospital and The Haemophilia Society.

Council of Governors

- **Governors Away Day**

  An informal meeting of the Council of Governors took place on 24 January 2019 at which the Governors were updated on the development process for the Trust's Organisational Strategy, the current financial position and the Business Planning process for 2019/20. The Council were then able to contribute to the process by providing views on the high level aims for the strategy. There were also some interesting discussions about how Governors could engage with Foundation Trust Members and the public to fulfil their role to represent their views to the Board.

  The next formal meeting of the Council is on 14 February in Margate and this will be followed by their annual joint meeting with the Non-Executive Directors. The latter will provide a good opportunity to continue with the work on the Organisational Strategy and to share the work that is being done on a new Council Membership Engagement and Communication Strategy for 2019/22.

CHAIR'S REPORT **18/110**

- **Joint Site Visits**

  Since my last report to the Board, there have been two Joint Site visits. The first was at the Kent and Canterbury Hospital (K&CH) on 4 December, visiting the parking office, ambulatory care, Marlowe Ward and renal outpatients. Many of the issues raised related to staffing, particularly the length of the recruitment process, which were noted by the Deputy Director of HR who was on the visit. The team noted the volume of work managed by all these departments and were impressed by the professionalism of the teams.

  The second visit was on 8 January 2019 at the Queen Elizabeth the Queen Mother Hospital (QEQMH); the departments visited were Endoscopy, Audiology, North Foreland Reception and the Clinical Library. On this occasion the theme of the issues raised was estates with some practical problems to be addressed, such as the ventilation in the library during summer. The Deputy Chief Executive was the Executive Director on the visit and took note of the issues raised.

Visits

A brief outline of the Non-Executive Directors' visits and commitments are noted below.

Chairman	8 January – Site Visit, Queen Elizabeth the Queen Mother Hospital (QEQMH) 15 January – HFMA Annual Chairs' Conference 18 January – Frimley Park Hospital Visit
Non-Executive Directors	6 December – Volunteer Christmas Lunch, Kent & Canterbury Hospital (K&CH) 11 December – Volunteer Christmas Lunch, QEQMH 13 December – Volunteer Christmas Lunch, William Harvey Hospital (WHH) 14 December – NED networking meeting 18 December – Introductory meeting between Sean Reynolds and Lee Martin, K&CH 7 January – Consultant T&O Foot and Ankle Interview Panel, WHH 8 January – Joint Site Visit with Governors, QEQMH 17 January – Consultant Paediatrician SCBU Interview Panel, K&CH 24 January – Council of Governors Strategy meeting, WHH 31 January - Consultant T&O Shoulder Interview Panel, WHH 5 February – Consultant Community Paediatrician Interview Panel, K&CH

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	N/A

CHAIR'S REPORT **18/110**

RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report.

CHIEF EXECUTIVE'S REPORT **18/111**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**BUSINESS SUPPORT OFFICER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: LATEST PUBLICATIONS AND RESOURCES**

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:

- Chief Executive Officer (CEO) / Trust Activity.
- Trust Seal Activity.
- Latest Publications and Policy Developments of Note.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks around Emergency Department (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 discuss and note the report.

CHIEF EXECUTIVE'S REPORT

1 CEO / Trust Activity

The following summarises key activity over the last month, either meetings I have attended or key developments in the Trust, which are not covered elsewhere on the Board agenda.

I am pleased to say that the Observation units have arrived at Margate and Ashford. Following internal building and kitting out, the Margate Observation unit has opened. The unit at Ashford should open next week. This will assist with the management of emergency admissions and will be a great relief after a few weeks of intense pressure. The enlarged resuscitation area will also open next week at Ashford helping the department cope better with the volumes of very poorly patients.

We have recently welcomed Sir Roger Gayle to the QEQM and Damian Green to the William Harvey Hospital. We were keen to show them the improvements in our Emergency Departments. At Ashford, we progressed to King's B ward where I introduced Sister Sally Wilson who kindly showed Damian and myself around the ward to meet the patients. Sister Sally Wilson has undertaken some innovative work around wound management and as a result has been nominated for a Royal College of Nursing award. She was highly enthusiastic and proud to point out that her ward was fully staffed.

I am also delighted to report that I met with Tracey Curley, Chief Executive of Ashford Borough Council to discuss joint working for patients with additional support with housing and health and wellbeing. We also held a discussion regarding the logistics and infrastructure of the WHH site as congestion is becoming more common with the work occurring on the M20 around Junction 10.

I am also extremely proud and delighted that the Trust has again been selected to appear in the new recruitment campaign for the NHS. This time, it focuses on IT and administrative staff, as well as a number of specialist clinical roles. It's good to see that the important role of non-clinical staff in patient care is being highlighted through the campaign - as an NHS Foundation Trust our clinical staff are literally in the front line of patient care but they rely on administrative, clerical and other supporting teams. I have met many of those staff in the last year and they always tell me how much they want to make a difference and support the clinical staff.

The Trust has a strong reputation for innovation in IT and data, and some of the pioneering work staff have done here – such as Dr Michael Bedford and Toby Wheeler's work on the Careflow system, and Jo Olagboyega, Dr Ciaran Crowe and Richard Ewins' work on the maternity app - are being filmed. As technology develops, healthcare has to change with it.

I thought I would mention the League of Friends ultrasound donation. This new scanner was unveiled this week at Cathedral Day Unit at Kent and Canterbury Hospital. A big thank you to the groups of volunteers who work relentlessly to improve patient care.

2 Events

The third CrowdFixing event as part of the Trust's Listening into Action journey took place on Thursday 24 January, with the junior doctors taking to the stage to explore ideas and issues that they currently experience. Presenters consisted of junior doctors, consultants, medical matrons, leaders in quality improvement and organisational development.

There was a strong emphasis on the impact of face-to-face communication and how this was preferred among the group, who wanted more team time and engagement with their peers and superiors. Common civilities and pleasantries such as being friendly and understanding to colleagues, saying 'hi' and giving feedback were all stressed to be of great importance, giving time to be human and improving the workplace culture, morale and mood during work.

There have also been crowd fixing events in maternity and speech and language therapy which were well attended and vibrant. All these events are supported by Executive sponsors and follow the LIA methodology.

I also had the pleasure of attending a presentation given by staff members of a programme called KENT. The programme equips participants with the knowledge, skills and power to implement change and improvement within the organisation. I am pleased to say that three projects have come to fruition to improve the way we work and the quality of the service we provide. There are over 50 projects currently being worked on as a result of the KENT programme and I look forward to these being showcased on a monthly basis to improve our working environment.

I can also report the Medi-leads training programme is progressing at a good rate with 20 junior doctors completing sessions on quality improvement, IT strategic development and Tipping Point.

I am also looking forward to the National Institute for Health and Care Excellence (NICE) question time meeting in Canterbury. This is an informative event and designed to show transparency in the workings of NICE. They welcome input from the general public, NHS staff, patients and healthcare providers.

3 Trust Seal Activity

- Deed of Novation of a contract and guarantee between IHSS LTD and EKHUFT 2Gether Support Services LTD
- Contract between EKHUFT and Intuitive Surgical LTD (Parent Company Guarantee)
- Contract between EKHUFT and Breathe Energy LTD and 2Gether Support Services LTD
- Contract between EKHUFT and Spirax Sarco LTD (Parent Company Guarantee)
- Contract for Additional Observational Bays to A & E at WHH & QEQM Hospitals
- Deed of Novation for decontamination Services EKHUFT and SRCL LTD and 2Gether Support Solutions LTD
- Deed of Novation for maintenance agreement and EKHUFT and 2Gether Solution Services LTD
- Deed of Novation for minor/major works framework. Booker and Best LTD and EKHUFT and 2gether Support Solutions LTD
- Deed of Novation for commitment rebate. GBUK Enternal LTD and EKHUFT and 2Gether Solutions LTD
- Deed of Novation for total cardiology solutions framework Lot 4. Kimal PLC and EKHUFT and 2Gether Support Solutions LTD
- Deed of Novation for minor/major works framework. Walker Construction LTd and 2Gether Support Solutions LTD
- Deed of Novation for software and services. Innovise and EKHUFT and 2Gether Support Services LTD
- Loan agreement between EKHUFT and 2Gether Support Solutions LTD
- Supplemental agreement relating to an asset transfer agreement between EKHUFT and 2Gether Support Solutions LTD
- Deed of Rectification relating to a lease of land and buildings at Kent and Canterbury Hospital between EKHUFT and 2Gether Support Solutions LTD
- Dees of variation relating to an operated healthcare facilities agreement between EKHUFT and 2Gether Support Solutions LTD
- Deed of Rectification relating to a lease of land and buildings at QEQM between EKHUFT and 2Gether Support Solutions LTD

3 Publications and Policy Developments of Note

3.1 Appendix 1 provides a list of resources available (new and a reminder of those available.

CHIEF EXECUTIVE'S REPORT **18/111**

APPENDIX 1

LATEST PUBLICATIONS / RESOURCES

LATEST NHSI PUBLICATIONS:

Long Term Plan for the NHS Published

Publication of the NHS Long Term Plan.

Have your say on the national patient safety strategy for the NHS

A national patient safety strategy is being developed alongside the NHS Long Term Plan and will be relevant to all parts of the NHS.

NHSI is running a consultation until Friday 15 February, and would like to hear what you think to make sure the strategy works for both patients and staff.

Find out more and share your views.

FREEDOM TO SPEAK UP GUARDIANS ANNUAL REPORT **18/112**

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**STAFF STORY: FREEDOM TO SPEAK UP GUARDIANS – ANNUAL REPORT**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**FREEDOM TO SPEAK UP GUARDIAN**
PURPOSE:	**DISCUSSION**
APPENDICES	**APPENDIX 1 – FREEDOM TO SPEAK UP GUARDIAN ANNUAL REPORT**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month the Board of Directors is invited to hear the experiences of the Trust's Freedom to Speak Up Guardians.

The attached paper summarises the development and activity of the Freedom to Speak up Guardians (FTSUG) over the last 12 months.

Key points the Board of Directors are invited to note are:

- Agreement on an organisational wide Freedom to Speak Up strategy is underway;
- The themes that staff are raising with the Guardians;
- A number of staff expressed concerns regarding the lack of anonymity and risks to confidentiality when using email. To address this we are developing a "Speak Up" icon on all Trust devices to give staff an alternative way to raise concerns and enable anonymous reporting. This will be signed off by the Patient Safety Committee in February;
- Updating of the website to include Champions' details and to advertise the Guardians' work mobile numbers as an alternative means of contact;
- Expansion of the FTSU Champion network. The approval of the ring fenced guardian time will enable the guardians to provide training and support;
- To work with Human Resources (HR) to triangulate data to identify hot spots of poor culture within the organisation;
- Implement a standardised approach to collect data on staff's experience of the service;
- A business case has been submitted to enable the guardian's to have some protected time. This will enable a greater visibility of the guardians with more opportunity for face to face contact with staff to explain and promote roles.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Impact on CQC Well-Led Domain – actions are outlined in the paper

FREEDOM TO SPEAK UP GUARDIANS ANNUAL REPORT **18/112**

LINKS TO STRATEGIC OBJECTIVES:	**People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 8 – Inability to attract, recruit and retain high calibre staff (substantive) to the Trust
RESOURCE IMPLICATIONS:	Awaiting outcome of the business case
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is invited to note the staff experience story and seek any further information or clarification from the Guardians present.

FREEDOM TO SPEAK UP GUARDIANS ANNUAL REPORT **18/112**

APPENDIX 1 – FREEDOM TO SPEAK UP GUARDIANS ANNUAL REPORT

Introduction and Background

FTSU Guardians have responsibility for raising the profile of raising concerns and the importance of getting it right. They are tasked with providing confidential advice and supporting staff to raise concerns and with ensuring that concerns raised are handled effectively. They also have responsibility for reporting to the board and senior management teams on the effectiveness of local arrangements, identifying and making recommendations for improvement, where necessary. Where there is serious misdirection or failure by the organisation to deal with issues, FTSU Guardians have the ability to escalate issues to the relevant regulator or other prescribed body.

They should act as an independent and impartial source of advice to staff raising a concern and are expected to have access to anyone in the organisation including the chief executive. They can be approached at any stage of a concern being raised; either at the outset, or later in the investigation if the individual has concerns with the way their concern is being handled or they are unhappy with outcome.

Concerns that are applicable for raising the with FTSU Guardians include:

- Unsafe patient care;
- Unsafe working conditions;
- Inadequate, induction or training of staff;
- Lack of, or poor response to a reported patient safety incident;
- Suspicions of fraud (which can also be reported to the local counter fraud team);
- A bullying culture (across a team or organisation rather than individual instances).

They are not expected to support those with individual grievances and these continue to be managed by Human Resources (HR).

Referrals are expected to be logged, monitored and dealt with within a specified time frame and quarterly reports of activity submitted to the Board of Directors. ‘Freedom to Speak Up’ is now part of the CQC well led domain.

The Trust has three Guardians in place. The third guardian has recently been appointed. A champion’s network is being established to increase the reach of the guardians.

Developing the Service

Over the last 12 months we have recruited seven “Freedom to Speak Up Champions” to cover QEQM and WHH. Their role is to be a listening ear for any concerns people might have and escalate to us any that concerns that cannot be dealt with at a local level. In addition a further FTSU Guardian, Mr Nitin Shrotri, Urology Consultant, has been appointed. We have no protected time for this role and include our duties within existing job plans, however a business case has been submitted to give each of us 0.1 WTE.

The faces and contact details of the two original guardians have appeared on the Trust home page banner for the last 12 months. We have combined resources with the corporate patient safety team and between us we cover every Trust Welcome Day explaining the different ways of raising concerns ensuring new starters are aware of the service. We also attend the new starter events for F1s, F2s and Registrars.

Over the last 12 months we have a number of sessions in the Quality Improvement and Innovation Hubs (QII

Hubs) and in addition, with the support of HR, we held events on all five sites during October 2018. We have given a number of presentations to staff groups who struggle to get to the QII hubs, for example theatres and SAS doctors. Despite this, it is clear from conversations with staff that our penetrance is patchy and our role is still requires clarification.

Addressing concerns regarding confidentiality when emailing a generic email address we have circulated our own email addresses and telephone numbers and are launching a “Speak Up” icon on the desktop to allow people to report concerns anonymously.

Responsibilities of Board

The National Guardian’s Office (NGO) required Trust Boards to complete a self-assessment tool to ensure awareness of their roles and responsibilities. A paper was presented to the executive management group in August 2018 and a workshop was held at the October Board meeting.

Relationships

We have strengthened links and joint working with HR and have linked up with the Guardian of Safe Working hopefully increasing awareness and strengthening the pathway for trainee doctors.

We had representation at the annual conference and have attended one of the regional networking days where we have had opportunity to clarify expectations from the national guardian’s office and to learn from our neighbours.

Updating Trust Policies

In response to the learning from published case reviews of other Trusts our Whistleblowing and Bullying and Harassment policies are being refreshed.

Concerns Raised

Below is a summary of the data included in the quarterly returns to the National Guardian’s Office. To date we have had 19 separate concerns raised this financial year. Table 1 shows the distribution between sites and Table 2 the number and nature of concerns raised in each Division/care group. There was considerable overlap between patient safety and behaviours in a number of concerns raised hence their inclusion under both headings. Two of the nineteen concerns were raised anonymously.

Table 1.

Site	WHH	QEQM	K&C	Other Sites
Quarter 1	4	2	0	0
Quarter 2	0	0	0	0
Quarter 3	4	2	4*	0
Quarter 4 (so far)	0	1	2	0
TOTAL	**8**	**5**	**6**	**0**

*One of these four speak ups was a group of five members of staff.

FREEDOM TO SPEAK UP GUARDIANS ANNUAL REPORT **18/112**

Table 2.

Care Group	UEC	GSM	G&A	SHN	W&C	CSS	CAN	CORP
Number of concerns	6	5	1	0	1	6	0	0
Behaviours	5	3	0	0	0	4	0	0
Patient Safety	5	1	0	0	0	0	0	0
Training	0	0	0	0	0	2	0	0
Other	0	1	1	0	1	0	0	0
"Punished" for speaking up	1	1	0	0	0	0	0	0

The proportion of staff from each professional grouping speaking up is very similar to the national picture, where nurses followed by Allied Health Professionals (AHPs) are the two most likely groups to raise concerns. Main differences are we have had no "speak ups" from Healthcare Assistants and very few concerns raised by admin and clerical (A&C) staff. Of the concerns raised in our organisation; 52% were from nurses, 22% AHPs, 17% Doctors, 4% A&C, and 4% Others.

The national picture is very varied with some Trusts reporting no "speak ups" per quarter and others 50-100. This probably reflects the nature of the service. For instance St George's Mental Health Trust which is one of the highest reporters has a 24/7 FTSU Guardian service contactable by mobile phone. Data from the 2018 guardian survey (https://www.cqc.org.uk/sites/default/files/20181101_ngo_survey2018.pdf) indicates that 68% of all guardians have protected time, ranging from 0.5 days to full time, 80% of those who have some protected time reported that they felt they were making a difference v 57% of those with no ring fenced time. Whilst they did not attempt to correlate number of speak ups against time available for guardians to promote the service it is reasonable to postulate there may be one. The other factor that might be responsible for the difference is that some organisations have anonymous electronic reporting systems. Our numbers are comparable with our neighbouring acute Trusts: In Q3 we had 10 concerns raised; Brighton, a similar size trust, had 14; MTW two; Medway none.

Common themes from concerns raised:

1. Local leadership
2. Lack of opportunity for staff to voice concerns and to discuss resolution at team level
3. Poor active listening and environments that don't support open and honest communication.

Learning:

1. Strengthen leadership development at middle management level
2. Improve opportunity for listening events / staff forums / local team meetings to give staff a voice and to address local issues
3. Increase opportunity for staff to develop active listening skills to facilitate open and honest dialogue at all level.

Next Steps

1. The website is being updated to include Champions' details and to advertise guardians' mobile numbers as an alternative means of contact.

2. The development of a "Speak Up" icon on all Trust devices to give staff an alternative way to raise concerns and enable anonymous reporting is now ready to be launched and will be presented to the Patient Safety Committee in February for sign off.

3. We need to expand the number of FTSU Champions across the three main sites. Once our protected time is funded we will have more time to provide training and support.

FREEDOM TO SPEAK UP GUARDIANS ANNUAL REPORT **18/112**

4. Preliminary work has begun on triangulating data to identify hot spots within organisation but needs to be developed further.

5. Following on from the Board workshop an organisational strategy is being developed. This will need to come to the Board for final approval.

6. We do not currently systematically collect data on staff's experience of the effectiveness of service and as to whether they would use it again. Whilst we have informal feedback that has been largely positive we need to have a standardised approach. As part of the development of the 'Speak up' icon we are generating an automatic feedback loop.

7. Approval of the business case for the Guardians' protected time will allow for a greater visibility of guardians with more opportunity for face to face contact with staff to explain and promote our roles.

MEDICAL DIRECTOR'S REPORT **18/113**

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**MEDICAL DIRECTOR'S REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

1. Kent and Medway Medical School

Kent and Medway Medical School has successfully completed and had approved its submission to the General Medical Council (GMC) for stage 3 of the new schools' accreditation process, allowing progression to the next stage of the GMC's new schools quality assurance process. The vision is that the programme will offer student doctors the opportunity to appreciate the critical importance of holistic, integrated, multi-professional care while they acquire the professional values, behaviours, skills and knowledge of a doctor. There is a planned GMC visit to the school in the early summer.

2. Duty of Candour

Duty of Candour has been a legal requirement since November 2014 and the CQC is able to take enforcement action when it finds breaches. There is now a precedent and in January 2019 the CQC issued a fixed penalty notice of £1250 to Bradford Teaching Hospitals NHS FT because it had failed to comply. The action was taken because the Bradford Trust was slow to inform a family that there had been delays and missed opportunities in the treatment of their child. East Kent Hospital University Foundation Trust (EKHUFT) recognised that following the introduction of duty of candour as a legal requirement uptake by the then Divisions, now Care Groups, was poor and we therefore introduced weekly reporting of compliance with duty of candour to the medical director's office to monitor and drive the process. Initial compliance across the Trust was less than 15% but this has now risen to 80% for the initial letter and 68% for the final letter for the year 2018/19 to date. Of note the Surgery & Anaesthetics Care Group lead the way and are 100% compliant with both the initial and final letters, Surgery – Head, Neck, Breast and Dermatology are at 89% for the initial letter and 100% for the final letter.

3. Child Safeguarding

The GMC advise that doctors must develop and maintain the knowledge and skills to protect children and young people at a level that is appropriate to their role. For most doctors this will be to level 2 (the minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and/or parents/carers) and for some to level 3 (clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns). The Royal College of Paediatrics advise that those doctors with a mixed caseload (adults and children) should be able to demonstrate a minimum of level 2 and be working towards attainment of level 3 core knowledge, skill and competence. The Royal College of Anaesthetists/Association of Paediatric Anaesthetists recommends there should be a minimum of one paediatric

anaesthetist with level 3 core competence in all DGH's and Tertiary centres. The precise number of Paediatric Anaesthetists requiring level 3 core competence should be determined locally based on an assessment of need and risk. The advice would be similar for general surgeons undertaking paediatric surgery but for those with a mixed caseload but constant exposure to children and young adults, such as A&E medical staff, level 3 training is mandated.

The CQC has raised with the Trust its compliance with child safeguarding. As at December 2018 Trustwide (all staff) recorded compliance with child safeguarding was 90% (91% level 1, 76% level 2 and 64% level 3). For doctors overall recorded compliance was 77% (86% level 1, 73% level 2 and 44% level 3). However, the Trust database records that 558 doctors should achieve level 3 compliance and 368 level 2, dictating a need to reassess the requirement for level 2 and level 3 training in doctors not working directly with children and young adults.

From the information provided by the Child Safeguarding team Care Groups have been requested to:

- determine by department those medical staff who are non-compliant for their Safeguarding Children mandatory training
- arrange for the staff identified to have time booked out to complete their online training and to have a date booked for the face to face training (if required for Level 3)
- provide written assurance to the Care Group governance team for onward transmission to the medical director's office

4. National Lung Cancer Audit 2018

In the NCLA 2018 there were 2 areas where the Trust was an outlier, both relating to therapy for lung cancer, detailed in the table below:

Metric	Result	Adjusted result*	National Mean	Alert Level
SACT in advanced NSCLC	47.0%	47.6%	65.0%	Alarm
Chemotherapy in SCLC	50.0%	47.3%	70.7%	Alarm
1 year survival	34.0%	32.1%	36.7%	Not significant

*adjusted for age, gender, performance status, disease stage, socio-economic status and comorbidity. SACT = systemic anti-cancer therapy; NSCLC = non-small cell lung cancer; SCLC = small cell lung cancer

Not shown in the data table are the actual numbers, the Trust total number of cases of both NSCLC and SCLC were 547 against a national mean of 253. In response to these alerts concerning treatment the lung cancer team have undertaken a detailed assessment which is summarised according to the 2 lung cancer types.

<u>Conclusion and Actions</u>

The predominant reason for the outlier status relates to delay in the lung cancer patient pathways, creating different treatment choices for patints. The actions are therefore focussed on reduction of delays to each component of the patient pathways. These include:

- Liaison with primary care to ensure that patients are aware of the reasons for 2WW referral and don't cancel their appointments. We have agreed a new 2WW card for GPs to help with correct referral
- Recruitment of 2 new Lung CNS (Macmillan Funded).
- Use of Navigators in Lung to triage and streamline patients at the front end and to

ensure 2ww compliance.

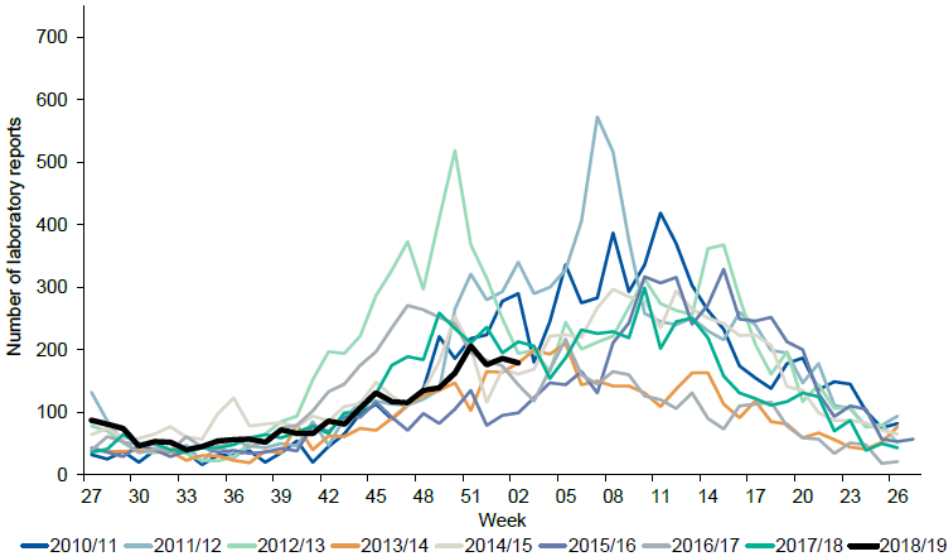
- Focussing on diagnostic waits including streamlining radiology reporting to reduce time delays and use of orange bags for cancer histopathology specimens to flag urgent specimens.
- Use of electronic patient tracking list (PTL) to pull patients through the system, reviewed weekly.
- Increased oncology support from the cancer centre (Maidstone & Tunbridge Wells Trust) to support treatment decision making and implementation and lung cancer multidisciplinary meetings.
- Implementation of a new organisational structure including a specific clinically led Cancer Care Group to give appropriate focus, together with the appointment of a new Cancer manager with a record of successful improvement of cancer pathways and outcomes.

5. Infection Prevention & Control

MRSA, MSSA, E.coli and C.difficile Healthcare Associated Infection metrics are reported in the Integrated Performance Report and will not be repeated here.

5.1 Influenza Vaccination Programme
This year's vaccination programme has been our most successful to date with an uptake of 76.6% in clinical staff and 72.1% of all Trust employees. National and Regional figures for clinical staff uptake are 65.8% and 62.6% respectively.

5.2 Norovirus
Since mid-November there have been isolated small outbreaks of Norovirus on all 3 sites involving 26 patients and 8 staff in total. Nationally numbers are comparable to the average number for the same period in the previous 5 seasons from season 2013/14 to season 2017/18 (see below)



5.3 WHH Neonatal Intensive Care Unit Pseudomonas Incident
This incident has now been closed by Public Health England. The immediate actions have been implemented and the only actions outstanding are those related to changes in the actual estate and fabric of the unit and these are all in train. There was only one actual infection related to this incident and there have been no further positive colonisation screening results since December. All actions were checked by the recent stocktake visit described at 5.2 below.

5.4 The new Kent & Medway Director of Infection Prevention & Control (IP&C) undertook a stocktake visit to assess the Trust's IP&C performance over 3 days in December 2018, visiting all 3 main sites and also Occupational Health. Initial

feedback identified many areas of good practice, such as staff knowledge of the recent WHH NICU Pseudomonas outbreak and the necessary actions emanating from the subsequent investigation in both the WHH NICU and the QEQMH SCBU. The use of a light box set up on entrance to the unit to teach parents and visitors and staff about hand hygiene technique was also singled out for praise as was the work of the Cheerful Sparrows wards link infection control nurse at QEQMH.

There were also some areas for improvement and some simple quick wins such as a review of use of fabric throughout the Trust to ensure use of disposable items wherever feasible, for example disposable curtains in areas of high risk.

The areas for improvement and the quick wins will be detailed and actioned by the IP&C team and reported through the Quality Committee for monitoring and assurance.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks: 1. Compliance with Duty of Candour is mandated by law and non-compliance risks regulatory action 2. Compliance with child safeguarding is a must do following the CQC inspections and non-compliance potentially puts children and young adults at risk from harm. Actions: Actions are detailed above.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to maintain the quality and standards of patient care CRR 47 - Inability to prevent deterioration in the number of healthcare associated infection metrics CRR 65 - Risk of prosecution by the CQC for a breach of parts 20(2)(a) and 20(3) of the Duty of Candour regulation without first serving a Warning Notice
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to note and discuss the Medical Director's report.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**MEDICAL DIRECTOR'S MORTALITY REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**N/A**

BACKGROUND AND EXECUTIVE SUMMARY

Key Messages

1. **Crude Mortality Rate**

   The 2 year trend shows the Trust to follow the peer trend but consistently at a higher crude rate. The peer distribution showed the Trust rate of 1.4% to be 0.2% higher than the peer rate for the 2 year period. For the last 12 month period (November 2017 to October 2018) the Trust rate was also 1.4%, 0.2% higher than peer rate for the 12 month period.

2. **Hospital Standardised Mortality Ratio (HSMR)**

   HSMR is in the 25th to 50th quartile of Acute Trust Peers and in the latest dataset period (November 2017 to October 2018) was 95.7 and remains below the peer value of 97.6. HSMR covered 86.8% of hospital deaths for this reporting period.

3. **Risk Associated Mortality Index (RAMI)**

   The latest RAMI of 89.1 was slightly higher than the peer value of 86.7 for this reporting period (November 2017 to October 2018).

4. **Summary Hospital Mortality Index (SHMI)**

   The latest SHMI reported on NHS digital is from the July 2017 to June 2018 period and was 1.05 (0.89-1.12, 95% over dispersion control limits).

5. **Learning from Avoidable Deaths**

   Since the introduction of the electronic template for reporting Learning From Avoidable Deaths and the roll out of the training programme for the nationally agreed methodology progress has been slow. Reviews undertaken using the structured judgement review (SJR) methodology have been predominantly in diagnostic disease groups identified by the mortality steering group as potential problem areas (fracture neck of femur, sepsis, acute myocardial infarction and cerebrovascular disease). To date 269 reviews have been completed using the SJR methodology and electronic tool since the review tool was introduced (6% of deaths). A review of each Care Group's performance in this area has been introduced as part of the Quality and Performance reviews to help drive this initiative.

6. Palliative Care Coding and Depth of Coding

The percentage of provider spells with palliative care coding is low compared with the England average (1.4% versus 1.8%) and the percentage of deaths with a palliative care code is also low (24.6% versus 32.5%). Similarly our depth of coding for both elective admissions (3.3 versus 4.2) and non-elective admissions (3.8 versus 4.5) is also below the England average. The implications of this are that our mortality may be lower than reported.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	**Risks:** • To patients from potentially avoidable increased mortality. • Reputational risk to the organisation from any failure to address areas of increased mortality and avoidable mortality. **Actions:** • Review of conditions alerting through triangulation of mortality indices (acute myocardial infarction, stroke and perinatal conditions) and monitoring of trends. • Appointment of clinician leads to drive the structured judgement review process, together with administrative support. • Further development of the mortality case notes review dashboard to identify and extract key learning themes to be disseminated across the organisation. • Review of coding to ensure accurate recording of disease codes and comorbidity.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to maintain the quality and standards of patient care CRR 28 - Lack of timely recognition of serious illness in patients presenting to the Emergency Departments CRR 47 - Inability to prevent deterioration in the number of healthcare associated infection metrics
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

Members of the Trust Board are requested to receive this report and to:

- Be advised that significant work has been undertaken to ensure the Trust's mortality rates are closely monitored and that any diagnostic groups with a higher HSMR, RAMI or SHMI are being reviewed and learning and action taken where applicable
- Note the progress being made with Structured Judgment Reviews and the further progress required
- Be advised that additional staff time resource will be required to achieve the necessary

implementation of the Learning from Deaths programme both corporately and at specialty level • Be assured that where deaths have been considered to be 'more than likely due to problems in care' these have been investigated by the Patient Safety Team.

Mortality and Learning from Avoidable Deaths

1. EKHUFT mortality rates and what the data are telling us

1.1 Crude Mortality (proportion of discharges where death is the outcome)

Crude mortality is the number of deaths occurring per unit of time and reflects underlying demographics and associated comorbidity. For the period November 2017 to October 2018 the Trust crude mortality was 1.4% and is within the 50th to 75th peer percentile of the Hospital Episode Statistics (HES) for Acute Trusts. How the Trust's crude mortality rate has varied over the last 24 month period is shown below.

The seasonal variation in crude mortality can be clearly seen with an increase in mortality rates from November through to January/February and this is reflected in National data too.

1.2 Hospital Standardised Mortality Ratio (risk adjusted mortality where patients die in hospital over a 12 month period within 56 diagnostic groups covering at least 80% of deaths)

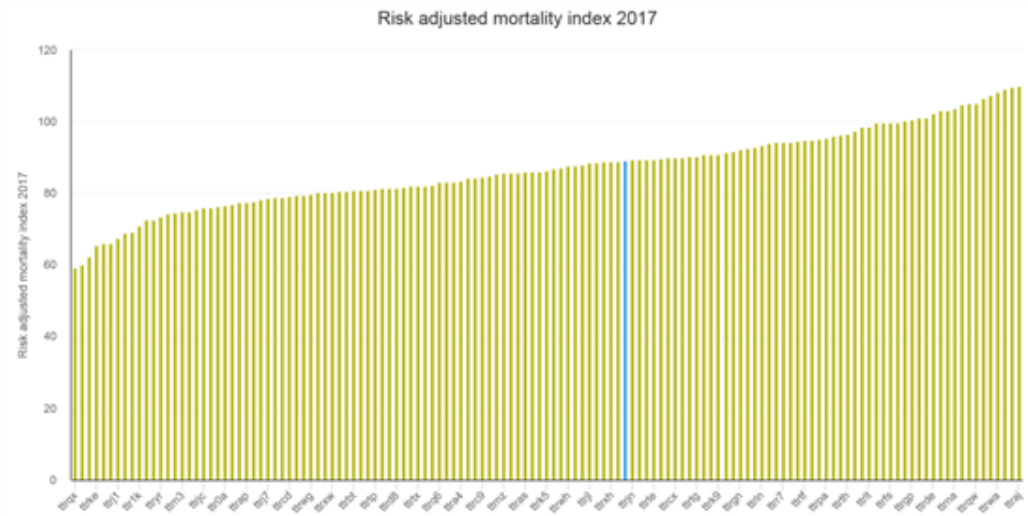
The hospital standardised mortality ratio (HSMR) for the latest period (November 2017 to October 2018) was 95.7 compared to a peer value of 97.6. This is in the 25th to 50th quartile of HES Acute Peers.

HSMR also varies throughout the year and follows the same pattern as crude mortality. The diagnostic groups are chosen to cover over 80% of in hospital deaths and during this reporting period covered 86.8% of in hospital deaths.

There is very little site variation between the 2 acute sites, but an understandably lower HSMR on the K&CH site.

1.3 Risk Adjusted Mortality Index (Includes all activity including well babies and palliative care)

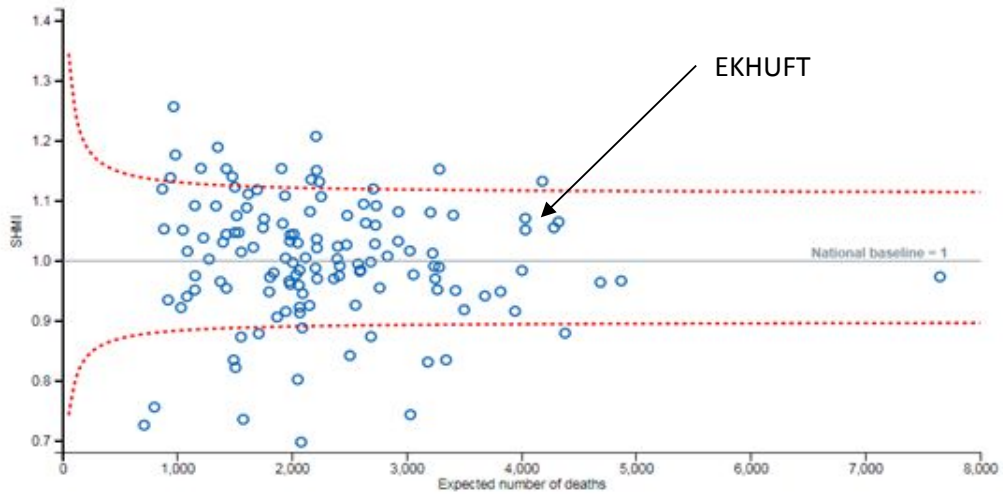
The latest risk associated mortality index (RAMI) of 89.1 for this reporting period (November 2017 to October 2018) is on the peer 50th percentile.



Again there is variation within year for both our Trust and the HES Acute Peers.

1.4 Summary Hospital Mortality Index (risk adjusted mortality including both within hospital deaths and deaths within 30 days of discharge)

The latest summary hospital mortality index (SHMI) reported on NHS digital is from the July 2017 to June 2018 period and was 1.05 (0.89-1.12, 95% over dispersion control limits).



A
o
J
ir

65.4% of deaths contributing to the SHMI occurred in hospital and 34.6% within the 30 days of discharge, these percentages have remained very consistent since October 2015 but are at variance with the England average (71.3% deaths occurring in hospital and 28.7% within 30 days of hospital discharge).

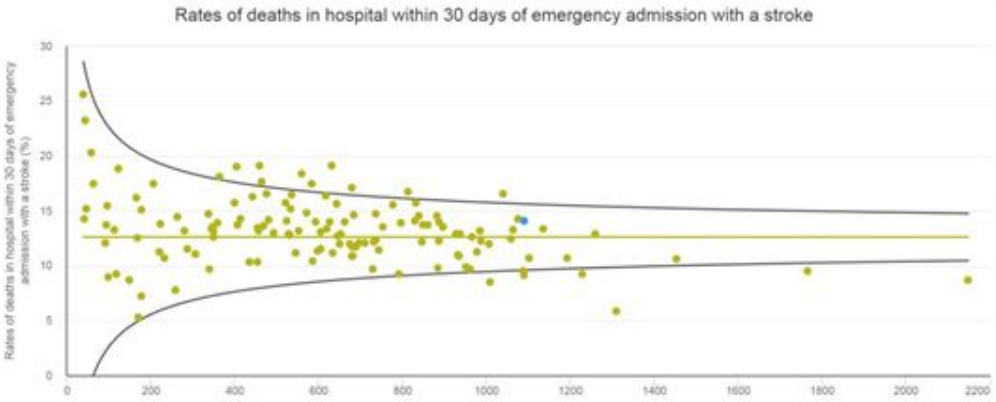
In May 2019 there will be some important improvements to SHMI reporting including publishing at site level in addition to Trust level, publishing control limits and SHMI bandings for a subset of the SHMI diagnosis groups (larger diagnosis groups), the inclusion of seasonality within the statistical models employed to calculate the expected number of deaths, and the inclusion of birth weight to improve the accuracy of the perinatal diagnosis group models and therefore the overall SHMI.

2. Which are the diagnostic groups most contributing to our mortality rates?

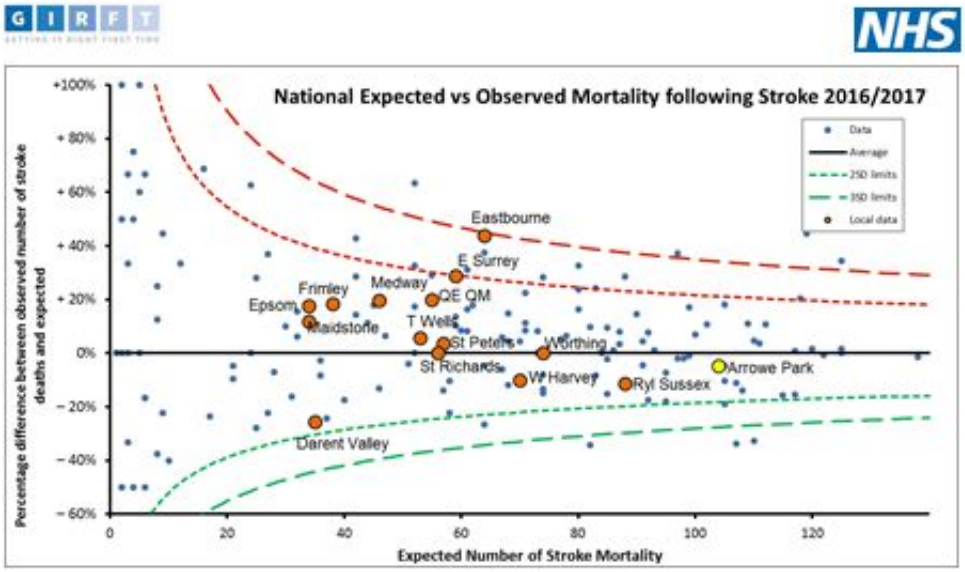
There are 140 diagnostic codes that contribute to the SHMI analysis and we look at both these and the diagnostic codes contributing to the RAMI and HSMR to identify conditions potentially alerting for increased mortality. From the latest SHMI data those conditions triangulating with RAMI and HSMR are acute myocardial infarction and perinatal mortality (although the latter does not appear in the SHMI list). The full list of conditions, number of spells and observed versus expected deaths are detailed in the table below and are as previously reported.

Diagnostic group	Spells	Observed	Expected
Acute Cerebrovascular disease	1181	251	217
Acute Myocardial Infarction	1573	151	122
Cancer of the lung	204	92	70
Cancer of the colon	309	39	32
Cancer of the oesophagus	80	27	21
Chronic obstructive airways dis.	1889	123	117
Gastrointestinal haemorrhage	843	68	61
Intestinal obstruction	421	47	37
Other GI disorders	1014	41	31
Septicaemia (except in labour)	3215	861	747

Diagnostic codes alerting in the SHMI, RAMI and HSMR data are triangulated through CHKS monitoring and reviewed by the mortality information group to assess trends. For example, the diagnostic code 'acute cerebrovascular disease' suggests increased mortality but performance in comparison to peers from CHKS data indicates similar performance for crude mortality.



When this is adjusted for comorbidity in the SSNAP data (albeit the data periods do not correspond) the William Harvey mortality compares particularly favourably).



SSNAP mortality is based patients reported to SSNAP, and records deaths within 30 days of admission (either in hospital or after discharge, linked to ONS data). Actual deaths are compared with "expected" deaths (which is case mix adjusted for stroke severity).

Source: SSNAP 2016/17

Finally, we look at cumulative sum control charts (CUSUM) to assess trends to guide which areas require additional information to provide the necessary level of assurance.

3. Learning from Avoidable Deaths

3.1 What does "Learning from Deaths" involve?

The National Guidance on Learning from Deaths includes a requirement for Acute Trusts to publish on a quarterly basis via Trust Board papers and in the annual Quality Accounts:

- the total numbers of in-hospital deaths
- the numbers of deaths fully reviewed as part of the relevant Specialty morbidity and mortality (M&M) process using the Structured Judgement Review tool (SJR) which is part of the National Mortality Case Record Review programme
- the number of deaths assessed as having been more likely than not to have been caused by problems in care
- evidence of learning and action that is happening as a consequence of this information

There are certain categories of deaths where a full review is automatically expected (ie children; patients with Learning Disabilities, Severe Mental Illness, following an elective procedure). Full reviews should also be undertaken where family, carers or staff have raised a concern about the quality of care provision; where there is the potential for learning and improvement; and where there is a CUSUM alert for a diagnosis group or a Quality Improvement initiative.

Case record review can identify problems with the quality of care so that common themes and trends can be seen, which can help focus organisations' quality improvement work. Review also identifies good practice that can be spread. Investigation (root cause analysis and after action review) is more in-depth than case record review as it gathers information from many additional sources. The

investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.

Death due to a problem in care is one that has been clinically assessed using a recognised method of case record review, where the reviewers feel the death is more likely than not to have resulted from problems in care delivery/service provision.

3.2 What progress have we made to date?

The Trust's policy governing Learning from Avoidable Deaths was published in September 2017 and the structured judgement review tool produced nationally has been adapted to use on an electronic platform to enable data capture and analysis. Alongside this a dashboard has been developed for reporting (see below) which remains under review through the mortality information group in terms of its final format.

4 members of the Trust underwent a 'training the trainers' programme in the structured judgement review methodology in October 2017. They in turn have since trained a further 79 reviewers across the Trust.

3.3 Learning From Avoidable Deaths Dashboard

As of January 2019 the dashboard records the first 269 structured judgement reviews that have been completed on the electronic platform. It should be noted that the majority of these reviews have been completed in areas where we expected to see some problems in the care provided. Of these 269 cases, in 5 the reviewers opinion was that death was more likely than not to have resulted from a problem in care, in 8 there were problems in care identified which may have contributed to death, and in 55 there were problems in care identified but these were very unlikely to have contributed to death.

The structured judgement review process also allows assessment and categorisation of problems in healthcare, some cases will have had more than one problem with care identified throughout the inpatient episode. Overall 134 of 269 cases reviewed had a problem with care identified and these were categorised as follows:

Problem	Led to Harm?		
	No	Probably	Yes
Assessment, Investigation or Diagnosis (including assessment of pressure ulcer, VTE or falls risk	25	2	8
Medication/IV fluids/electrolytes/oxygen	17	4	8
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	21	3	4
Infection control	4	1	3
Related to operation/invasive procedure (other than infection control)	18	1	2
Clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	13	0	7
Resuscitation following a cardiac or respiratory arrest (including CPR)	3	0	0
Any other problem not fitting the categories above	32	4	2

The areas identified above triangulate well with information coming from the Datix incident reporting system and to the corporate risk register.

3.4 Next Steps

As the number of clinicians trained in the methodology increases and once the process has been embedded in each departmental mortality review meeting, supported by the appointment of clinician leads across the Trust the proportion of all deaths reviewed will increase to the desired level (ideally circa 30%), driven by those clinician leads. Coupled with this work further development of the dashboard will assist in extraction of key learning themes for dissemination across the Trust.

QUALITY COMMITTEE CHAIR REPORT **18/115**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

The following provides feedback from the January 2019 and December 2018 Quality Committee meetings. The report seeks to answer the following questions in relation to the quality and safety performance:

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

MEETING HELD ON 29 JANUARY 2019

1. The following went well over the period:

1.1 The Committee received and discussed the report from the Clinical Quality and Patient Safety Report, noting the key points below:

1.1.1 The Friends and Family Test (FFT) inpatient satisfaction rate remains positive at 97%. There was improvement in the position for outpatients, day cases and inpatients. Care, staff attitude and implementation of care are the three top positive themes for December 2018.

1.1.2 Harm free care (new harms) registering green at 99% and remains within control limits. Prevalence of new Venous Thromboembolism (VTE); Catheter and new Urinary Tract Infections (UTIs) remains below the average for Acute Hospitals. Improvement work continues for falls.

1.1.3 Overall Harm Free Care (HFC) related to harms patients are admitted with as well as those they acquire in the Trust's care. The Safety Thermometer remains within control limits and continues to register green in December. There has been a marked improvement in Urgent and Emergency Care with a rise to 97.75% (92.05% November 2018).

1.1.4 Healthcare Associated Infection (HCAI); there have been no Methicillin Resistant Staphylococcus Aureus (MRSA) and the Trust is registering green (below Trust limit) in December. C Diff cases remain green and below Trust limit. E coli bacteraemia recorded post 48 hours has decreased for the second consecutive month, now reporting below lower control limit (registering green). The underlying causes of community onset E.coli bacteraemia are similar.

1.1.5 Complaints performance in relation to complaints responded to within timescales has improved for the third consecutive month registering green for December (exceeding Trust target). Considerable work is on-going to

improve the timeliness of response to all complaints and reduce the average time open. Acknowledgement of complaints within 3 working days has increased to 97%. There were two complaints that did not achieve this standard and these are being reviewed to identify and address the reasons why.

1.1.6 The Committee discussed and noted a detailed complaints report regarding the recovery actions in place being taken forward to achieve improvements in the complaints process.

1.1.7 The Committee received and discussed a report on medication incidents noting the improvements in medication safety, which had plateaued. Focussed actions continue to progress the medication safety plan to ensure improvement is sustained, in relation to omitted medicines and missed critical medicines, robust documentation, and drugs charts, storage and security. It was emphasised the importance of having dedicated undisturbed periods when staff are carrying out drug rounds and that those staff wear visible tabards to clearly identify when they are carrying out this duty. An update report was requested to be presented to the next Committee meeting regarding progress against the actions as well as improving the practice when carrying out drug rounds.

1.1.8 The Committee received and discussed an update report regarding the Serious Incidents (SIs) process along with the current status of SIs in relation to improving compliance with National SI timeframes.

1.1.9 In relation to Liaison Psychiatry, the partnership Commissioning for Quality and Innovation (CQUIN) relating to frequent attenders to the Emergency Department (ED) has proved successful to date, and it is anticipated that all milestones will be met for Year 2 as they were in Year 1.

1.1.10 The Trust is working with the Kent and Medway NHS and Social Care Partnership Trust on registration for mental health activity with the Care Quality Commission.

1.2 The Committee received and discussed a report regarding the Neonatal Intensive Care Unit (NICU) pseudomonas outbreak, noting:

1.2.1 The results following the identified colonisation indicate that there was no single infection reservoir identified, neither did the results indicate consistent cross-transmission.

1.2.2 Immediate infection prevention and control actions were implemented and an incident control meeting was held with Public Health England (PHE).

1.2.3 Additional environmental testing has taken place throughout the delivery and post-natal areas in Ashford and in the Special Care Baby Unit (SCBU) at Margate to determine any additional preventative actions required.

1.2.4 An incident closure meeting took place on 15 January 2019 and PHE took assurance from the actions taken and the planned actions for the future. As well as the microbiological information and the positive findings from an Infection Prevention & Control stocktake undertaken by the Kent & Medway Director of Infection Prevention & Control together with her NHS Improvement (NHSI) counterpart.

1.2.5 Routine microbiological screening is undertaken.

2. Concerns highlighted over the reporting period:

2.1 The Committee received and discussed the report from the Patient Safety Committee (PSC), noting the following:

2.1.1 Care Groups are now reporting Venous Thromboembolism (VTE) assessment recording to PSC by specialty and by site in order to drive improved compliance. The Cancer Care Group reported an overall compliance for December 2018 of 99.9%, Surgery have improved to 93.3% and Women's & Children to 93.9%.

2.1.2 Performance remained static with regards to Medicines Safety

Thermometer. Care Groups are now exception reporting and the Medicines Safety Officer is providing individual Care Group reports broken down to level of wards to enable more focused action.

2.1.3 Twelve new Serious Incidents (SIs) reported in December. Seven breached SI cases.

2.1.4 Two Never Events declared in January, a wrong site block (outside theatres/augmented care areas), and a fall from restricted window. The Root Cause Analysis (RCAs) are on-going.

2.1.5 The Committee raised the importance that the PSC closely monitors SIs, around investigations, actions and learning, and that these discussions are detailed in the minutes and key highlights included in the PSC report presented to the QC.

2.2 The Committee received and discussed the report from the Clinical Quality and Patient Safety Report, noting the key points below:

2.2.1 FFT in maternity fell slightly 97.7% (99% November 2018), this is unexpected for maternity and the reasons behind this are being determined to secure timely recovery.

2.2.2 The ED remains around 85% for FFT depicting sustained improvement from several months ago.

2.2.3 There was a slight increase in the number of mixed sex accommodation (MSA) breaches in December. Trust performance remains (positively) within Trust trajectory set as part of the MSA collaborative. In recognising the impact of seasonal pressures action continues to ensure that all possible action is being taken to prevent justifiable breaches.

2.2.4 Overall Patient Experience, calculated from the average of key questions within the local inpatient survey is registering amber. Improvement actions are in place, around peer review visits across all sites and Care Groups, and progressing the '#Hello my name is' initiative.

2.2.5 Hand hygiene reporting at 94% compared with 96.2% in November albeit fluctuating around the mean and within control limits. This is subject to heightened surveillance through the relevant Care Group clinical governance teams to actions at the point of care in association with infection prevention and control.

2.2.6 The Trust category 2 Pressure ulcer (PU) rate registered amber in December and is within control limits. There were no avoidable deep ulcers reported. Recovery actions are being progressed, which include 'react to red' and 'bottoms up' campaigns.

2.2.7 Staffing - The percentage fill of planned (funded establishment) and actual (filled shifts) by hours is required to be reported monthly by registered nurse and care staff, by day and by night, in line with National Quality Board expectations. During December the average overall fill rate was 98.5% compared to 101.0% in November. Low fill rates on several wards was due to a combination of sickness, maternity leave and vacancies. A revised format was requested for presentation at future meetings providing the required assurance that the appropriate processes are in place to confirm sustained sufficient staff rostering ensuring safety of patients.

2.2.8 Staffing levels in paediatrics is reviewed daily, and assurance is being secured and reported to the Executives regarding safety and staffing within ED and paediatric wards. Specialist support is being secured to test and develop the Trust's service and staffing models.

2.2.9 The Committee received and discussed a nursing fill rates and rostering report.

2.3 The Committee received reassurance from each Care Group that there were no patient safety concerns raised in relation to the current performance levels against the National Constitutional Standards, regarding the 4 hour emergency access, 18

week Referral to Treatment (RTT), cancer and 6 week diagnostic.

2.4 The Committee received and discussed the principal mitigated quality risks. The report did not provide the level of assurance in relation to the progress updates as some of these were not updated in the month around mitigation of the risks, and it was vital that updates are provided against all the risks. It was highlighted that the responsibility for updating progress against the risks in relation to the actions being taken forward to mitigate these is for all the leads across the organisation as a whole. The key areas noted:

2.4.1 A change to one residual risk score relating to CRR 36: Inadequate safeguarding training arrangements Trust-wide (adult and children) that has been reduced to 12 (moderate) from 16 (high).

2.4.2 The de-escalation of a risk from the Corporate Risk Register to a local risk register relating to CRR 31: Exposure to Cyber Security attacks, as sufficient controls are now in place to mitigate the risk to a tolerable level; and CRR 39: Delays in radiological reporting was closed as the major fluctuations have been reduced, and the current backlog is in a good position and monitored closely.

2.4.3 An emerging health and safety (H&S) risk in relation to the window restrictors at Kent and Canterbury Hospital (K&CH) complying with H&S Executive guidance.

2.4.4 There were no new risks, no risks proposed for closure and no risks recommended for merging.

2.5 The Committee received and discussed the Quarterly Integrated Incidents, Patient Experience and Claims Report: Quarter 1 2018/19. The Committee noted:

2.5.1 The Medical Director and Chief Nurse & Director of Quality have set a target of 100% compliance with Duty of Candour (DoC) for 2018/19. Additional training has been provided to improve the current position and support the Care Groups in achieving the target. Additional training on investigative techniques, writing RCAs and developing action plans is scheduled for staff.

2.5.2 The Deputy Chief Nurse will be liaising with another Acute Trust who successfully improved their complaints procedure to discuss opportunities for learning and implementing improvements around their improvement programme.

2.6 The Committee received and discussed a report regarding the National Institute of Clinical Excellence (NICE)/Clinical Audit and Effectiveness Committee (CAEC). Concern was raised regarding the poor performance in relation to the clinical audit programme and a detailed progress update report will be presented to the next Committee meeting.

2.7 Following an action from the previous meeting in relation to chest x-ray film reporting the Committee received and discussed a report summarising the current position within the Trust. It was agreed that the current policy and procedure needed to be reviewed and recommendations made. This would be discussed by the Clinical Executive Management Group (CEMG).

3. Other topics discussed:

3.1 The Committee received and discussed a report from the Patient Experience Group (PEG) noting:

3.1.1 The End of Life (EoL) Board provided an update on progress against the Trust wide action plan. Noting that the required EoL National and Local audits had been completed and the results are expected in the Spring. A number of initiatives have been implemented that include:

3.1.1.1 The introduction on the wards of comfort packs for relatives of dying patients.
3.1.1.2 The availability of wedding boxes for dying patients to assist a last minute arrangement.
3.1.1.3 A patient tracking electronic list for EoLC tracks dying patients on the wards which are identified on vital pack, allowing a facilitated approach for EoLC patients on the wards.
3.1.1.4 EOLC is included in all EKHUFT staff induction programmes.
3.1.1.5 Education and training programmes are in place across all disciplines plus facilitated learning on the wards where practice may need enhancing.
3.1.1.6 Newsletter for EOLC, a facilitating method of communication and staff engagement with EOLC Innovations.

3.2 The Committee received and approved the proposed structure regarding the Care Group governance, noting:
3.2.1 Monthly performance meetings reviewing finance, activity and workforce will be presented to the Finance and Performance Committee and Strategic Workforce Committee.
3.2.2 Monthly Quality and Risk reports will be presented to the QC.
3.2.3 The revised terms of reference for the new Care Group Governance meetings will be approved at the CEMG.
3.2.4 The revised terms of reference for the PSC, PEG and NICE/CAEC will be presented to the QC for approval at the next QC meeting.
3.2.5 The Committee approved the change in attendees at the QC from the Clinical Directors to the Care Group Heads of Nursing (HoN).

3.3 The Committee received and discussed a Care Quality Commission (CQC) update report, noting:
3.3.1 The implementation of a new reporting structure with the introduction of Quality and Risk Governance meetings for each of the Care Groups. This enables focussed discussions in relation to performance, quality and safety.
3.3.2 The actions and improvements implemented to progress the paediatric action plan following the inspection in October 2018. Positive paediatric huddles are taking place that are proving effective with good engagement from staff. The majority of the actions have been completed and the remaining five actions are on track to be completed.
3.3.3 Progress against the paediatric action plan is overseen by the monthly Improvement Plan Management Group (IPDB) meetings.

3.4 The Committee received and discussed Quality, Risk and Governance reports from each of the seven Care Groups. The revised format was welcomed by the QC, as these reports provided much more robust information regarding performance, quality and safety, and risks. The QC agreed that future meetings would include allocated time at the beginning of each meeting to receive a focussed update briefing from each Care Group.

MEETING HELD ON 18 DECEMBER 2018

4. The following went well over the period:

4.1 The Committee received and discussed a report on the mechanisms implemented to support improving the SI process across the organisation and will now be embedded. This is around achieving timely completion of SI investigations, and evidencing of achievement of the SI Framework (NHS England 2015) quality assurance standards.

4.2 The Committee received and discussed a mortality report from the Medical

Director. The full Mortality paper is on the Board agenda.

4.3 The Committee received and discussed an introductory report regarding the National Getting it Right First Time (GIRFT) programme, designed to improve medical care within the NHS by reducing unwarranted variation. Local actions from each visit are collated into the GIRFT action plan.

4.4 The Committee received and discussed the principal mitigated quality risks, noting:

4.4.1 The changes to two residual risk scores in relation to CRR 40: Lack of robust antenatal and new-born screening programmes, which has been increased from 6 (low) to 9 (moderate) following a PHE visit; and CRR 67: Sustained high level of Ambulance conveyance activity to the Queen Elizabeth the Queen Mother Hospital (QEQMH) results in delayed treatment and an inability to stream patients safety, reduced from 9 (moderate) to 6 (low) following receipt of the live audit report and that the number of incidences has significantly reduced.

4.4.2 One new corporate risk in relation to 1121: Missed doses of medicines, following the medication safety thermometer audit identifying that a high percentage of patients missed doses in the previous 24 hours.

4.4.3 Two emerging risks, a new risk in relation to the implementation of the Patient Administration System (PAS) that is having an impact on the financial position for non-coded episodes; and an escalated risk in relation to the process and capacity of the radiology department to report on chest x-rays requested internally. GP requested chest x-rays are all reported.

4.4.4 No risks for closure and no risks recommended for merging.

4.5 The Committee received and noted a report on the East Kent Transformation Programme regarding the clinical standards for clinical sustainability around the progress made to date.

4.6 The Committee received and approved the Safeguarding Children Annual Report 2017/18 noting:

4.6.1 Key achievements:

4.6.1.1 Section 11 compliance audit undertaken.

4.6.1.2 Further increase in safeguarding activity.

4.6.1.3 Approval of the business case to increase team capacity to deliver additional training and activity.

4.6.2 Key challenges:

4.6.2.1 Training compliance is still below the national requirements at Levels 2 and 3.

4.6.2.2 Increasing Safeguarding Supervision compliance.

4.7 The Committee received and approved the Adult Safeguarding Annual Report 2017/18.

4.7.1 Key areas of success:

4.7.1.1 Training compliance has risen to the required 85% compliance rate.

4.7.1.2 More doctors are attending face to face training.

4.7.1.3 There has been a significant improvement in staff reporting concerns regarding patients.

4.7.2 Key challenges:

4.7.2.1 Overall, reporting numbers for Deprivation of Liberty Safeguards has dropped.
4.7.2.2 There are on-going difficulties with data quality relating to PREVENT.

5. Concerns highlighted over the reporting period:

5.1 The Committee received and discussed the report from the Patient Safety Board (PSB), noting the following:
5.1.1 VTE assessment compliance remained below 95%.
5.1.2 There were 17 new SIs reported in November.
5.1.3 An issue was raised regarding chest x-ray plain film reporting, the Committee requested a report to be presented to the next QC meeting regarding the current position and planned actions to mitigate any risks.

5.2 The Committee received a verbal update regarding Clinical Quality and Patient Safety, as due to the timing of the QC meeting data was unavailable to be presented as a report. The key points were noted below:
5.2.1 MSA breaches had risen significantly from zero the previous month to 22 in the current month.
5.2.2 Staffing was the key risk and for November the care hours and fill rate had improved. Winter pressures was challenging along with agency spend and the level of agency expenditure needed to be reduced. A number of actions were in place and being progressed around a more pre-emptive approach. The Committee took reassurance from the Chief Operating Officer, Chief Nurse and Director of Quality, and the Care Group leads, in relation to robust and appropriate processes are in place to mitigate this risk.

5.3 The Committee received and noted a Care Quality Commission (CQC) update report, which did not provide the level of assurance required regarding the current position and the status of the actions around progress against the action plan. A revised and much more robust report was requested to be presented at the next QC meeting.

5.4 The Committee noted that the previous meetings of the PEG and NICE/CAEC had not been quorate. This raised concern regarding the lack of attendance at key senior meetings and the importance of having in place a Care Group structure that allows time for the required leads to be able to attend the necessary meetings as well as eliminating any unnecessary attendance.

6. Other topics discussed:

6.1 The Committee discussed the required format of the Quality Improvement Strategy 2018 – 2021 objectives and agreed that a revised report would be presented to a future QC meeting.

6.2 The Committee received and discussed the Quality, Risk and Governance reports from each of the seven Care Groups, these were presented in a new format and were positively received by the QC. It was acknowledged that these reports are work in progress and provided more visible data and information regarding performance, quality and safety, and risks in the Care Groups.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss, note and accept the report for approval from the Quality Committee.

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)**
BOARD SPONSOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX A: RISK MANAGEMENT STRATEGY AND POLICY** **APPENDIX B: BOARD ASSURANCE FRAMEWORK** **APPENDIX C ANNUAL PRIORITIES 2018/19** **APPENDIX D: IAGC TERMS OF REFERNCE (TOR)**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

MEETING HELD ON 17 JANUARY 2019

Positive assurance was received in relation to:

1. The Committee received and discussed a report on the Full Strategic and Corporate Risk Registers, noted the changes that had been made to the risk register. The Committee took assurance from the progress updates provided in relation to the management of the risks, but emphasised that there remained 17 extreme and high risks on the register. It was highlighted that statistically it was likely that some of these risks would crystallise during the year and that there needed to be in place appropriate action plans to mitigate these risks. The Committee noted the following:

   1.1 The heat map showed 32 live (open) strategic and corporate risks;
   1.2 The change to the residual risk score regarding SRR 8 – Inability to attract, recruit and retain high calibre staff (substantive) to the Trust. This has been reduced due to the improved recruitment processes and subsequent increase in the number of new starters. There had also been a change to one target score for SRR 16 – Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes, which has decreased from 8 (moderate) to 6 (low);
   1.3 There were two risks proposed for closure and these were agreed; CRR 39 - Delays

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

in radiological reporting, as the major fluctuations had been reduced and the current backlog is in a good position and monitored closely; CRR 31 - Exposure to Cyber Security, as sufficient controls are now in place to mitigate the risk to a tolerable level;

1.4 There were no risks that had been requested for escalation;

1.5 An emerging Health & Safety (H&S) risk in relation to window restrictors at Kent and Canterbury Hospital (K&CH) in terms of compliance with H&S Executive (HSE) guidance as to the depth of the window restrictors.

2. The Committee received and discussed a verbal Cost Improvement Programme (CIP) deep dive update regarding the theatre improvement plans. The Committee received assurance that a realistic and achievable improvement plan is in place and will be taken forward, albeit that this plan had been deferred to the next financial year 2019/20.

3. The Committee received and considered a report on the annual review of the Standing Financial Instructions (SFIs). The SFIs have been revised and the final version will be presented to the Board in March for approval. The Committee noted:

   3.1 The revised SFIs take account of the new management structure around the Care Groups and the setting up of the Trust's wholly owned subsidiary, 2gether Support Solutions Limited;

   3.2 The significant change in relation to the introduction of a £1m contract value limit over which Board approval is required for requisitioning goods and services;

   3.3 That the numbering and alignment will be adjusted when the final version is approved.

4. The Committee received and considered the revised Risk Management Strategy and Policy, and recommended this for approval by the Board (Appendix B). This has been revised to reflect the new Care Group structure and has also been moved to the new policy template.

5. The Committee received and approved the 2018/19 Annual Accounts Process and Accounting Policy. The Committee noted the key deadlines and the high level actions to ensure the Trust remains on track for completing the accounts process. The draft (unaudited) accounts and Provider Finance Return forms (PFR) are required to be submitted by noon on 24 April 2019, and the audited accounts and PFRs by noon on 29 May.

The following reports were also discussed:

6. The Committee received and discussed the Quarter 2 report on the Board Assurance Framework (BAF) (Appendix C) and Annual Priorities 2018/19 (Appendix D): Delivery against priorities Quarter 2. These reports are attached for the Board to note.

   6.1 The Committee noted that the Partnership Strategic Objective was currently outside the Board's agreed risk appetite tolerance and this strategic risk was aggregated as extreme (significant). This is as a result of the delays that continue around the delivery of the Sustainability and Transformation Partnership (STP). The Committee highlighted the importance of taking forward the necessary actions to progress the delivery of the STP and requested that there is focussed work to ensure this is progressed and that the residual risk score is reduced;

   6.2 A communication will be issued to all risk owners for individual risks that are extreme in terms of taking the required actions to reduce the residual risk score;

   6.3 Work with partner organisations continues to develop an East Kent Accountable Care Partnership/Integrated Care System. This included work around delivering a frailty pathway, developing an Estates Strategy, Kent Care Record, and the programme around the pathology partnership;

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

6.4 The Committee noted the amber rated performance and adequate assurance achievements regarding the other strategic objectives for Patients, People and Provision;
6.5 The Committee noted that the overall performance for Provision was currently Red, which is a deterioration from Amber in Q1 and that this reflected the challenges in the Emergency Departments (EDs).

7. The Committee received and discussed a report on the methodology and results of the annual review of the Trust's risk management maturity based around the Risk Management Policy. The Committee noted:

7.1 The disappointing poor response to the self-assessment questionnaires as only 12 out of the 44 questionnaires sent were completed and returned, which could have been due to the timing that this was undertaken during the Christmas and New Year period. The review process will be considered to be undertaken again following the Board risk appetite session;
7.2 Following this annual assessment the Trust's risk maturity remains at the start of Level 3 with an overall score of 67/110, this describes the Trust's risk as "Risk management applied consistently and thoroughly across the organisation", which is the same score as the 2017/18 assessment;
7.3 A key area for improvement is delivering training to embed risk management across the new Care Group structures;
7.4 An internal audit exercise on risk management will be undertaken towards the end of this financial year, the recommendations from this will be consolidated with the results of the annual review to support the development of a comprehensive work plan for 2019/20 to strengthen the risk management of the Trust.

8. The Committee received and discussed a report regarding the system wide management of Strategic and Partnership Risks. Systems are in place across the individual organisations and the Committee noted the challenges around when these risks are shared with partners across the NHS. It was acknowledged the advantages of adopting a standard approach for partnership risks and that risk management is a key element to the successful delivery of the NHS long term plan.

9. The Committee received and discussed a quarterly Freedom to Speak Up Guardian (FTSUG) report providing an update on the activity of the FTSUGs in Q3, which was beginning to get traction. The following was noted:

9.1 Ten cases have been reported to the FTSUGs;
9.2 The common themes were around local leadership development, lack of opportunity for staff to voice concerns and to discuss resolution at a team level, the need for active listening and environments that support open and honest communication;
9.3 Learning as a result around strengthening leadership development at middle management level, improving opportunity for listening events, staff forums and local team meetings. This will give staff a voice and also enable issues to be addressed locally;
9.4 The activity of the FTSUGs during Q3, which included collaborating with HR around the events held on all of the Trust's five sites in October promoting speaking up. A Schwartz Round was also held on this topic at the William Harvey Hospital (WWH). A review of relevant policies has been undertaken with the HR Team, and amendments have been agreed to comply with the NHS Improvement (NHSI) guidance. There has been preliminary work to triangulate data to identify hot spots within the organisation. The Trust's website has been updated to include the FTSU Champions and also the FTSUGs mobile numbers providing an alternative means of contact for people to raise any issues;
9.5 A third FTSUG has been appointed, who is a Urology Consultant;
9.6 The successful recruitment of FTSU Champions across the three main hospital

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

sites;

9.7 A 'Speak Up' icon is being developed on all Trust devices to give staff an alternative way to raise concerns and also to enable anonymous reporting, it is anticipated that this will be launched at the end of February/beginning of March 2019;

9.8 The Trust acknowledges the importance of allocating ring fenced time for the appointed FTSUGs to carry out their roles, and continues to work on having in place a formalised process.

10. The Committee received and discussed the draft Internal Audit Report on the Single Tender Waiver (STW) arrangements. The Committee noted:

    10.1 The Internal Audit Report, which was not positive but that the internal process had been improved and was much more robust;
    10.2 The recommendations around learning and closing gaps in internal control;
    10.3 This remained an area of concern. An action plan will be produced, which will be presented to the next IAGC meeting;
    10.3 That the Trust had commissioned a wider review of the procurement and tendering process.

11. The Committee received and discussed an update report on CRR 34 – Inadequate H&S Systems Embedded within Care Groups. The Committee noted:

    11.1 Performance had deteriorated;
    11.2 There has been a lack of engagement from Care Groups with the Internal Auditors, who are currently undertaking an audit focussing on H&S performance;
    11.3 The exposure as a result of the lack of improvements achieved and the importance of embedding the required level of H&S management within the organisation;
    11.4 The 5 Control of Substances Hazardous to Health (COSHH) related Care Quality Commission (CQC) required improvement actions;
    11.5 The H&S Team will be working closely with the Care Group leads to formalise H&S responsibilities and also create clear H&S management structures. The Team will be supporting Care Groups by attending the monthly quality and safety meetings, are also looking at offering more in-house courses as well as bidding for extra funding for CQC improvement areas including COSHH management.

12. The Committee received and discussed a report on the results of the annual IAGC effectiveness survey in relation to the views of members and regular attendees regarding its effectiveness in line with its ToR and the Healthcare Financial Management Association (HFMA) NHS Audit Committee Handbook. The Committee noted the feedback and the positive results of the survey, a few amendments were recommended to the ToR that were approved along with a couple of recommendations. The Committee approved the amended ToR and recommend these for approval by the Board (Appendix E).

13. The Committee received and discussed an update report regarding raising concerns, noting that five concerns were received, and that the Policy had been revised. Regular meetings will be held with the Employee Relations Team and the FTSUGs to discuss any trends and offer feedback.

14. The Committee received and discussed a progress update from External Audit regarding the work undertaken during the quarter reported, and approved the Audit Plan 2018/19.

15. The Committee received and discussed the Internal Audit progress report. Three internal audit reports had been completed and were reported to the Committee, these were regarding Workforce and Rostering, Monitor Licence and T3 Project Management. Two of these audit reports were issued with substantial assurance and one Workforce and Rostering was issued with partial assurance in relation to financial management.

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

The Committee noted that steady progress has been made on the follow up of management actions.

16. The Committee received and discussed the Counter Fraud progress report and noted the following:

    16.1 The Fraud Check exercise regarding gambling had been completed;
    16.2 Face to face training had been provided to over 60 staff along with all of the Finance Divisions via the on-line learning package;
    16.3 Various policies had been reviewed in relation to fraud proofing these.

17. The Committee received a report regarding the appointment of the Trust's External Auditors. As the current contract for the provision of external audit services expires on the completion of the 2018/19 audit. The report explained the appointment process and for the IAGC to consider the recommendation made by the Council of Governors' Audit Committee. The IAGC approved the recommendation for the appointment of the Trust's External Auditors for a three year period commencing with the 2019/20 audit, which will be proposed to the Council of Governors (CoG) at the Full CoG meeting on 14 February for approval and ratification.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to:

a) Discuss the report;
b) Approve the revised SFIs;
c) Approve the revised Risk Management Strategy and Policy;
d) Approve the IAGC ToR.

East Kent Hospitals University
NHS Foundation Trust

East Kent Hospitals University
NHS Foundation Trust

Risk Management Strategy and Policy

Version:	12.1
Author:	Trust Risk Manager
Approving committee:	Board of Directors
Date approved:	
Date ratified by Policy & Compliance Group	
Director responsible for implementation:	Chief Nurse and Director of Quality
Date issued:	
Next review date:	December 2019

Version Control Schedule

Version	Date	Author	Status	Comment
1	Apr 08	Steve O'Neill	Agreed	
2	Nov 08	Steve O'Neill	Agreed	Updated to reflect Foundation Status
3	Aug 09	Sally Moore	Agreed	Annual review
4	Oct 10	Sally Moore	Agreed	Updated risk metrics to incorporate financial impact
5	Aug 10	Helen Goodwin	Agreed	Updated reporting and risk assessment criteria. Incorporation of CQC registration Forward planning for divisional re-structuring
6	Oct 11	Helen Goodwin / Julie Pearce	Agreed	Revised structure and reporting schedules Risk and Governance responsibilities Inclusion of health and safety
7	Aug 12	Helen Goodwin / Julie Pearce	Agreed	Divisional risk and governance responsibilities and reporting structures; incorporation of risk appetite
8	Jul 13	Helen Goodwin	Agreed	Revised to reflect the impact of the Francis Inquiry reports, alignment with annual objectives and clinical audit plan
9	Sep 14	Helen Goodwin	Agreed	Revised to incorporate the revised meetings structures and associated ToR. Roles and responsibilities for risk reviewed
10	Feb 16	Helen Goodwin	Agreed	Further revision of meeting structures and ToRs. Risk appetite defined and specific roles and responsibilities outlined

11	Jul 16	Helen Goodwin	Agreed	Revised to include references to the 4Risk system, the Strategic Risk Register and simplify the risk process for Staff. ToR of Committees removed.
11b	Feb 17	Dorothy Otite	Agreed	New risk appetite agreed by the Trust Board
12	Dec 17	Dorothy Otite	Agreed	Revised to reflect the strategy and policy status; includes references to BAF; applicability to Programme/Project risks and Partnership risks; Risk Management Maturity monitoring; Trust Risk Manager and Trust Secretary responsibilities outlined; FIC; FIOG; Divisional Boards and Local Governance Boards/Meetings responsibilities outlined; Clarity on multiple impact scoring; likelihood scoring and a revised Awareness/Activity Plan.
12.1	Dec 18	Rhiannon Adey	Draft	Revised structures to align with new Care Groups

Consultation and Ratification Schedule

Name of Committee	Date Reviewed
Risk Group	January 2019
Clinical Executive Management Group	January 2019
Integrated Audit and Governance Committee (IAGC)	January 2019
Board of Directors	March 2019

Associated Documentation

Quality Strategy

Trust Health and Safety Policy

Control of Substances Hazardous to Health Policy

Incident Management Policy

Management of complaints, concerns, comments and compliments

Managing Violence and Aggression Policy

Central Alert System (CAS) and Internal Alerts Policy

Management and Control of Outbreaks of Infections in EKHUFT

Stress Management Policy and Procedure

Prevention of Slip Trips and Falls Policy

Patient Transfer and Escort Policy

Security Policy

Bullying and Harassment Policy and Procedure

Raising Concerns (Whistleblowing) Policy and Procedure

Development and Management of Organisation Wide Policies and Other Procedural Documents

Training Needs Analysis

Contents

1. Policy Summary 6
2. Introduction 7
3. Definitions 9
4. Purpose and Scope 9
5. Duties 12
6. Risk Appetite 20
7. Board Assurance Framework 22
8. Risk Management Process 23
9. Applicability of the Risk Management Strategy and Policy 26
10. Risk Management and Review (including Assurance) 26
11. Process for the management of risk locally, which reflects organisation-wide risk management strategy and policy 27
12. Training 28
13. Key Stakeholders, Consultation, Approval and Ratification Process 29
14. Review and Revision Arrangements 29
15. Dissemination and Implementation 29
16. Document Control including Archiving Arrangements 29
17. Monitoring Compliance 29
18. References 31
19. Appendices 31

Appendix A – Relevant Committees with Responsibilities for Risk Management 32
Appendix B - Organisational Chart for Committee Structure Responsible for Risk Management 35
Appendix C – Risk Assessment/Scoring 36
Appendix D – Multiple impact domains guidance 37
Appendix E – Risk Ownership/Escalation Matrix 40
Appendix F – Overview of the Risk Maturity Self-Assessment Methodology 41
Appendix G - Equality Analysis (EA) 43
Appendix H – Plan for Dissemination of Policy 45

1. Policy Summary

1.1. East Kent Hospitals NHS University Foundation Trust (EKHUFT) is committed to proactive management of risk and on-going development of robust systems of governance and assurance. This document presents EKHUFT's formal Risk Management Strategy and Policy, which has been ratified by the Trust's Board of Directors.

1.2. The Strategy applies to the management of all types of risk associated with the services, operations and business of the Trust incorporating both clinical and non-clinical risks (including Health & Safety, Partnership and Project and Programme risks). The resources for managing risk are finite and the aim of the Strategy is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the risk identified. The amount of risk that is judged to be tolerable and justifiable to the Trust is defined as the "risk appetite".

1.3. There is a clear responsibility of the Trust Board in response to the second Francis Report, published in February 2013, to provide assurance that patient safety is at the top of the agenda; this is reflected in the content of the Strategic and Corporate Risk Registers and through the information provided to Commissioners and other external stakeholders. Patient safety and quality risk assessment follows the consistent risk stratification model outlined in the Strategy.

1.4. The interface with the annual Clinical Audit Plan on areas of emerging clinical risk is fundamentally linked to the Francis Reports and to the recommendations. There is a work plan through the Integrated Audit and Governance Committee (IAGC) and Quality Committee (QC) to ensure the Plan is responsive to emerging areas of clinical risk. The Trust is responsible for ensuring that skills, knowledge, and risk awareness become embedded into the normal running of the organisation as described in the Trust's approach to risk management training and the associated Training Needs Analysis.

1.5. Incidents, Near misses and Serious Incidents (SI's) are reported as detailed in the Trust's Incident Management Policy.

1.6. Incident reporting is monitored by the Corporate Patient Safety and Clinical Risk Management Team. Clinical teams are responsible for local investigation and management of incidents with support and advice from the corporate team. Where specific areas of concern are identified, the Patient Safety and Clinical Risk Management Team work with clinical teams to minimise and manage the risk.

1.7. Risk Registers are reviewed by the Care Group Board and Risk and Governance Groups for progress and effectiveness before review by the Corporate Risk Management Team. Key risks on Care Group Risk Registers are presented to the Risk Group, on a rolling programme at least six times a year (bi-monthly).

1.8. The Quality risks on the Corporate Risk Register (CRR) are reviewed by the Quality Committee (QC) monthly. The Integrated Audit and Governance Committee (IAGC) receive the Strategic Risk Register (SRR) and an updated position on the Principal risks on the CRR at each meeting and the CRR in full twice per year. The Board of Directors receive the SRR and the CRR in full twice per year and a summary of the SRR and the Principal risks on the CRR in accordance with the Board workplan.

1.9. The Clinical Executive Management Group (CEMG) receives new risks for proposed inclusion on the CRR monthly and identifies any emerging risks or any changes required to the assessment of existing risks. The Trust Secretary produces the Board Assurance Framework (BAF) from the Trust's annual objectives and the CEMG reviews the BAF on a quarterly basis to monitor progress and to identify any additional Strategic risks. The IAGC receives a report on the BAF at least twice per year.

1.10. The Risk Group reviews the risk actions for key risks on Care Group Risk Registers, and ensures that the actions are implemented as appropriate.

1.11. An annual review of the duties and responsibilities of key individuals within the Trust and Committees with responsibility for risk is carried out as part of the preparation of the Annual Governance Statement and publication within the Annual Report and Accounts.

1.12. The Strategy supports the key principles of the Quality Strategy and the Quality, Improvement and Innovation (QII) Hub as an enabler to share good practice and support the principles of standardisation.

2. Introduction

2.1. The Risk Management Strategy and Policy (hereafter referred to as 'The Strategy') document outlines East Kent Hospitals University NHS Foundation Trust's (hereafter known as EKHUFT) commitment to managing risks in an effective and appropriate manner to enable the provision of the highest quality of care to our patients. Of equal relevance is the legal duty of the Trust to control any potential risk to staff and the public, as well as safeguarding the Trust's assets. It is supported by the Risk Management Activity/Awareness Plan and detailed guidelines (Risk Management

Handbook and Summary) for the implementation of risk management across the Trust.

2.2. EKHUFT's approach to risk management aims to be forward looking, innovative and comprehensive; to make the effective management of risk an integral part of everyday practice. The overall vision of the strategy is to continually improve the maturity of the risk management framework and ensure EKHUFT's strategic objectives are not jeopardised by risks that have not been identified and/or managed.

2.3. EKHUFT recognises that healthcare provision and the activities associated with caring for patients, employing staff, providing premises and managing finances are all, by their very nature, risk activities and will therefore carry an inherent degree of risk. These risks are present on a day-to-day basis throughout the Trust. The management of risk is therefore a key organisational responsibility and is the responsibility of all staff employed by the Trust.

2.4. The Trust is committed to ensuring the Health and Safety of patients, staff and the public through the integrated management of all aspects of governance and risk. Good governance, i.e. the way that the organisation is directed, controlled and held to account, is at the heart of controlling risk in any organisation. The Trust has adopted an integrated approach to the overall management of risk irrespective of whether risks are clinical, non-clinical, organisational or financial. Risk management is embedded within the Trust's overall performance management framework and informs business planning and investment decisions.

2.5. The Trust's organisational arrangements for addressing risk management are in keeping with best practice guidance and it is recognised that a systematic approach to assessing and managing risk is essential in order to deliver high quality patient care and the health and safety of staff and the public.

2.6. This Strategy is an "umbrella" document covering all aspects of risk management within the Trust. The Trust already has a number of policies and procedures related to risk management which should be read in conjunction with this Strategy, specifically the Trust's Quality Strategy 2018-2021, and the overarching Health and Safety Policy.

2.7. The Trust is committed to defining and documenting a formal statement on risk appetite in line with British Standard (BS31100). Risk appetite is defined as "the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time." HMT – Orange Book (2005).

3. Definitions

3.1. **Untoward incident** – Any event/incident or circumstance leading to unintentional harm or suffering.

3.2. **Serious incidents (SIs)** – May require reporting externally to Serious Incidents for Investigation and External Notification (STEIS). Investigated using root cause analysis approach.

3.3. **Board Assurance Framework (BAF)** – A tool for the Board corporately to assure itself (gain confidence, based on evidence) about successful delivery of the organisation's Corporate objectives.

3.4. **Hazard** – Situations with the potential to cause harm.

3.5. **Inherent Risk** – The risk that an activity would pose if no controls or other mitigating factors were in place

3.6. **External Audit** – External Audit is an essential element of corporate governance, contributing to the stewardship and process of accountability for use of resources. The scope of audits is extended to cover not just financial statements but the arrangement to secure value for money.

3.7. **Internal Audit** – The Trust currently engages RSM as its Internal Auditors. They primarily provide an independent and objective opinion to the Trust on the degree to which risk management, control and governance processes support the achievement of the Trust's objectives.

3.8. **Near Miss** – Any event/incident which could have caused harm to patients, staff or reputation of the Trust, had it been allowed to reach it's natural conclusion.

3.9. **Residual Risk** – The risk that remains after controls are taken into account

3.10. **Target Risk** – The desired risk level over a period of time after risk actions have been implemented.

3.11. **Risk Assessment** – Consists of a combination of the likelihood of a perceived threat and the magnitude of its impact upon objectives.

4. Purpose and Scope

4.1. EKHUFT is committed to actively managing all types of risk inherent in the organisation.

4.2. Risk is defined by the Department of Health in 'Organisation with a Memory' (2000) as "the likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm." (See Section 3.1). Risk Management is the identification, assessment and

control of the impact of events to which EKHUFT is exposed. This process is carried out in order to minimise the likelihood and impact of adverse events. It covers the full range of risk exposure and therefore includes financial, regulatory and clinical and non-clinical risk as well as any risk that threatens the achievement of the Trust's annual and strategic objectives. The Strategy demonstrates a system of internal control and supports an assurance framework to enable the Chief Executive to sign the annual Governance Statement. The Strategy provides the assurance that the Board has been properly informed about the totality of the risks, and has arrived at their conclusions based on all the evidence presented to them. A copy of the Governance Statement is available in the document library after it has been submitted with the annual accounts and annual report.

4.3. The Board of Directors recognises that Risk Management is an integral part of good management practice and to be most effective should be part of the Trust's culture. The Board is, therefore, committed to ensuring that Risk Management forms an integral part of its philosophy, practices and business plans rather than viewed or practiced as a separate programme and that responsibility for implementation is accepted at all levels of the organisation. All people recognise and manage risk as part of their roles and responsibilities. This Strategy ensures that a systematic and focused approach is taken to the management of risk, which is coordinated and consistent throughout all areas of the Trust. Adopting a common approach to risk assessment for all types of risk provides the organisation with the ability to make a meaningful comparison of the risks identified regardless of their origin, for example, clinical, financial, technological, and organisational. The Board is able to make informed strategic business decisions based upon risk assessment and is able to prioritise key targets for action. The CRR and SRR, in conjunction with the Board Assurance Framework (BAF), identifies where there are gaps in assurance and details the associated actions being taken to manage identified risk.

4.4. Risk assessment falls into four components:

4.4.1 the inherent risk – i.e. before any controls are put in place;

4.4.2 risk control – i.e. management actions in place;

4.4.3 residual risk – i.e. with controls in place;

4.4.4 target risk – i.e. after actions have been implemented

4.5. The inherent risk score could be as high as 25 before risk controls are considered.

4.6. The residual risk score should reflect the controls in place to mitigate the risk.

4.7. The residual risk score needs to reflect the risk appetite and may be different for each type of risk.

4.8. The key objectives of this Strategy are to provide the framework for:

4.8.1 minimising the potential for harm to patients, all staff and visitors;

4.8.2 the assessment of clinical and non-clinical risk and evidence of action taken;

4.8.3 anticipating and responding to changing circumstances (social, environmental, legal, financial etc.) or events;

4.8.4 maintaining full registration without conditions with the Care Quality Commission (CQC) and fulfilling the requirement of other Regulators to maintain compliance;

4.8.5 production of the Board Assurance Framework to enable the annual Governance Statement;

4.8.6 assessing the risks associated with achievement of the annual and strategic objectives;

4.8.7 a clear alignment to the quality strategy ensuring that the principles of standardisation are embedded across the Trust and staff are enabled to adopt these models;

4.8.8 the integration of Risk Management and Health and Safety within the Trust's strategic aims and objectives. The Governance and Risk Management structure is identified in Appendix B;

4.8.9 integration of governance encompassing financial, clinical, corporate, information, performance and research governance;

4.8.10 achieving compliance with the Health and Safety at Work Act 1974

4.8.11 ensuring that the Trust remains within its licensing authorisation as defined by NHS Improvement (NHSI) and to deliver a risk management framework which highlights to the Executive Team and Trust Board any risks which may prevent the Trust from complying with its licensing authorisation;

4.8.12 achieve an overall continuity of service rating of 3 or above and a green governance rating.

4.9. The objectives of the Strategy will be achieved by;

4.9.1 Embedding risk management in all key areas across the Trust;

4.9.2 Ensuring a standardised and structure process for identifying, assessing, mitigating, monitoring and reporting on risks;

4.9.3 Creating a culture that supports risk management;

4.9.4 Providing the tools to support risk management;

4.9.5 Providing the training to support risk management; and

4.9.6 Measuring the impact of implementation

4.10. The changing national climate around the quality of service provision and ensuring that patients are the priority for all healthcare related activities has been clarified following the publication of the second Francis Report. This Strategy links directly to the Trust action plan in response to this Report, to the Quality Strategy and to the Quality Governance Framework.

4.11. Lessons learned from the Francis Inquiry into Mid-Staffordshire NHS Foundation Trust demonstrate the importance of an overarching assessment of risk to the Trust. The degree to which risks are interconnected and sometimes sequential and of the cumulative impact and disruptive effect on a number of risks occurring at the same time are considered within risk registers.

5. Duties

5.1. The responsibilities for risk and risk management lie at the levels of the organisation to which the risks belong. As such, it is the responsibility of the Board and Management Team to undertake the strategic risk management activities and for the Clinical/Corporate Boards and Divisions to undertake the tactical, operational and project risk management activities. These responsibilities and EKHUFT's risk management goals are built into individuals' objectives and personal development goals.

5.2. **Board of Directors**: The Trust Board is accountable to NHS Improvement in ensuring that sound governance systems are in place and that risks associated with any of its functions are managed within a robust compliance framework.

5.2.1. The Board of Directors is responsible for reviewing the effectiveness of all Internal Controls (financial, organisational, clinical and health and safety). The Board is required to produce statements of assurance, which demonstrate that it is doing its 'reasonable best' to ensure that the Trust meets the approved

Strategic and Annual objectives and protects patients, staff, the public and stakeholders against risk of all kinds.

5.2.2. The Board of Directors inform the Annual Governance Statement (AGS) made by the Chief Executive in the Annual Report and Accounts. The Board of Directors must be able to demonstrate that they have been informed, through the Board Assurance Framework, about all significant risks affecting the achievement of these objectives and of if the significant risks are controlled within defined tolerance limits. Conclusions on the totality of risk, risk appetite and the management of risks identified must be based on the evidence presented to them.

5.2.3. Delegation to Executive and Divisional managers the responsibility to design, implement and monitor the Strategy;

5.2.4. ensuring risk assessments are performed on a continual basis;

5.2.5. ensuring that the frameworks and methodologies that are implemented increase the probability of anticipating unpredictable risks;

5.2.6. ensuring Executive and Divisional managers consider and implement responses appropriate to the level of risk;

5.2.7. ensuring Executive and Divisional managers undertake a continual risk monitoring process;

5.2.8. receiving assurance regarding the effectiveness of the risk management process;

5.2.9. aligning the Quality Strategy and the Quality Governance Framework to the Strategy in order to ensure standardisation and consistency of the assessment and management of risk.

5.2.10. ensuring there are processes in place to enable complete, timely, relevant accurate and accessible risk disclosure to stakeholders.

5.3. **Chief Executive**: The Chief Executive has overall responsibility for risk management at East Kent Hospitals University NHS Foundation Trust as the Accountable Officer.

5.3.1. The Chief Executive is responsible for ensuring that a risk management system is established, implemented and maintained in accordance with this policy.

5.3.2. There will be cases when risks identified at the tactical, operational or project level will be significant to EKHUFT. Such

risk will be escalated to the appropriate level through the Trust's line management processes. The Management Team and Board will set the risk appetite of EKHUFT and the system for enabling risk control and contingency decisions.

5.4. **Executive Directors**: Executive Directors have overall responsibility for the implementation of the Strategy.

5.4.1. They are responsible for the oversight of the processes for identifying and assessing risk, and for advising the Chief Executive as required.

5.4.2. They must ensure that, so far as it is reasonably practical, resources are available in order to manage risk. The Trust Functional Structure describes the core business areas and key business output for each Executive lead.

5.5. **Medical Director**: Provide a leadership focus for clinical risk management activities throughout the Trust and to ensure that training and resources are available to support risk management activities.

5.5.1. Where an incident is serious and involves a research subject or a research study then the decision about which incidents to investigate, how the investigation should be organised and the terms of reference for any investigation should be taken in conjunction with the Director of Research and Development.

5.6. **Chief Nurse and Director of Quality**: Provides Executive sponsorship of risk management activities across the Trust, ensuring that the Trust's key risk management objectives are met.

5.6.1. Executive responsibility for ensuring that risk management processes are reviewed, updated and driven forward by the Trust.

5.6.2. Accountable to the Chief Executive and the Board for ensuring that this Strategy is implemented effectively and evaluated consistently.

5.6.3. The Chief Nurse and Director of Quality and the Executive Medical Director are both responsible for assessing potential Serious Incidents and deciding which incidents will be analysed/investigated and notified externally (This is further described within the Incident Management policy).

5.7. **Trust Secretary**: Ensuring an appropriate Board Assurance Framework (BAF) is prepared and regularly updated, and that it receives appropriate consideration at relevant committees and groups.

5.7.1. Co-ordinates the Annual Governance Statement and ensuring it adequately reflects the risk management process within the Trust.

5.8. **Patient Safety and Clinical Risk Team**: Responsible for monitoring all incidents on the Trust's incident, claims and complaints system (Datix).

5.8.1. Analysis and trends are regularly fed back to Care Groups and Departments, and, in anonymised form, to the central national team within NHS England.

5.8.2. To ensure that systems and processes are in place across the Trust so that risks are identified, assessed, recorded, reported and managed in a way that minimises the risk of injury, damage or financial loss to the Trust, its staff, patients and visitors.

5.8.3. To line manage staff working on key risk management processes including the trust-wide incident reporting system, incident investigations and risk registers.

5.8.4. To promote an open and just culture throughout the Trust, where the focus of risk management activities is on learning lessons and improving services which are sustained.

5.8.5. To advise the Patient Safety Board and Board of Directors on trends and statistical analyses of incidents, near misses, complaints and claims.

5.9. **Risk Manager**: The development of strategy, policies and process documents with regard to risk management.

5.9.1. Responsible for the implementation of all aspects of risk management including embedding risk management across the Trust.

5.9.2. Maintaining the Trust Corporate and Strategic Risk Registers.

5.9.3. Supporting the Care Groups with ensuring their Care Group Risk Registers are fit-for-purpose.

5.9.4. Undertaking an audit of local risk registers on a quarterly basis.

5.9.5. Provision of training, information and support for Trust staff in relation to risk management.

5.9.6. Continuing development of a proactive risk management culture and practice throughout the Trust; actively promoting and ensuring good risk management practices.

5.10. **Deputy Director of Risk, Governance and Patient Safety**: Operational management responsibility for the implementation of the Risk Management agenda through the management of the Risk Management and Patient Safety functions.

5.10.1. Responsible for the Management of the Corporate Risk Team

5.10.2. Advising on external reporting requirements.

5.10.3. Maintaining and monitoring the reporting system of incidents within the Trust.

5.10.4. Analysing trends to inform clinical divisional decisions and corporate management decisions.

5.10.5. Supporting reviews of serious incidents.

5.10.6. Reviewing samples of incidents for consistency and identifying lessons to be learned.

5.10.7. Advising on the need for independent investigations by external agencies or individuals.

5.11. **Information Governance Manager**: Responsible for the production and implementation of the Information Governance policies and procedures and ensuring that Caldicott principles are embedded.

5.11.1. Responsible for submitting the NHS annual Information Governance Toolkit and ensuring the implementation and management of the initiatives detailed therein.

5.12. **Head of Health and Safety**: Leading the Health and Safety at Work Act (1974) compliance and supporting the site-based Health and Safety Advisors to the Trust.

5.12.1. Ensuring that managers and staff are provided with non-clinical risk management information and support.

5.12.2. Promoting the use and understanding of risk assessment and audit processes throughout the Trust.

5.12.3. Investigating and reporting on all non-clinical accidents and incidents.

5.12.4. Providing an input into the aggregated quarterly and annual reports on incidents, claims and complaints.

5.13. **Legal Services Managers**: Liaising with the Trust’s legal advisors on claims efficiently and effectively.

5.13.1. Ensuring that lessons are learnt from claims to minimise the chances of a recurrence this is in collaboration with the Care Groups, individuals and teams involved in claims to prevent recurrence.

5.13.2. Working collaboratively with the Risk Team and Patient Experience Team Manager to promote aggregated learning from complaints, claims, incidents and risk assessments.

5.13.3. Providing advice and support for staff involved in claims and Coroners' inquests.

5.13.4. Providing up to date intelligence from the Trust's legal advisors on open and closed claims for the purposes of education and facilitation of training.

5.14. **Head of Patient Experience Team**: Ensuring complaints and concerns are responded to quickly, openly and efficiently.

5.14.1. Providing analyses of complaints, resolving complex and difficult complaints to avoid unnecessary litigation.

5.14.2. Ensuring that lessons are learnt from complaints to minimise the chances of a recurrence.

5.14.3. Working collaboratively with the Risk Team and Claims Manager to promote aggregated learning from complaints, claims, incident and risk assessments.

5.15. **Care Group Directors**: Leading risk management strategies within their divisions and ensuring appropriate risk structures and processes are maintained and delivered.

5.15.1. Monitoring incident trends and outcomes and ensuring comprehensive investigation and action for incidents of a serious nature.

5.15.2. Leading and collation risk assessments and reviewing and updating risk registers across their care group.

5.15.3. Ensuring that controls and assurances are in place and working for areas of substantial risk.

5.15.4. Ensure staff understand and contribute to the compliance requirements for the Care Quality Commission (CQC) and other compliance requirements pertinent to Care Group activity and implement as part of their governance agenda.

5.15.5. Promoting an open culture within the Care Group and facilitating/supporting Trust wide learning from risk issues.

5.15.6. Ensuring there are robust internal systems to ensure that the duty of openness, transparency and candour is embedded within the Care Group.

5.16. **Risk Management Leads**: Implementing the Strategy at a local level by ensuring risk assessments are carried out, risk registers are updated on 4Risk and reviewed through clear internal governance processes and incidents are reported in a timely manner by staff.

5.16.1. Raising awareness of risk management systems and processes locally, and taking local action to reduce risks where appropriate.

5.16.2. Working collaboratively with the Corporate Risk Management Team to ensure that local intelligence on risk is communicated appropriately throughout the organisation, incidents are reported and analysed and the corporate risk register is updated with information from departmental risk registers.

5.17. **All Managers**: Reviewing clinical and non-clinical incidents, accidents, mistakes and ‘near misses’ reported to their department.

5.17.1. Undertaking initial categorisation of the type of event and seriousness on the incident report form.

5.17.2. Fostering an environment in which staff are encouraged to report incidents and discuss the implications constructively and openly.

5.17.3. Maintaining departmental policies and procedures and ensuring staff are made aware of them and are trained to follow them.

5.17.4. Ensuring that there is a regular multidisciplinary governance meeting which reviews serious incidents and actions arising and all relevant policies and procedures.

5.17.5. Deciding who should lead the review of incidents and investigations and when this should be escalated beyond the departmental level.

5.17.6. Aligning the clinical audit programmes with actual and emerging clinical risks.

5.17.7. Ensuring that full disclosure, where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff – whether or not the patient asks.

5.17.8. Ensuring that the required actions have been taken and are followed through and evidence of change is recorded.

5.17.9. Implementing and monitoring any identified risk management control or assurance measures within their designated area/and scope of responsibility. Departmental managers are expected to address low-level risk issues as they arise.

5.17.10. In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate and where local resolution has not been satisfactorily achieved, managers are responsible for and have the authority to:

5.17.10.1. Arrange for addition of the new/emerging risks to their relevant risk area on the 4Risk System.

5.17.10.2. Bring these risks to the attention of the Local Care Group Management Team who in turn may raise them for discussion at the Risk Group, the CEMG or Strategic Health and Safety Committee(SH&SC).

5.17.10.3. Escalate key risks to the appropriate Director and manage in accordance with Strategy (See Appendix E).

5.17.10.4. Request that the Risk Group, CEMG or SH&SC consider key risks for addition to the Corporate Risk Register.

5.17.10.5. Develop and submit business cases where appropriate to support mitigation and improvements.

5.18. **All staff**: Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks.

5.18.1. Report incidents in accordance with the Trust's Incident Reporting Procedure (detailed in the Policy for the Management of Incidents, including Serious Incidents for Investigation and External Notification Incident Management Policy).

5.18.2. Resolve risks or bring immediate risk issues to the attention of their line manager.

5.18.3. Act safely at all times.

5.18.4. Comply with the Trust's policies, procedures and guidelines that are in place to protect the health, safety and welfare of anyone affected by the Trust's activities.

5.18.5. Be familiar with and comply with the Trust's risk management and Health & Safety procedures.

5.18.6. Where staff feel that raising issues may compromise them or may not be effective they should be aware of and encouraged to follow the Trust's Raising Concerns Policy.

5.18.7. Neither intentionally, nor recklessly interferes with, nor misuse any work equipment, nor with the equipment provided for the protection of health and safety.

5.18.8. Undertake training and any other risk training deemed necessary for their role as described in the Trust Risk Management Training Needs Analysis.

5.18.9. Comply with professional guidelines (as applicable to their role and profession) and act in accordance with such guidelines and codes of practice.

5.18.10. Maintain confidentiality of patient and Trust information.

5.18.11. All staff have individual responsibility for engaging in risk management activities at EKHUFT. Staff are made aware of this Strategy by publication on 4Policies, through the published minutes of corporate, divisional and local governance meetings and through its implementation. Using this mechanism staff are supported and committed to the identification and minimisation of risk.

6. Risk Appetite

6.1. Communication and application of the Board of Directors attitude to risk is essential if decision-making is to be successful. This must be clear and be consistent with the strategic objectives for the Trust. Risk appetite is a series of boundaries, which are authorised by the Board and by delegated authority, which guides all staff on the limits of risk they can take.

6.2. The Board undertook a review of the corporate risk appetite using a recognised framework against a number of core areas of activity.

6.3. Financial risk appetite

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

6.4. Compliance/Regulatory risk appetite

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

6.5. Innovation risk appetite

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

6.6. Quality/Patient Related Outcomes risk appetite

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

6.7. Reputational risk appetite

6.7.1. The Trust has SIGNIFICANT tolerance for risks to its reputation arising from the implementation of a new clinical strategy and/or its key strategies, where the potential benefits outweigh those

risks. It will pursue new ideas seen as potential enhancing to the Trust' reputation, but it will not otherwise accept risks or circumstances that could cause reputational damage to the Trust.

6.8. Workforce/Staff Engagement risk appetite

6.8.1. The Trust has SIGNIFICANT tolerance for risks to Workforce/Staff Engagement. This means it will be innovate in undertaking workforce transformation projects that will offer potentially high staff, patient and organisational benefits. But it will not accept risks in relation to suitability of staff.

6.9. Performance risk appetite

6.9.1. The Trust has a HIGH tolerance for risks in relation to Performance. This meant that, as it seeks to meet internal and external performance standards, it will be willing to consider all potential delivery options that provide an acceptable level of delivery (and/or patient related outcomes measures). Where there is likely to be adverse consequences, the Trust would prefer not to take risks with compliance to external performance standards, unless similar situations elsewhere have been successfully defended.

7. Board Assurance Framework

7.1. The Board Assurance Framework (BAF) provides clarity over the risks (defined as strategic risks) that may impact on the Trust's ability to deliver its strategic objectives. This simplifies Board reporting and prioritisation, which in turn allowed more effective performance management. The BAF, which is reported to the Trust Board at least four times a year, also facilitates the preparation of the Board agenda and the reporting of key information to the Board. At the same time, it records structured positive assurances about where risks are being managed effectively and objectives are being delivered.

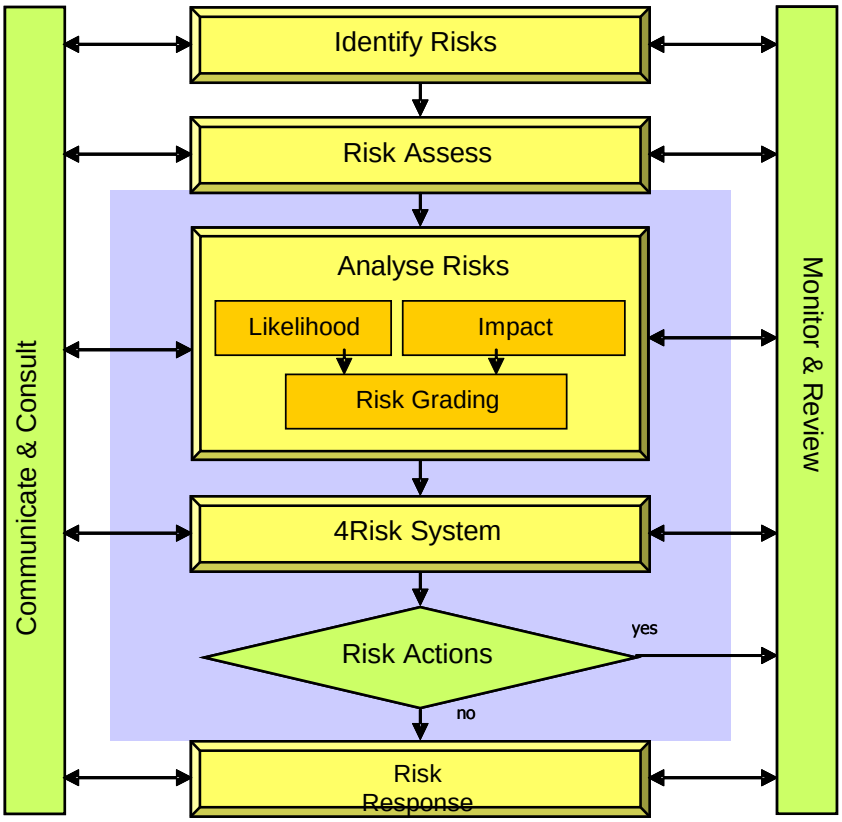
7.2. Any new strategic risks will be considered and approved by the Board before being accepted as such and added to the BAF. The Board will also consider for approval any recommendation to remove strategic risks from the BAF.

7.3. The populated BAF articulates clearly the key strategic controls in place to ensure that strategic risks are being managed and the sources of evidence, or assurance, that the controls are operating effectively to secure delivery of the Trust's strategic objectives.

7.4. Individual Executive Directors review their BAF entries at least quarterly to monitor progress against actions and to identify changes that need to be reported in the next BAF update.

7.5. In addition, the Integrated Audit and Governance Committee reviews the BAF at least four times a year with a particular focus on the quality and reliability of assurances. This is part of the IAGC;s overarching role in reviewing the establishment and maintenance of an effective system of internal control which supports the achievement of the Trust's strategic objectives, and providing assurance to the Board on the adequacy of the organisation's controls.

8. Risk Management Process



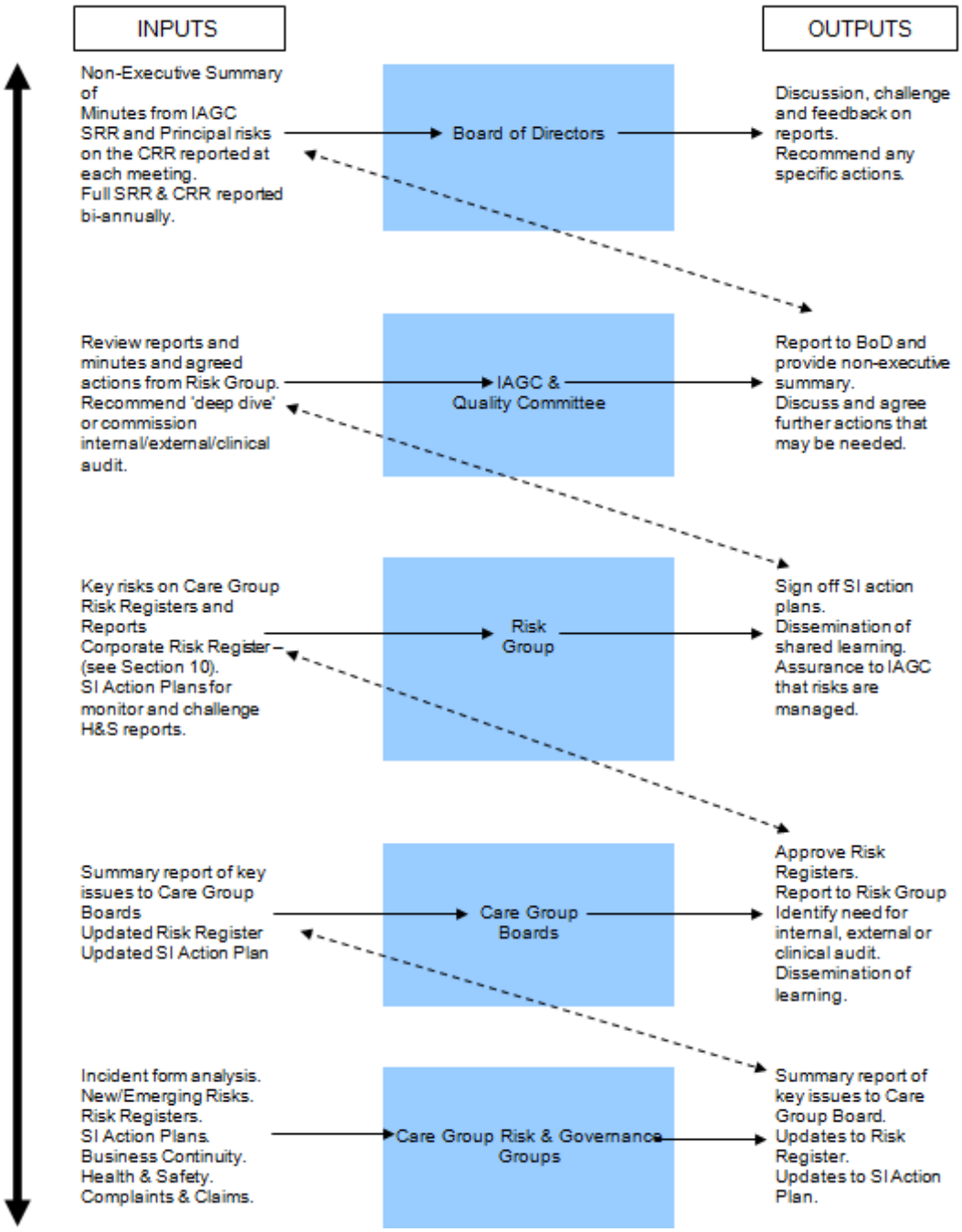
8.1. Figure 1 Risk Management Flow Chart

8.2. The Trust's approach to identifying, analysing, evaluating and responding to risks follows best practice guidance. All the stages above should be employed. (Refer to Appendix C and D).

8.3. The risk management process is dynamic. Risk likelihood and impact, as well as risk appetite can change over time through circumstances and

experience. The perception of the public to risk and confidence in the Trust's ability to identify and mitigate risk successfully can also shift in light of adverse publicity and risk events outside the direct control of the Trust. Risk awareness and communication plan an important part in protecting the Trust's reputation.

8.4. Inputs and Outputs from the Risk Pathways



9. Applicability of the Risk Management Strategy and Policy

9.1. This strategy applies to the management of all risks within the Trust associated with the services, operations and business of the Trust. These include:

9.1.1. Strategic risks: high level risks that directly threaten the achievement of the Trust strategic objectives

9.1.2. Corporate risks: threats to the key aims of the Trust (cross-cutting operational, financial risks, IT risks and risks to the Trust reputation).

9.1.3. Clinical risks: risk of harm to patients, staff and relatives, in carrying out clinical activities.

9.1.4. Non-clinical risks: includes health and safety – the range of risks associated with personal health and safety of staff, patients and visitors.

9.1.5. Programme and Project risks: risks relating to a programme or project which may impact on the delivery of the project.

9.1.6. Partnership risks: risks relating to joint working arrangements with other NHS and non-NHS organisations may be identified as part of the planning process. Elements of these risks may be outside of the control of the Trust and therefore appropriate assurances should be sought from the partner organisation, by the relevant Director or member of staff, and clearly documented as part of the planning and continuing risk assessment/management process.

10. Risk Management and Review (including Assurance)

10.1. Local Risk Registers, Care Group Risk Registers, the Trust CRR, SRR and the BAF recorded on the 4Risk system, provide the means for risk monitoring. To assist in the monitoring and review of risks and their management the following processes take place:

10.1.1. Incidents, near misses and SI's are reported and analysed as detailed in the Trust Incident Management Policy.

10.1.2. Local risk assessments are completed at source using the Trust Risk Grading system with each identified risk recorded on the 4Risk System and each reported incident recorded on the Datix system. The local systems mirror the Trust policy; risk assessments, risk registers, incident analysis and SI's are discussed at Care Group Governance Groups.

10.1.3. Risk assessment of incidents are completed at several levels; some as formal risk assessments, others as incident reports, care plans, SI reports, etc., as detailed in the Trust Incident Management Policy and Trust Health and Safety Policy.

10.1.4. Each Care Group records risks on the 4Risk System based on their assessment of current or emerging risks that contain controls, assurances and actions as detailed in the Strategy.

10.1.5. Key risks on Care Group Risk Registers are presented for review at least six times yearly by the Risk Group.

10.1.6. For each risk, the controls and actions will be allocated a responsible manager or lead Director to ensure risk management actions are delivered as planned.

10.1.7. Where a risk control or action is assessed to be critical (i.e. were it not present the level of the risk would be “Extreme” or “High”) the means of assuring that controls are in place will be defined and recorded in the appropriate risk register(s) and / or assurance framework.

10.1.8. As part of the Care Group Executive Performance Reviews, monthly reviews of the key risks will take place including progress of control measures, assurances and action plans.

10.1.9. The CRR and SRR will be reviewed regularly at the Risk Group as a mechanism for monitoring the effective management of Principal risks.

10.1.10. The Principal risks on the CRR and the SRR are reviewed by the Board of Directors on a monthly basis, with the full risk registers reviewed bi-annually.

10.1.11. The Integrated Audit and Governance Committee and the Quality Committee receive reports and the minutes from the Risk Group and provide a report to the Board of Directors on a bi-monthly basis.

11. Process for the management of risk locally, which reflects organisation-wide risk management strategy and policy

11.1. It is the responsibility of the Care Groups/Corporate Departments to identify and assess risks as part of routine management practice.

11.2. Care Groups/Corporate Departments are responsible for validating, prioritising and identifying solutions to their risks. These will then be

recorded on the 4Risk system and the mitigation and actions taken updated.

11.3. Care Groups/Corporate Departments are responsible for identifying risk owners within their Care Groups/Corporate Departments who will update the risks they are responsible for using the 4Risk System.

11.4. Care Groups/Corporate Departments are responsible for ensuring that action plans are effectively implemented and monitored to mitigate risks.

11.5. Risk escalation from Care Groups/Corporate Departments to the Corporate Risk Register should be done in line with the Risk Ownership/Escalation matrix in Appendix E. If, after local management action, a residual level of risk remains, this should then be discussed with the Deputy Director of Risk, Governance and Patient Safety for agreement to escalate to the Risk Group and the CEMG.

11.6. Care Group/Corporate Governance Groups should review their Risk Registers regularly (at least monthly)/ The key risks are reviewed by the Care Group Performance Reviews at each meeting.

11.7. Care Groups Board should scrutinise and validate their risks:

11.7.1. Before submission of reports to the Risk Group

11.7.2. At regular intervals to ensure that action plans are being implemented and risks mitigated; this process normally occurs at the Care Group governance meetings held on a monthly basis.

11.8. All senior managers should use their local risk registers as a management tool and ensure that the risk registers are used to inform the annual business planning process.

12. Training

12.1. The Trust has a responsibility to ensure that its employees are safe and competent with the appropriate knowledge and skills to deliver high quality care to its service users. Risk Management training, for all staff groups, is described in the Trust’s Training Needs Analysis and the expectation is that all staff will comply and undertake the appropriate training programme.

12.2. Training will be appropriate to the staff groups receiving it and commensurate with their risk management responsibilities. The Trust reserves the right to identify how, where and when risk training will take place.

12.3. Trust Board and Directors and Very Senior Managers:

12.3.1. Risk management awareness training will be delivered to all board members, (including Executive and Non-Executive Directors) executives and senior managers (Care Group Leadership Team) on an annual basis.

12.4. The aim of all risk training is:

12.4.1. To develop a more risk-aware mind-set within the Trust

12.4.2. To shift the culture from one of reactive to proactive prevention

12.4.3. To ensure that all those who have general responsibility for managing and preventing risks are aware of their roles

12.4.4. To ensure those who have specific responsibility for managing and preventing risks have the necessary skills to be able to do this.

13. Key Stakeholders, Consultation, Approval and Ratification Process

13.1. Type policy–specific text

13.2. This policy will be ratified by the Policy and Compliance Group.

14. Review and Revision Arrangements

14.1. This policy will be reviewed as scheduled in three years' time unless legislative or other changes necessitate an earlier review.

15. Dissemination and Implementation

15.1. Refer to Appendix H.

16. Document Control including Archiving Arrangements

16.1. This policy conforms to the policy for the Development and Management of Procedural Documents.

16.2. Archiving of this policy will conform to the EKHUFT Information Lifecycle policy, which sets out EKHUFT's policy on the management of its information.

16.3. This policy will be uploaded to the Trust's policy management system.

17. Monitoring Compliance

17.1. The effectiveness of this strategy will be monitored as follows:

1. Key process/part of this policy for which compliance or effectiveness is being monitored	2. Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	3. Job title and department of person responsible for leading the monitoring	4. Frequency of the monitoring activity	5. Monitoring Committee responsible for receiving the monitoring report/audit results etc.	6. Committee responsible for ensuring that action plans are completed
The process for managing risks locally is aligned with the overarching policy.	Local risk registers reviewed	Care Group risk and governance leads	Quarterly	Care Group governance meetings	Care Group governance meetings
Reporting arrangements into the high level Committees and the Board.	Review Terms of Reference and minutes of meetings/reports to IAGC, QC and BoD	Trust Secretary	Annually	Risk Group	CEMG /QC
Compliance with the process for Risk Registers.	Review of Care Group and Trust Risk Registers.	Care Group Directors	At least Annually	Risk Group	Risk Group
Ensuring that strategic risks are assessed and reviewed and aligned with the annual objectives via the Board Assurance Framework.	Review of the Assurance Framework content and process – annual audit of process by internal audit.	Trust Secretary	Annually	IAGC	Board
Risk management training for Board members and very senior managers, including divisional leadership teams	Review of compliance, attendance and the process of following up non-attendance as described in TNA	Deputy Director, Risk Governance & Patient Safety	Annual	IAGC	IAGC

17.2. In addition to Section 17.1 above, a formal review of the Trust's risk management maturity will be conducted annually and reported to the Integrated Audit and Governance Committee. The Trust has adopted a risk management maturity framework (see Appendix F) based on the HM Treasury Risk Management Assessment Framework and the Alarm National Performance Model for Risk Management in Public Services will be employed to measure the impact of the Strategy. This self-assessment framework measures the extent to which good risk management is being embedded across the Trust.

It covers seven core areas with each category having an individual assessment that is then aggregated up to provide an overall rating for the Trust. The seven core-areas are:

i. Risk leadership and management

ii. Risk Strategy and Policy

iii. People

iv. Partnerships, Shared Risks and Resources

v. Risk Management Processes

vi. Risk Handling and Assurance

vii. Outcomes and Delivery

17.3. The Trust reserves the right to change reporting and monitoring processes as required.

18. References

19. Appendices

Appendix A – Relevant Committees with Responsibilities for Risk Management

The following describes how responsibilities of different Trust committees for risk management are executed.

It may be necessary for the structure to change during the year. Updates will be added to this Strategy without the need for re-approval. All committees/groups within the structure have a responsibility for escalating risks discussed at the committee in line with the Trust Risk Ownership/Escalation Matrix in Appendix E; however the following groups have specific functions pertaining to risk management.

Board of Directors, Committees and Executive Groups reporting structure is at Appendix B.

Integrated Audit and Governance Committee

Reporting to the Board, the Integrated Audit and Governance Committee has responsibility for monitoring and review of the risk, control and governance processes which have been established in the organisation, and the associated assurance processes. This is in order to help the Board of Directors be fully assured that the most efficient, effective and economic risk, control and governance processes are in place and the associated assurance processes are optimal. The Integrated Audit and Governance Committee also receive reports from the Trust Patient Safety Board, the Information Governance Steering Group and from the Strategic Health and Safety Committee.

Finance and Performance Committee

Reporting to the Board, the Finance and Performance Committee has responsibility for reviewing the financial strategy and for monitoring and review of the risk, control and governance processes associated with financial management of the Trust. The outcomes of discussion on any additions to or changes in the evaluation of financial risks are noted by the Finance and Performance Committee and incorporated into the Corporate Risk Register.

Strategic Workforce Committee

Reporting to the Board, the Strategic Workforce Committee has responsibility for raising concerns (if appropriate) to the Board on any workforce risks that are significant for escalating. They also consider the control and mitigation of workforce-related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

Clinical Executive Management Group

This committee reports to the Executive Officer and is responsible for the development of the Strategy and associated policies and procedures. It is

responsible for monitoring the effectiveness of the Strategy, and ensuring that actions to mitigate and manage risk are taken in a timely manner. It provides the IAGC and the QC with regular reports and will work with both committees to strengthen the systems of control, governance and assurance.

Care Group Boards

The Care Group Boards underpin the Clinical Executive Management Group in being responsible for the day-to-day delivery of health care and related services. The Care Group Boards are responsible for ensuring systematic and effective risk management takes place (including recording of risks on 4Risk) across the areas within their sphere of responsibility; ensuring that risks are brought to their attention and either managed within their resources or escalated where appropriate to the Clinical Executive Management Group.

Local Governance Groups/Ward/Department Management Meetings

Each Local Governance Group/Ward/Department Management Meeting is responsible for managing risks locally and ensuring risk registers are in place for the areas within their sphere of influence. Where the risks are not amenable to local resolution, they are responsible for escalating risks to the Care Group Board.

Strategic Health and Safety Committee

This committee is supported by Site based Health and Safety Committees to meet the requirements of section 2 (7) of the Health and Safety at Work Act 1974 and reports to the Clinical Executive Management Group. The Strategic Health and Safety Committee acts as the operational committee for supporting the management of health and safety risks.

Quality Committee (QC)

This committee reports to the Board of Directors and is responsible for ensuring the risks associated with quality and the achievement of the Quality Strategy is met. It provides control, governance and assurance to the Board on quality related risks.

Financial Improvement Committee (FIC)

This committee reports to the Finance and Performance Committee (FPC) and is responsible for reviewing the financial assurance framework on a monthly basis to ensure risks are being mitigated, critical success factors met and identify any new risks or matters that require escalation to the Finance and Performance Committee. They are also responsible for responding and resolving risks to delivery identified through the escalation process.

Financial Improvement Oversight Group (FIOG)

This committee reports to the Financial Improvement Committee (FIC) and is responsible for ensuring all identified financial risks are being managed and

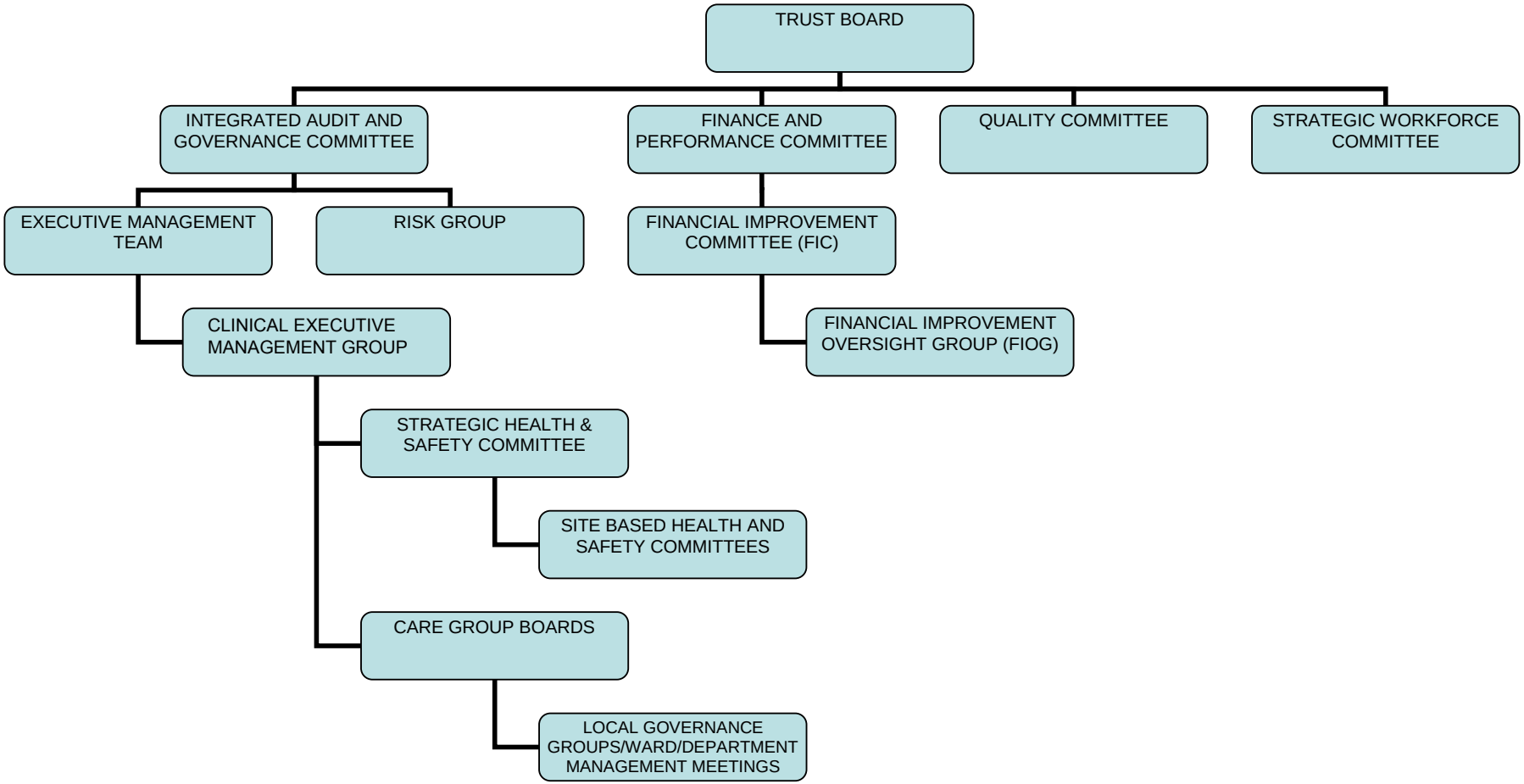
mitigated within the Financial Assurance Framework and to provide a forward look to the Trust on emerging financial risks.

Board of Directors

The Board of Directors is ultimately accountable for ensuring that the Trust is complying with its Terms of Authorisation, which includes its arrangements for integrated governance and effective risk management. The Board of Directors and the Chief Executive are also responsible for ensuring that an open and just culture is developed and sustained throughout the Trust; this is an essential foundation for effective risk management.

The Chief Nurse and Director of Quality ensures that papers received to be discussed at Clinical Executive Management Group and Board of Directors address the issue of risk in line with this Strategy.

Appendix B - Organisational Chart for Committee Structure Responsible for Risk Management



Appendix C – Risk Assessment/Scoring

LEVEL	**IMPACT** OF RISK (SEE APPENDIX D FOR OTHER APPLICABLE MULTIPLE IMPACT DOMAINS)
1	Negligible - no obvious harm, disruption to service delivery or financial impact. Reputation is unaffected.
2	Low - The Trust will face some issues but which will not lower its ability to deliver quality services. Minimal harm to a person/people; local adverse publicity unlikely; minimal impact on service delivery. Financial impact up to £1 million non-recurrent/one off or up to £2 million over 3 years.
3	Moderate – The Trust will face some difficulties which may have a small impact on its ability to deliver quality services and require some elements of its long term strategy to be revised. Level of harm caused to a person/people requires medical intervention resulting in an increased length of stay. Local adverse publicity possible. Financial impact between £1 million and £3 million non-recurrent/one off, or between £2million and £ 6million over 3 years.
4	Significant – The Trust will face some major difficulties which are likely to undermine its ability to deliver quality services on a daily basis and / or its long terms strategy. Major injuries / harm to a person/people resulting in prolonged length of stay. External reporting of consequences required. Local adverse publicity certain, national adverse publicity expected. Likelihood of litigation action. Temporary service closure. Financial impact between £3million and £5million non recurrent/one off or between £6 million and £10million over 3 years.
5	Extreme – The Trust will face serious difficulties and will be unable to deliver services on a daily basis. Its long term strategy will be in jeopardy. Serious harm may be caused to a person/people resulting in death or significant multiple injuries. Extended service closure inevitable. Protracted national adverse publicity. Financial impact at least £5 million non recurrent/one off, or at least £10 million over 3 years.
LEVEL	**LIKELIHOOD - F**REQUENCY/**P**ROBABILITY OF RISK CRYSTALLISING\RECURRENCE
1	**F**: Rare – Not expected to occur for years/ This will probably never happen/recur
	P: Will only occur in exceptional circumstances or <20%
2	**F**: Unlikely – Expected to occur annually/ Do not expect it to happen/recur but it is possible it may do so
	P: Unlikely to occur or 20% - 40%
3	**F**: Possible – Expected to occur monthly/ Might happen or recur occasionally
	P: Reasonable chance of occurring or 40% - 60%
4	**F**: Likely – Expected to occur at least weekly/ Will probably happen/recur, but it is not a persisting issue/circumstances
	P: Likely to occur or 60% - 80%
5	**F**: Almost Certain – Expected to occur at least daily/ Will undoubtedly happen/recur, possibly frequently
	P: More likely to occur than not or >80%

RISK MATRIX

Impact	**5. Extreme**	5. L	10. M	15. H	20. E	25. E
	4. Significant	4. L	8. M	12. M	16. H	20. E
	3. Moderate	3.V L	6. L	9. M	12. M	15. H
	2. Low	2. VL	4. L	6. L	8. M	10. M
	1. Negligible	1. VL	2. VL	3. VL	4. L	5. L
		1. Rare	**2. Unlikely**	**3. Possible**	**4. Likely**	**5. Almost certain**
		Likelihood				

E	Extreme Risk
H	High Risk
M	Moderate Risk
L	Low Risk
VL	Very Low Risk

Appendix D – Multiple impact domains guidance

Domain	Negligible 1	Low 2	Moderate 3	Significant 4	Extreme 5
Injury (Physical/ Psychological)	►Adverse event requiring no/minimal intervention or treatment. ►No time off required.	►Minor injury or illness – first aid treatment needed ►Health associated infection which may/did result in semi-permanent harm ►Affects 1-2 people ►Requiring time off work for <3days	►Moderate injury or illness requiring professional intervention ►No staff attending mandatory / key training ►RIDDOR / Agency reportable incident (4-14 days lost) ►Adverse event which impacts on a small number of patients ►Affects 3-15 people	►Major injury / long term incapacity / disability (e.g. loss of limb) ►>14 days off work ►Affects 16 – 50 people	►Fatalities ►Multiple permanent injuries or irreversible health effects ►An event affecting >50 people
Patient Experience	►Reduced level of patient experience which is not due to delivery of clinical care	►Unsatisfactory patient experience directly due to clinical care – readily resolvable ►Increase in length of hospital stay by 1-3 days	►Unsatisfactory management of patient care – local resolution (with potential to go to independent review) ►Increased length of hospital stay by 4 – 15 days	►Unsatisfactory management of patient care with long term effects ►increased length of hospital stay >15 days ►Misdiagnosis	►Incident leading to death ►Totally unsatisfactory level or quality of treatment / service
Environmental Impact	►Onsite release of substance averted	►Onsite release of substance contained ►Minor damage to Trust property – easily remedied <£10K	►On site release no detrimental effect ►Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K – £50K	►Offsite release with no detrimental effect / on-site release with potential for detrimental effect ►Major damage to Trust property – external organisations required to remedy - associated costs >£50K	►Onsite /offsite release with realised detrimental / catastrophic effects ►Loss of building / major piece of equipment vital to the Trusts business continuity
Staffing & Competence	►Short term low staffing level (<1 day) – temporary disruption to patient care ►Minor competency related failure reduces service quality <1 day ►Low staff morale affecting one person	►On-going low staffing level – minor reduction in quality of patient care ►Unresolved trend relating to competency reducing service quality ►75% - 95% staff attendance at mandatory / key training ►Low staff morale (1% - 25% of staff)	►Late delivery of key objective / service due to lack of staff ►50% - 75% staff attendance at mandatory / key training ►Unsafe staffing level ►Error due to ineffective training / competency we removed ►Low staff morale (25% - 50% of staff)	►Uncertain delivery of key objective / service due to lack of staff ►25%-50% staff attendance at mandatory / key training ►Unsafe staffing level >5days ►Serious error due to ineffective training and / or competency ►Very low staff morale (50% – 75% of staff)	►Non-delivery of key objective / service due to lack of staff ►Ongoing unsafe staffing levels ►Loss of several key staff ►Critical error due to lack of staff or insufficient training and / or competency ►Less than 25% attendance at mandatory / key training on an ongoing basis ►Very low staff morale (>75%)
Complaints/ Claims	►Informal / locally resolved complaint ►Potential for settlement / litigation <£500	►Overall treatment / service substandard ►Formal justified complaint (Stage 1) ►Minor implications for patient safety if unresolved ►Claim <£10K	►Justified complaint (Stage 2) involving lack of appropriate care ►Claim(s) between £10K - £100K ►Major implications for patient safety if unresolved	►Multiple justified complaints ►Independent review ►Claim(s) between £100K - £1M ►Non-compliance with national standards with significant risk to patients if unresolved	►Multiple justified complaints ►Single major claim ►Inquest / ombudsman inquiry ►Claims >£1M

Domain	Negligible 1	Low 2	Moderate 3	Significant 4	Extreme 5
Financial	►No obvious harm, disruption to service delivery or financial impact.	►Financial impact up to £1 million non recurrent/one off or up to £2 million over 3 years.	►Financial impact between £1 million and £3 million non recurrent/one off, or between £2million and £ 6million over 3 years.	►Financial impact between £3million and £5million non recurrent/one off or between £6 million and £1 0million over 3 years.	►Financial impact at least £5 million non recurrent/one off, or at least £10 million over 3 years.
Objectives/ Projects	►Interruption does not impact on delivery of patient care / ability to provide service ►Insignificant cost increase / schedule slippage	►<5% over project budget / schedule slippage	►5 – 10% over project budget / schedule slippage	►10 – 25% over project budget / schedule slippage	►>25% over project budget / schedule slippage ►Key objectives not met
Business/ Service Interruption	►Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	►Short term disruption, of >8 hours, with minor impact	►Loss / interruption of >1 day ►Disruption causes unacceptable impact on patient care ►Non-permanent loss of ability to provide service	►Loss / interruption of > 1 week. ►Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ►Temporary service closure	►Permanent loss of core service / facility ►Disruption to facility leading to significant 'knock-on' effect across local health economy ►Extended service closure
Inspection/ Statutory Duty	►Small number of recommendations which focus on minor quality improvement issues ►No or minimal impact or breach of guidance / statutory duty ►Minor non-compliance with standards	►Minor recommendations which can be implemented by low level of management action ►Breach of Statutory legislation ►No audit trial to demonstrate that objectives are being met (NICE; HSE; NSF etc.)	►Challenging Recommendations which can be addressed with appropriate action plans ►Single breach of statutory duty ►Non-compliance with core standards <50% of objectives within standards met	►Enforcement action ►Multiple breaches of statutory duty ►Improvement Notice ►Critical Report ►Low performance rating ►Major non-compliance with core standards	►Multiple breaches of statutory duty ►Prosecution ►Severely critical report ►Zero performance rating ►Complete systems change required ►No objectives / standards being met
Adverse Publicity / Reputation	►Rumours ►Potential for public concern	►Local Media – short term – minor effect on public attitudes / staff morale ►Elements of public expectation not being met	►Local media – long term – moderate effect – impact on public perception of Trust & staff morale	►National media <3 days – public confidence in organisation undermined – use of services affected	►National / International adverse publicity >3 days. ►MP concerned (questions in the House) ►Total loss of public confidence
Fire Safety/ General Security	►Minor short term (<1day) shortfall in fire safety system. ►Security incident with no adverse outcome	►Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area) ►Security incident managed locally ►Controlled drug discrepancy – accounted for	►Fire code non-compliance / lack of single detector – patient area etc. ►Security incident leading to compromised staff / patient safety. ►Controlled drug discrepancy – not accounted for	►Significant failure of critical component of fire safety system (patient area) ►Serious compromise of staff / patient safety	►Failure of multiple critical components of fire safety system (high risk patient area) ►Infant / young person abduction
Information Governance/ IT	►Breach of confidentiality – no adverse outcome. ►Unplanned loss of IT facilities < half a day ►Health records /	►Minor breach of confidentiality – readily resolvable ►Unplanned loss of IT facilities < 1 day	►Moderate breach of confidentiality – complaint initiated ►Health records documentation incident – patient care affected	►Serious breach of confidentiality – more than one person ►Unplanned loss of IT facilities >1 day but less than one	►Serious breach of confidentiality – large numbers ►Unplanned loss of IT facilities >1 week ►Health records /

Domain	Negligible 1	Low 2	Moderate 3	Significant 4	Extreme 5
	documentation incident – no adverse outcome	►Health records incident / documentation incident – readily resolvable	with short term consequence	week ►Health records / documentation incident – patient care affected with major consequence	documentation incident – catastrophic consequence

Appendix E – Risk Ownership/Escalation Matrix

Residual Risk Score	Risk Level	Risk owner	Risk Type	Decision to Accept Risk	Risk Register
20 - 25	Extreme risk	Executive Director/Chief Executive	Strategic	Trust Board	Strategic
			Cross-cutting Operational		Corporate
15 - 16	High risk	Executive Director/Chief Executive	Strategic	Trust Board	Corporate
			Cross-cutting Operational		Corporate
		Divisional Director	Operational	Divisional Board	Divisional/Corporate Departments
8 - 12	Moderate risk	Executive Director/Chief Executive	Strategic	Trust Board	Strategic
			Cross-cutting Operational		Corporate
		Divisional Director	Operational	Divisional Board	Divisional/Corporate Departments
4 - 6	Low risk	Executive Director/Chief Executive	Strategic	Trust Board	Strategic
		Local Management	Operational	Local Governance Board/Ward or Departmental Meeting	Local
1 - 3	Very Low risk	Executive Director/Chief Executive	Strategic	Trust Board	Strategic
		Local Management	Operational	Local Governance Board/Ward or Departmental Meeting	Local

Appendix F – Overview of the Risk Maturity Self-Assessment Methodology

Core Areas

The following core areas form part of the assessment process:

Core Area	Description
Risk Leadership & Management	Do the Board and Leaders promote risk management?
Risk Strategy & Policy	Is there a clear risk management policy?
People	Are people equipped to manage risks well?
Partnerships, Shared Risks & Resources Processes	Are there effective arrangements for managing risks with partners?
Risk Management Processes	Do the Trust's processes incorporate effective risk management?
Risk Handling & Assurance	Are risks handled well?
Outcomes & Delivery	Does risk management contribute to achieving outcomes?

Assessment levels

The levels of assessment provide a means of quantifying and monitoring existing performance, in identifying and setting targets for improvement and in judging progress towards those targets. Each assessment has five levels to gauge progress in developing the necessary risk management capabilities and to assess the effectiveness of risk handling and impact on delivering successful outcomes. In summary these levels are:

Levels	Description
1	Awareness and understanding (Engaging)
2	Implementation Planned and in progress (Happening)
3	Implementation in all key areas (Working)
4	Embedding and Improving (Embedded & Working)
5	Excellent capacity established (Driving)

*The majority vote from the participants being the final assessed level for each core area.

Core Area Weighting

In order to determine the Trust's Overall Risk Maturity Rating, weightings have been applied to core areas (weights 1 - 5) indicating level of importance to the Trust (5 being very important and 1 less so).

The weightings applied to the Trust's core areas are:

Core Area	Weighting
Risk Leadership & Management	4
Risk Strategy & Policy	3
People	3
Partnerships, Shared Risks & Resources Processes	2
Risk Management Processes	3
Risk Handling & Assurance	2
Outcomes & Delivery	5

Overall Assessment Levels / Rating

Level	Score	Descriptor
1	1 - 30	The organisation has an awareness and understanding of risk management
2	31 - 60	Approaches for addressing risks are being developed and action plan for implementation being devised
3	61 - 80	Risk management applied consistently and thoroughly across the organisation
4	81 - 95	The organisation is proactive in driving, and maintaining the embedding of risk management and integration in all areas of the organisation
5	96 - 110	The organisation sustains risk capability, organisational & business resilience and commitment to excellence in risk management, leaders regarded as exemplars

Appendix G - Equality Analysis (EA)

An Equality Analysis not just about addressing discrimination or adverse impact; the policy should also positively promote equal opportunities, improved access, participation in public life and good relations.

Person completing the Analysis		
Name	**Dorothy Otite**	
Job title	Trust Risk Manager	
Division/Directorate	Clinical Quality and Patient Safety	
Date completed	August 2017	
Who will be impacted by this policy	[X] Staff (EKHUFT) [ ] Staff (Other) [ ] Service Users	[ ] Carers [ ] Patients [ ] Relatives

Assess the impact of the policy on people with different protected characteristics.
When assessing impact, make it clear who will be impacted within the protected characteristic category. For example, it may have a positive impact on women but a neutral impact on men.

Protected characteristic	**Characteristic Group**	**Impact of decision** Positive/Neutral/Negative
e.g. Sex	Women Men	Positive Neutral
Age	**None**	**Neutral**
Disability	**None**	**Neutral**
Gender reassignment	**None**	**Neutral**
Marriage and civil partnership	**None**	**Neutral**
Pregnancy and maternity	**None**	**Neutral**
Race	**None**	**Neutral**
Religion or belief	**None**	**Neutral**
Sex	**None**	**Neutral**

Sexual orientation	**None**	**Neutral**

If there is insufficient evidence to make a decision about the impact of the policy it may be necessary to consult with members of protected characteristic groups to establish how best to meet their needs or to overcome barriers.	
Has there been specific consultation on this policy?	No
Did the consultation analysis reveal any difference in views across the protected characteristics?	N/A

Mitigating negative impact: Where any negative impact has been identified, outline the measures taken to mitigate against it.	N/A

Conclusion: Advise on the overall equality implications that should be taken into account by the policy approving committee.	N/A

Appendix H – Plan for Dissemination of Policy

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

Title of document:	Risk Management Strategy and Policy		
Version Number:	12.1		
Approval Date:	March 2019	**Dissemination lead:**	Deputy Director of Risk, Governance and Patient Safety
Previous document already being used?	Yes		
If yes, in what format (paper / electronic) and where (e.g. Directorate / Trust wide)?	Trust-wide document on 4Policies		
Proposed instructions regarding previous document:	To be retained for the purposes of audit and monitoring of compliance		
To be disseminated to:	**How will it be disseminated, who will do it and when?**	**Format (i.e. paper or electronic)**	**Comments:**
All Staff Trust-Wide	Trust Risk Manager	Electronic	**March 2019**

Board Assurance Framework

Report Date	31 Dec 2018
Risk Status	Open
Risk Register	1. Strategic Risk Register
Control Status	Existing
Action Status	Outstanding

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 2	Failure to maintain the quality and standards of patient care **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 11 Dec 2018 **Latest Review Date:** 03 Dec 2018 **Latest Review By:** Alison Fox **Latest Review Comments:** The risk may require revision to ensure it adequately reflects the current position in relation to regulatory requirements. This will be carried out during December 2018.	**Cause** *The Trust came out of Quality Special Measures early 2017 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. * A particularly difficult and challenging Winter compounded an already pressurised system. * The most recent CQC inspection gave a rating of RI demonstrating a stable position. **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	I = 5 L = 5 Extreme (25)	Agreed Improvement Plan in place with supporting Care Group plans. **Control Owner:** Sally Smith	Quality Improvement Programme Manager manages the updates to the Improvement Plan on at least a monthly basis.	Improvement Board monitor progress (meets monthly) BoD receives exception and progress reports (bi-monthly)	NHSIProgress Review meetings - provides challenge over progress of Trust in meeting deadlines CQC Inspection 07/15 - improved rating Internal Audit on CQC readiness completed - adequate assurance given. CCG assurance provided monthly	Adequate		I = 5 L = 4 Extreme (20)	Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Nov 2018	**09 Oct 2018** **Sally Smith** Public consultation is reliant on the pre-consultation business case (PCBC). Clinical Commissioning Groups now identified the timeline PCBC to be drafted by December.	I = 4 L = 2 Moderate (8)	Quality Committee
				External Consultancy and NHSI/E support in delivering the improvement programme. **Control Owner:** Lee Martin	*Carnal Farrar providing a PMO service to manage the delivery of the A&E Improvement Plan *Weekly monitoring *Report to the COO	Report to the Board of Directors	Carnal Farrar commissioned by NHSE/I	Adequate			Delivery of the emergency pathway improvement work. Actions as per CRR 28 & 61 **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	**05 Dec 2018** **Rhiannon Adey** Winter plan commenced. Ward opened at WHH. Observation units on track to be mobilised by mid January on both sites.		
				External help from Community Trust, social care, CCGs to deliver improvements in the emergency pathway. **Control Owner:** Lee Martin	Twice daily site meetings; Twice daily site 'huddles'; Board Rounds; Length of stay meetings; Weekly monitoring of the improvement initiatives; Escalation policies and procedures.	Patient Safety Board Clinical Executive Management Group Quality Committee Board of Directors	Fortnightly whole system calls Weekly MADE (Multi Agency Discharge Event) calls (CEO level) CCG contract meetings NHSI performance meetings	Limited	Delivery is not evident at present.		Implementation of the system wide NHSI/NHSE/CQC - Safety Plan **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2019	**09 Oct 2018** **Sally Smith** Assurance received at the oversight meeting in September. Plan being delivered except 4 hour performance and Duty of Candour which are requiring closer monitoring and focus. The next meeting's focus will be Infection Control for October's meeting.		
				Local improvement plan is in place meeting weekly to deliver an improvement plan. **Control Owner:** Lee Martin	Operational Programme Management Office in place	Steering Committees for referral to treatment times, emergency department access and cancer waiting times in place to assist with clinically led improvement. Highlight reports presented to Finance and Performance Committee.		Adequate						
				NHSI Improvement Director is working with the Trust. **Control Owner:** Sally Smith				Limited			Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 30 Apr 2019	**03 Dec 2018** **Rhiannon Adey** Review of current strategy with the improvement director has taken place and the strategy will be aligned to the actions required in the various CQC reports.		
				Quality Strategy is in place. **Control Owner:** Sally Smith	Published on the Trust website	Approved by QC and monitored quarterly by the QC (objectives are monitored)		Limited			Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 01 Sep 2020	**03 Dec 2018** **Rhiannon Adey** Board workshop took place in November to discuss wider improvement plan.		

Board Assurance Framework

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

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

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 4	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Elizabeth Shutler **Last Updated:** 18 Dec 2018 **Latest Review Date:** 14 Nov 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Clinical Commissioning Group timeline now identifies the Pre-Consultation Business Case (PCBC) to be drafted by December 2018.	**Cause** - Backlog of work (£74million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	I = 4 L = 5 Extreme (20)	An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Elizabeth Shutler	Deputy Director of Estates and Director of Capital receive information from all areas of the Trust regarding maintenance and undertake a first pass at prioritisation. Capital PLanning Group - review the prioritisation exercise	FPC receive reports about Backlog maintenance showing the risks.		Adequate		I = 4 L = 4 High (16)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee **Person Responsible:** Elizabeth Shutler **To be implemented by:** 29 Mar 2019	**18 Dec 2018** **Elizabeth Shutler** PCBC now due for circulation to NHSI and NHSE March 2019.	I = 4 L = 2 Moderate (8)	Quality Committee
											The Trust has engaged with NHSI to agree priorities to spend in 18/19 and 19/20. This is with a view to reduce the Trust Backlog position further. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020	**18 Dec 2018** **Elizabeth Shutler** Business Case being prepared and will be completed in January 2019 for sign off at Trust Board in March 2019.		
				Interim Estates Strategy in place **Control Owner:** Elizabeth Shutler	*Approved by Clinical Executive Management Group	- Strategy approved by the Trust Board - New NED in place to provide challenge		Adequate						
				Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Clinical Executive Management Group receives reports from Director of Strategy and Capital Planning. Business cases are received on an ad-hoc basis - some of which require improvement to infrastructure	FPC and Trust Board receives quarterly reports on capital spend.		Adequate						
				Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2017/18 **Control Owner:** Elizabeth Shutler	PEIC Action Plan available to view - The Patient Environment Investment Committee (PEIC) manages the annual investment, replacement and repair programme	*Plan approved by SIG in May 2017 *Strategic Investment Group (SIG) monthly reviews progress of action plan		Adequate						

Board Assurance Framework

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

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

AO2: People: Identify, recruit and develop talented staff

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

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 8	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** Andrea Ashman **Last Updated:** 18 Dec 2018 **Latest Review Date:** 16 Nov 2018 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Action updated - new processes taken to CEMG and are in place	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff * Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) * Uncertainty due to the STP plans * Increase in service demand * Potential negative impact that may arise from the publication of the Staff Survey Results. * Reputation of some medical specialties * Split site organisation increases the intensity of on call rotas **Effect** * Potential negative impact on patient outcomes and experience * High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups * Patient safety * Service delivery * Turnover * Unsafe staffing * Overtime * Withdrawal of GMC support	I = 5 L = 5 Extreme (25)	The Trust has a plan in place that supports the retention of newly qualified nursing staff locally. **Control Owner:** Sally Smith	*Dedicated Practice Development Nurse lead for supporting students on placement. *Progress monitoring and clinical support of all students. *Mentor support and training	*Regular meetings with Canterbury ChristChurch University - Contract monitoring meetings, faculty learning placement committee, curriculum group attended regularly. *100% students who apply to work with us are offered a post. *Monitoring of numbers of newly qualified nurses recruited and reported within N+M workforce plan. This demonstrates an improvement from 50% to 70% since 2014.		Adequate		I = 5 L = 3 High (15)	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:** 28 Feb 2019	**23 Nov 2018** **Rhiannon Adey** Working with the Chair of the Strategic Workforce Committee to develop the KPIs	I = 5 L = 3 High (15)	Strategic Workforce Committee
											Revise and implement Care Group Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 29 Mar 2019	**13 Nov 2018** **Jane Waters** Listening into Action feedback analysed and themed. Ten projects launched and underway		
				Care Group Great Place to Work Action Plans in place **Control Owner:** Jane Waters	- Plans available for all to access on Staff zone - Reviewed at the Care Group Business Boards	Progress of Plan reviewed quarterly at Clinical Executive Management Group and annually at the Strategic Workforce Committee		Adequate	Action Plan requires updating following receipt of the Annual NHS Staff Survey Results		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	**09 Oct 2018** **Sally Smith** As per previous action - update received today at October's SWC. Some additional actions agreed to ensure we retain our staff and recruit the people we need as we expand for Winter.		
				Hard to recruit plan in place and being implemented **Control Owner:** Louise Goldup	*Updated fortnightly by the Resourcing team *Sent to the HRBPs on a monthly basis	*Signed off at the end of July 2017 *Reported monthly as part of the high level CQC improvement plan		Adequate	Plan may not be progressing					
				Implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Discussed at the Workforce CIP meeting	Regularly reviewed at SWC (deep dives on Turnover and Exit information)		Adequate			Develop and implement a plan to recruit nurses from the UK and Europe **Person Responsible:** Louise Goldup **To be implemented by:** 30 Apr 2019	**09 Oct 2018** **Sally Smith** The plan is in place. The Board has approved the attract and retention initiatives. This is monitored monthly through the IPR.		
				Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Highlight Occupational Health reports Director and Deputy Director of HR Exit Interviews and Picker Survey reports highlight areas of concerns	Occupational Health Reports to SWC quarterly		Adequate						
				Recruitment process in place **Control Owner:** Andrea Ashman	Length of time to recruit is monitored monthly and provided as part of the IPR	Workforce KPI reviewed by the SWC at every meeting		Adequate	Programme of work being looked at to reduce time to hire (target to reduce this to 8 weeks). Updated Recruitment Improvement Plan produced which will support delivery of this timescale.					

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Revised recruitment process has been implemented **Control Owner:** Andrea Ashman				Adequate						
				Staff Performance Appraisals in place **Control Owner:** Jane Waters	*HR BPs carry out audit on the quality of the process and monitor the numbers of appraisals that take place	- Regular monitoring through a number of routes - Care Group Governance Boards, EPR meetings and Strategic Workforce Committee and Board	Annual staff survey results and the Picker Exit survey	Substantial	Achieved target set by the Board and now moving towards monitoring of the quality of appraisals					
				Training plans in place in each Care Group / corporate area that supports staff development. **Control Owner:** Andrea Ashman	- Each Division agrees their training plan - HR BPs review the plans on an annual basis	- Annual review by the Divisions - Annual reports to the Integrated Education Board		Adequate	*Funding gap - more bids than can be supported *Understanding of process and outcomes					

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 12	Insufficient capacity and capability of the leadership team (Executive and Care Group Clinical Directors) to develop and deliver key strategies and recovery plans **Risk Owner:** Susan Acott **Delegated Risk Owner:** Sandra Le Blanc **Last Updated:** 23 Oct 2018 **Latest Review Date:** 23 Nov 2018 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** The Leadership Framework was presented to Senior Leads in September at a Leadership Away Day. First cohort of Care Group Leadership teams commenced development programme Friday 16 November.	**Cause** *The Trust is not meeting its constitutional standards *Large number of complex priorities that need to be delivered including the sustainability and transformation plan, A&E recovery plan, Financial Special Measures turnaround plan, Cost Improvement Plans as well as business as usual *The Trust is under the Financial Special Measures regime *Those tasked with delivery have focus diverted due to other urgent external matters *The move of acute medicine, acute geriatric medicine and Stroke from the K&C site *Governance structure fails to support the delivery of CIPs *Increased Patient activity in A&E during the winter period **Effect** * Inability to achieve strategic priorities * Failure to come out of Financial special measures * Further Regulation action/concerns * Reputational damage * Financial loss * Negative impact on patient safety / care / experience * Reduced staff morale * Failure to meet operational performance standards (RTT/A&E/Cancer) * Failure to meet regulatory requirements (CQC / NHSI, GMC and HEKSS)	I = 4 L = 5 Extreme (20)	Chief Executive in place (experienced CEO in the NHS) **Control Owner:** Elizabeth Shutler	Objectives agreed with the Chairman	Reports to the Board	Liaised with NHS Improvement	Adequate		I = 3 L = 3 Moderate (9)	Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Dec 2018	**23 Nov 2018** **Rhiannon Adey** The Leadership Framework was presented to Senior Leads in September at a Leadership Away Day. First cohort of Care Group Leadership teams commenced development programme Friday 16 November.	I = 3 L = 2 Low (6)	Strategic Workforce Committee
				Business Partnering roles in place (Finance, HR & Information) together with support from central governance team. They are an integral part of the Care Group Leadership Team (Capacity) **Control Owner:** Lee Martin	- BPs exist with clear job descriptions and provide support to each Care Group to ensure delivery of Strategic Objectives - Line Management appraisals in place	Support within Care Group Report to Performance reviews		Adequate						
				Car Group Clinical Director responsible for the national Performance Standards e.g. Cancer, ED, 18weeks (Capacity) **Control Owner:** Lee Martin	*Reviewed at 121s with COO at least monthly and appraisals (discussion around resources required for their teams) *ED and Flow: Site management in place as part of the recovery plan	Reviewed at EPR monthly - capacity discussed	*Regular contract performance meetings with the CCGs *NHSI single oversight/performance review meetings monthly	Limited	Reviewing related team capability (e.g.validation)		To finalise the Trust–wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme. **Person Responsible:** Jane Waters **To be implemented by:** 31 Dec 2018	**13 Nov 2018** **Jane Waters** Draft framework developed and feedback gained at Leadership Forum. Work is currently being done to provide the feedback in electronic format supported by relevant resources.		
				Deputy Chief Operating Officers appointed with both site and portfolio responsibilities. **Control Owner:** Lee Martin	Reporting to the COO with clearly defined objectives, linked to Board priorities for 2018/19			Limited			Develop operational leadership and tactical competencies at Clinical Director, Head of Nursing and Director of Operations level, General Manager and Matron level provided by external facilitator and NHS Elect. **Person Responsible:** Lee Martin **To be implemented by:** 29 Mar 2019			
				Director of Finance in place with continuity in delivery of the FSM **Control Owner:** Susan Acott	*Reports to the CEO	*Supported and Continuity by the FID *Reports produced and the FPC provides oversight of the FRP	Delivery of FRP and monthly reporting to the NHSI	Adequate						
				Experienced COO appointed **Control Owner:** Sandra Le Blanc	Clear objectives set by the Chief Executive to mirror those agreed by the Board of Directors.	Regular reporting to Quality Committee and Finance and Performance Committee.		Adequate			Review of key action plans in line with capacity and capability (A&E Improvement Plan and Cancer) **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	**05 Dec 2018** **Rhiannon Adey** Action plans underway		
				External Consultancy Support (2020, Carnal Farrar, A&E Improvement Director, Financial Improvement Director) supporting Care Groups and the Corporate Team to deliver transformation programmes (Capacity) **Control Owner:** Lee Martin	*Regular reports through the Executive Team meetings and Management Board *Financial Improvement Director reports to CEO *2020 - 2 site based teams for 12 weeks with targeted support	*Reviewing monthly at Board Sub-Committees and Executive (Quality, FPC and SWC) and weekly telephone calls with NEDs *Performance Reviews (IPR)	*Peer review and Benchmarking (Reports by Consultants include this) *Weekly single oversight meetings (twice a week meetings with NHSI and NHSE)	Adequate	Sustainability of the 2020 improvements following their exit		Design and deliver the Executive Development and Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 01 Apr 2019	**09 Oct 2018** **Sally Smith** Plum are working with the Trust to develop the new Care group leadership and management development.		

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Leadership Development Plans and targeted development plans for individuals in place (Capability) **Control Owner:** Sandra Le Blanc	- Senior Leadership has 6 monthly objectives and appraisals - Executive review succession plans and talent pipeline for Senior Leadership and key posts quarterly	- Nominations Committee review the Appraisals, objectives and Talent pipeline six monthly - Latest update of the talent pipeline went to the Nominations Committee in April 2017 - The CE has 6 monthly objectives and appraisals - done by Chair of the Board SWC - regular updates and reports on Leadership development		Adequate						
				Leadership development programme in place for Clinical staff all professions (Capability) **Control Owner:** Sally Smith	The programmereflects the shared purpose framework and Trust values, and the Quality Strategy.	The Senior Leadership & Quality Forum meet every 6 weeks with the Chief Nurse to review progress.		Adequate	Work in progress to refresh the fortnightly band 7 catch up forums.					
				New clinician development programme (now into the 6th cohort) (Capability) **Control Owner:** Paul Stevens	5 programmes have already been completed and from these cohorts several doctors have gone on to take on leadership roles in the organisation			Adequate	*Routine monitoring of Clinician Development Programme by SWC					
				Outline Programme Plan in place for the Leadership Development Programme (Capability) **Control Owner:** Sandra Le Blanc	Reports to Clinical Executive Management Group monthly	Reports to SWC and Board monthly	NHSI review - Initial feedback was received from NHSI on 9 August 2017. A conference is planned to respond to this and re-submit the business case.	Limited	Re-submission of the business case to NHSI following MB approval					
				Performance Reviews in place where delivery is challenged to support senior leadership team in prioritising and highlighting competing pressures (Capacity) **Control Owner:** Susan Acott	Meetings taking place monthly with minutes and actions	Exceptional reports to Clinical Executive Management Group to highlight issues with wider organisational impact		Adequate						

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Recent appointment to two key posts in the Trust below Executive Director level (Capability) **Control Owner:** Sandra Le Blanc	*The two posts are the Head of Transformation reporting to the CEO and Director of Strategy and Business Development reporting to the Director of Strategy and Capital Planning and Deputy Chief Executive. *Induction programme in place			Adequate						
				Substantive staff in place for Executive and Care Group Clinical Director positions (Capacity) **Control Owner:** Sandra Le Blanc	* Currently no vacancies exist for Executives and Divisional Directors *Succession plans in place *Substantive Chief Executive has been appointed	The Nominations Committee reviews Succession plans; Appraisals and Performance Development Plans for Executives and Divisional Directors six-monthly		Adequate						
				Succession Plan in place for Executive Directors, Care Group Clinical Directors, Care Group Directors and key posts to the organisation **Control Owner:** Sandra Le Blanc				Limited						
				Targeted resources into key CIP schemes in place e.g. patient flow, Cardiology (Capacity) **Control Owner:** Philip Cave	Head of PMO and Financial Improvement Director posts in place	Regular updates to the Executive Team from the Head of PMO to identify gaps		Limited	Recruit into identified gaps					
				Transformation Programme in place (designed and resourced) (Capacity) **Control Owner:** Simon Hayward	*Governance structure in place which links to Financial Special Measures	*Approved by the Trust Board on 10 April *Time limited implementation team in place (Purpose agreed by EMT in June 2017) *Reports to EMT and the Transformation Board		Limited						

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

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

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 5	Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime **Risk Owner:** Philip Cave **Delegated Risk Owner:** David Baines **Last Updated:** 09 Oct 2018 **Latest Review Date:** 03 Dec 2018 **Latest Review By:** Philip Cave **Latest Review Comments:** At the end of M7 the Trust is £2.5m behind plan with a forecast risk position of up to £22m off plan by year end but a likely position of £7m worse. New actions have been added this month to try to ensure the plan is achieved and the risk fully mitigated.	**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 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 CCGs 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**	I = 5 L = 5 Extreme (25)	Cash Committee in place **Control Owner:** Philip Cave	*Led by the Director of Finance *Report on Daily and weekly cash balances	*Monthly review by FIOG; and FPC	*Submission of cash profile/capital plan to NHSI and Department of Health (on a 13 week rolling basis)	Substantial		I = 5 L = 4 Extreme (20)	Develop the Cost Improvement Plan for 2019/20 **Person Responsible:** Philip Cave **To be implemented by:** 31 Dec 2018	**28 Nov 2018** **Rhiannon Adey** As at 22 November 2018 £16.4 million of ideas has been identified. See attached for details.	I = 5 L = 3 High (15)	Finance & Performance Committee
				Clinical engagement in delivery of CIPs requiring Clinical Practice changes **Control Owner:** Paul Stevens	*Clinical engagement forums led by CEO and Medical Director *Review by the Confirm & Challenge meetings with Divisions	*Review by FIC; and feeds into the FPC and Board	Annual survey of Medical Engagement scale (last done in September 2016 with two of three scales rated low)	Limited	Poor clinical engagement					
				Cost Improvement Plan targets in place with workstream in support **Control Owner:** Philip Cave	*Monthly Executive Performance Review and Key Metric Reviews *Fortnightly confirm and challenge meetings with the Financial Improvement Director (FID)	* Executive review weekly * Turnaround report to FPC * Exception reports to BoD	- NHSI challenge at Performance Review meetings (monthly) - NHSI carrying out deep dive review around sustainability for 2017/18, 2018/19 (including Governance) - Appointment of Financial Improvement Director	Adequate			Mobilise care groups to deliver the £30 million CIP ideas for 2019/20 programme **Person Responsible:** Lee Martin **To be implemented by:** 31 Dec 2018	**05 Dec 2018** **Rhiannon Adey** Financial controls reviewed and further communication and actions taken to deliver 2018/19 financial plan		
				Financial Improvement Director in place to provide support **Control Owner:** Susan Acott	Reports to CEO	- Report to Executive Team and Board - Report to FPC	Appointed by NHSI and reports to NHSI	Substantial			Design and implement finance function training for clinicians **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	**05 Dec 2018** **Rhiannon Adey** Commenced in November, General Manager and Matron development commencing in January.		
				Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Philip Cave	*Chaired by the Finance Director	*Monthly reports to FIC	NHSI and FID attend FIOG meetings	Adequate			Ensure accountability for budgetary management by developing a standard objective for all budget holders **Person Responsible:** Philip Cave **To be implemented by:** 01 Apr 2019			
				Financial Recovery Plan in place **Control Owner:** Philip Cave	- Care Groups, PSO and FID developed plans	*Board received plan on 10/04/17 *Reviewed at FPC monthly	* Approved by NHSI in April 2017 with monthly Financial Special Measures (FSM) meetings to review progress	Substantial			Develop Trust wide financial culture training for budget holders **Person Responsible:** Philip Cave **To be implemented by:** 28 Jun 2019			
				Fortnightly confirm and challenge meetings with the Care Groups (including Corporate) **Control Owner:** Philip Cave	*Chaired by the Financial Improvement Director	*Monthly review by FIC		Adequate			Develop strong relationships with commissioners **Person Responsible:** Philip Cave **To be implemented by:** 28 Jun 2019			
				Local Vacancy Control Panel in place **Control Owner:** Philip Cave	Chaired by the Deputy Chief Executive	*Escalation to weekly EMT meetings *Review at Confirm and Challenge sessions with the FID		Adequate						
				Monthly Financial Special Measures (FSM) review meetings with NHSI. This has now been combined with the local IAM meeting with NHS I. **Control Owner:** Philip Cave	DoF and DDoF produce slides with FSM position for review with the Executives	*Internal pre-meet review prior to meeting with NHSI. *Following FSM meeting, update at MB and FPC	Feedback from NHSI positive year to date	Substantial						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
		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		New approach to developing CIPs in place **Control Owner:** Philip Cave	Led by Financial Improvement Director	Review of progress of CIP monthly by the FPC	*Part of review process at monthly FSM meetings *Internal audit on CIPs with substantial assurance	Substantial						
				New Care Group (clinically led structure)implemented with action plans to deliver national standards and agreed trajectories. **Control Owner:** Lee Martin	Care Group management of the standards through Governance and Business Boards	*Compliance reports to Performance Reviews, Clinical Executive Management Group, Finance and Performance Committee Board of Directors and Council of Governors *Review at A& E Governance (meeting three times a week)	External review from: * CCG's through monthly performance reviews; * NHSI through 6 weekly progress review meetings; *Single Oversight meetings with NHSI, NHSE, KCC etc.)	Limited	Key operational performance targets (A&E, RTT, Cancer) not being met.					
				Payment by results infrastructure (coding and data quality) **Control Owner:** Philip Cave	*Data validation done monthly by team *Monthly Contracts, Finance and Internal Contracting meeting to review activity and income level *Monthly confirm and challenge meetings with the Financial Improvement Director	*Review by the FOIG; and monthly report to the Finance & Performance Committee	External Audit: *External validation of clinical coding data *Positive External Audit results on costing as part of National Audit "Costing Assurance Review"	Adequate	Clinical activity not consistently captured, coded and costed.					
				Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Philip Cave	*Escalated through the FD to the CEO	*Escalate concerns to NHSI *Finance & Technical Group meetings with NHSI	*New MoU signed with the Commissioners	Adequate	Trust is seeking assurance from NHSE/I about next steps - Commissioners challenge					
				Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Philip Cave	*Information and Income Teams monitor and report on plan *Information Team produce monthly update of Productivity plans (with forward looking indicators)	Review by the FIOG; and FIC if escalation is required		Adequate						
				Programme Support Office (PSO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Philip Cave	*Weekly CIP tracking *Direct line management by Director of Finance	*Monthly reports to CEMG, EPR and FPC	Regular contact with NHSI	Adequate						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Regular reporting on the Trust's Financial position to the Trust Board and senior management team (including ensuring the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood). **Control Owner:** Philip Cave	*Review by Executive Management Team *Care Groups attend FPC on a four monthly rolling basis	*Regular updates to FPC, Board, Clinical Executive Management Group and Transformation Improvement Group *Review at the A&E Governance Board (currently meeting three times a week)	Monthly FSM meetings with NHSI and FID.	Adequate						
				Signed MoU in place with commissioners that provides greater clarity on specific areas of agreement which were previously disputed **Control Owner:** Philip Cave	*Contract management meetings with CCGs *2018/19 planning discussions with CCGs	Review at EMT, FPC and FIC	MoU signed with the CCGs	Adequate						
				Workforce and Agency Control Group in place **Control Owner:** Sandra Le Blanc	Chaired by Director of HR	Monthly review by FIC		Adequate						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 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:** 21 Dec 2018 **Latest Review Date:** 21 Dec 2018 **Latest Review By:** Simon Hayward **Latest Review Comments:** Agree a Transformation programme of work with clear owners and milestones that links to the Trust priorities - link this to the Trust objective planning for 2019 that is being delivered in January 2019	**Cause** * Lack of experience / capability in the particular area of change * Lack of capacity of those who need to lead and embed the change * Lack of resources to deliver / implement and sustain change * Trust's lack of appetite for change in some areas to be implemented *Unavailability of the space and physical resources to implement and embed improvements * Mechanism / governance structures for Transformation is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to deliver the transformation required to meet Trust objectives * Licence restrictions *Regulatory concerns * Reputational damage	I = 4 L = 5 Extreme (20)	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	Direct line reporting to the Chief Executive as well as NHS Improvement	Chairs Confirm and Challenge sessions with the Divisional Teams and Executives to ensure delivery moves at pace and any blocks addressed. Involved in development of the financial special measures governance process and has attended the Finance and Performance Committee who oversee the delivery of the financial position of the Trust on behalf of the Board.	Financial Improvement Director liaises with NHS Improvement to discuss the Trust's engagement and performance.	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 Dec 2018	**09 Oct 2018** **Sally Smith** LiA is in place and progressing although the NHSI leadership development business case has not yet been approved by NHSI.	I = 3 L = 2 Low (6)	Board of Directors
											Agree a Transformation programme of work with clear owners and milestones that links to the Trust priorities - link this to the Trust objective planning for 2019 that is being delivered in January 2019 **Person Responsible:** Simon Hayward **To be implemented by:** 22 Feb 2019	**13 Nov 2018** **Simon Hayward** New TIG agenda and standard documentation agreed and now being taken to all Care Group leads for first submission by meeting on 14th December		
				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	Working relationships between linked NED and Lead Executive	Non-executive input at Board of Directors and Committees in relation to development and delivery of the transformation and financial recovery plans.		Adequate						
				Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Sandra Le Blanc	Implementation plan in place and completed for Phase . Alignment review completed and shared with NHSI	EMT workshops held between February and April 2017 to agree transformation work-streams linked to financial recovery CIPs and annual priorities.		Adequate						
				Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS and European / International hospitals **Control Owner:** Elizabeth Shutler	*Programme Manager does monthly horizon scanning *Periodic trips to other European Health Services *Periodic visits to other NHS Trust with similar issues to identify good practice.	*Reports on Horizon Scanning are presented for information to EMT and Management Board. * Presentations to committees and Board on an ad hoc basis.	Clinical Senate reviews held periodically - reviews models of care and adherence to best practice	Adequate	Links to transformation / service improvement from learnings not explicit.					

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Time limited implementation team in place for the Transformation Programme **Control Owner:** Simon Hayward	*Implementation Team in place to deliver 8 point agenda *Skills audit complete *Head of Transformation in post and Chairing Group *Focus on training and development and Trust wide methodology	*Purpose agreed by EMT in June 2017 *Reports to EMT and the Transformation Improvement Group *Programme, project and improvement methodology for the Transformation journey was submitted the Transformation Improvement Group in October 2017 - to be agreed with programme refresh in 2018 *Improvement proposal going to Trust board March 2018		Adequate						
				Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	*Principles for the transformation governance agreed through alignment review, workshops and follow-up work with EY / Plum *Financial recovery governance included input from Financial Improvement Director and linked to Transformation governance.	* EMT review of governance structures via email * Board reviewed the draft proposal (10/4/17)	Discussed at a Financial Oversight meeting with NHSI	Adequate						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	1st Line	2nd Line	3rd Line	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 10	Non-delivery of a timely Sustainability and Transformation Plan that can be resourced **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 09 Oct 2018 **Latest Review Date:** 18 Dec 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Reviewed	**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)	I = 5 L = 4 Extreme (20)	Clinical standards reviewed **Control Owner:** Elizabeth Shutler	Reviewed at the Clinical Strategy Group	Minutes received by MB	Final response received from Clinical Senate	Substantial	Needs feeding back into the PCBC	I = 5 L = 4 Extreme (20)	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:** 29 Mar 2019	**18 Dec 2018** **Elizabeth Shutler** PCBC now due for circulation to NHSI and NHSE March 2019.	I = 5 L = 2 Moderate (10)	Finance & Performance Committee
				East Kent Programme Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Susan Acott	- Trust Executive membership of the Board to influence the discussion. - Trust Secretary holds all copies of agendas/minutes	- Reported monthly to Clinical Strategy Board and Management Board	In attendance are all Health economy partners	Limited						
				Internal Clinical Strategy Group in place **Control Owner:** Elizabeth Shutler	Chaired by CEO			Adequate			Produce Financial Plan linked to delivery of the STP **Person Responsible:** Philip Cave **To be implemented by:** 01 Aug 2019	**03 Dec 2018** **Philip Cave** The action date has been moved back to August in line with the latest guidance from NHS I which sets out that STPs should create a 5 year plan by Summer 2019. A new 10 year NHS plan is due out in December 2018 along with more detailed planning guidance.		
				Kent and Medway STP Programme Board in place **Control Owner:** Elizabeth Shutler	*Trust CEO and Chair of East Kent Delivery Board attends to influence the programme. *Trust CEO is on the Management Board and Chairing the Hospital work stream which Deputy CE is the Lead for *PMO established	- Various Senior Managers involved in STP work streams - Trust Board sighted on presentations to Programme Board	PMO reviewed by NHSE and found to be adequate	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 Sep 2019	**18 Dec 2018** **Elizabeth Shutler** Consultation now planned for September 2019.		

		Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
PATIENTS: Providing high quality care to patients with great outcomes for their health and lives - getting the basics right every time and building healthcare that is best in class																									
We will improve FFT satisfaction for ED	Achieve national average	85%	80.60%	85%	83.20%	85%	85.50%	85%	80.00%	85%	83.70%	85%	80.10%												
We will improve patient experience	Monthly survey against national benchmark	90	91.1	90	91.4	90	91.1	90%	91.90%	90%	89.80%	90%	90.10%												
	Annual inpatient survey against national benchmark	Annual reporting -						National benchmark 82.3%	80%																
Promote effective care to patients with mental health needs and Learning Disabilities	Implement best practice guidelines/NCEPOD report on mental health in general hospitals	Quaterly reporting - baseline against NCEPOD awaited - progress to be reported to the August Patient Expereience Group and Quality committee								Behind schedule. Meeting with key stakeholders November. Executive lead updated - monthly reporting to be established to support required pace.															
	Improved mortality rates	An audit was carried out in 2015 in relation to mortality rates and a repeat audit is scheduled for February 2019.																							
	Improved length of stay																								
	Improved readmission rates																								
Ensure that EKHUFT work in partnership with our service users to define, monitor and deliver great care	Scope current patient involvement within EKHUFT	Quaterly reporting - progress measured against action plan; Preliminary scoping to be completed and detailed plan in progress by end of quarter 2. On track with plan - presentation of plan and outcome of initial scoping to be presented to next (September) complaints steering group - quaterly reporting against plan thereafter.						Patient involvement scoped - current activity described and future plans presented to the October PEG. On track.																	
	Identify and implement best practice models	On track with plan - quaterly reporting						On track. Supportive strategy in development action plan in place - next report to the PEG December 2018. . Harder to reach groups included within current activity with establishment of a youth forum (which had its first meeting in October).																	
Embed a patient safety culture	Measured through improvement against Texas safety culture tool	Quarter one baseline. Testing results from previous staff survey results. Culture tool developed electronically						Results from 3 years' worth of staff surverys segmented and reviewed. Survey design reviewed and plan in place to fit with latest IT Portal/web-based platform. Slight hiatus due to PAS implementation. Survery renamed to Safety Climate Survey. All other actions in line with plan.																	
Deliver on our CQC Improvement journey	improvement plan completion	Improvement plan cleansing underway						Work is in place to integrate CQC improvement milestones into the Trust Quality Strategy																	
	subsequent CQC inspections	Outcome of May and June 2018 visit(s) awaited								Remains "Requires Imrovement"															
Strengthen engagement with our academic partners	Scope out potential for Clinical Research Facility on at least one EKHUFT site	Q1 saw the finalisation of these priorities in discussion with key members of the research and innovation department, Jane Ollis and Paul Stevens. These will be reported on in terms of agreed timelines for delivery as most are longer term.						Currently undertaking work with Strategic Development to define (high level) estate requirements to inform approximate costings																	
	Relaunch the Trust's Research Session Scheme (RSS) with goal to realise at least two external grant applications (of which one successfully funded) within 24 months of RSS funding start							RSS relaunched. 1st round of applications were considered in July and 2 form 3 applications were approved (1x 0.2 WTE, 1x 1 PA). A further call has gone out, for consideration in Nov 2018. Too early to expect conversion from RSS awards to external grant funding awards.																	
	Refresh the Trust's IP policy and establish a clear process that supports EKHUFT staff to develop innovations, including early stage funding via the R&I Catalyst and a new late-stage innovation fund, and the establishment of an innovation committee							Updated IP policy remains in draft. Will now be presented to R&I committee in Feb 2019 (intention had been Oct 2018). Innovation Committee ToR to be included as an appendix to redrafted policy and membership of IC have been approach. Funds set aside (£20k per annum, carried over if unutilized) for Innovation Fund.																	

		Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
PEOPLE: Attracting the best people to our team, who are passionate, motivated and feel able to make a difference and investing in them																									
Staff engagement:Deliver a programme of work including Listening into Action methodology to deliver an improved staff engagement	Staff FFT / National Staff Survey (baseline)	Not available in Q1 - annual report						Not available in Q2 - annual report																	
	Treatment (54%)	70%	70%	70%	70%	FFT not run in June 2018 due to Listening in to Action survey		FFT not run in Q2 due to Listening in to Action survey																	
	Work (43%)	50%	48%	50%	48%																				
Staff retention: Retain skilled and experienced staff to provide continuity of person centred care	Turnover Baseline All Staff: 13.5% (Jan 2018) 12.77% (YTD)	13.50	12.59	13.50	12.33	13.50	12.17	13.50	12.80	13.50	12.09	13.50	12.29												
	Turnover Baseline Nursing Staff: 10% (January 2018) (204 YTD)	10.00	19.14	10.00	15.43	10.00	25.02	10.00	14.75	10.00	20.76	10.00	17.89												
Leadership development: Implement the Trust wide leadership and management development programme	Deliver to 200 staff by the end of 2018/19	The Board will be aware that NHS Improvement did not support the Trust in the consultancy spend for this piece of work. Therefore this objective will need to be delivered in=-house and will not commence until Spring 2019																							

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
PARTNERSHIP: Work in partnerships to design health and social care which transcends the boundaries of organisations and geography													
Work with partner organisations to develop an east Kent Accountable Care Partnership / Integrated Care System by	establishing an agreed programme of work that focuses on setting up clear patient pathways for the frail elderly population of east Kent and creating a joint east Kent Department of Geriatrics with KCHFT	MOU has proposed pathways for joint work included within it - frail elderly is a priority			There are on-going discussions around joint working and frailty initiatives. There is a proposal being developed and this is at an early stage.								
	working with KCHFT, KCC and KMPT to expand and finalise the MOU by June 2018	Work underway. Draft MOU written and discuused at EMT. Comments incorporated and due to go back this month then sign off at August board			Under review								
Subject to the production of the pre-consultation business case (PCBC), finalise a 5 year Estates Strategy that looks at public and private sector partnerships to deliver high quality health and social care from campus style sites	Deliery of an estates strategy	When a preferred option has been decided the estates strategy will be drafted and approved by the Board of Directors			In the meantime the Trust is working with NHSI to address that the backlog estates issues and bid for £27.7m to invest over the next 3 years, In addition priority investments have been the subject of business case to NHSI and the Trust has seen investment on observations bays, wards and A&E estate and IT.								
Deliver the EKHUFT elements and work with the Sustainability and Transformation Programme for Kent and Medway	Finalise consultation on the Trust Clinical Strategy in line with the CCG timeline	EY has been engaged by CCG to undertake a state of readiness for PCBC and consultation.In adition changes to national assurance governance have become more stringent. The EY report identifies a number of gaps which need to be completed before PCBC can be completed. The gaps are around governance , lack of a robust local care plan and perceived lack of clarity for option 2. Action plan and work to rectify this well underway			Completed the hurdle criteria on the long list of options to generate a medium list of options. This list will now be taken to the next step of the process (evaluation of the medium list of options) to generate the shortlist and inform the Pre Consultation Business Case (PCBC) The PCBC is being drafted with a deadline for early 2019. Public Consultation is scheduled to commence in late Spring / early Summer of 2019.								
	Contribute to a system wide PCBC (Pre Consultation Business Case) for the east Kent reconfiguration work stream in line with the deadline for capital bidding process in 2018	PCBC as above. Wave 4 capital bids completed and submitted in line with STP time-line.			EKHUFT secured central funding to expand capacity in the two A&E Departments at the William Harvey and the Queen Elizabeth The Queen Mother Hospital. These projects are on track to deliver the adddional capacity by the end of December 2018. Programme on the production of the PCBC as above.								
	Continue to work with partners on a joint pathology project in line with the STP revised timeframe	Project Director appointed (Mark Hackett) investment in IT solutions identified by all partners and programme now moving at pace			Business case being prepared for single Pathology system (EKHUFT & MTW).								
	Develop an approach to look at more effective models of providing back office functions such as facilities management, estates and procurement, learning from other NHS successes	2gether support solutions limited established, transfer of first phase staff 1 August 2018			Second phase completed on 1 October 2018 when Equipment and Estates management transferred to the new wholly owned company (total 1,150 employees). Engaged an NHS subsidiary to deliver and support the project.								
	Progress the Kent Care Record project with partners with a view to delivering: Phase 1 - readiness for market by July 2018. Phase 2 - procurement by May 2019 Phase 3 – mobilisation by May 2020	Ready to go to market in July 2018. Estabishing that the required resources are available through the STP			We are currently in the procurement phase and is expected to complete by July 2019								

		Apr-18		May-18		Jun-18		Jul-18		Aug-18		Sep-18		Oct-18		Nov-18		Dec-18		Jan-19		Feb-19		Mar-19	
		Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
PROVISION: The provision of high quality care through the use of technology, research, education, innovation and intelligence																									
Improve people's experience of and our performance in emergency care: ED RECOVERY PLAN: - Implement and deliver sustainable improvement in the ED to be measured against the agreed improvement trajectory / standard (linked to STF trajectory	Compliance with 4 hour access standard (trajectory) (performance)	78.60%	76.93%	77.50%	80.80%	78.50%	82.55%	83.89%	79.18%	85.37%	80.04%	85.39%	77.15%												
	Number of patients seen by a clinician in the first hour (performance)	55%	46.20%	55%	49.50%	55%	51.70%	55%	52%	55%	43%	55%	48%												
	Bed occupancy (performance)	95%	100%	95%	101%	95%	95.80%	95%	94.11%	95%	94.75%	95%	95.94%												
	Friends and Family test (ED) (quality)	85%	80.60%	85%	83.20%	85%	85.50%	85%	80.90%	85%	83.75%	85%	80.13%												
	Emergency re-admission rate (quality)		9.61%		9.08%		9.29%		9.8%		9.8%		8.6%												
Deliver value for money for the taxpayer: FINANCIAL PLAN: Deliver the financial plan for the Trust, measures against the final plan submitted to NHSI on 30 April 2018	Income: achievement against plan	£45.7m	£45m	£48.6m	£49.9m	£50.0m	£51.4m	£48.9m	£52.6m	£47.4m	£49.7m	£48.9m	£52.6m												
	Expenditure: achievement against plan	£48.9m	£47.9m	£49.5m	£51m	£49.5m	£50.9m	£48m	£51.8m	£49.2m	£51.9m	£48m	£51.8m												
	Cost Improvement Programme: achievement against plan	£1.5m	1.2m	1.5m	£1.8m	£1.6m	£1.6m	£3.4m	£4m	£2.2m	£1.8m	£1.3m	£1.6m												
CONTRIBUTION: Increase the contribution of particular services	Neurology	Finance and Performance Committee recommendation to the Board that the areas listed are those to be focused on in 2018/19. Chief Operating Officer to review the list and confirm that these fit with the overall business plan for 2018/19						The Divisions CIP programmes are in place with actions to improve the contribution and are monitored monthly through performance reviews. The schemes will be reviewed by the new Care Group leadership teams over Q3/4																	
	Gastro / endoscopy																								
	Trauma and orthopaedics																								
	Vascular																								
	ENT																								
	Obstetrics and Paediatrics																								

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

NHS
East Kent
Hospitals University
NHS Foundation Trust

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)

TERMS OF REFERENCE

1 CONSTITUTION

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

2 PURPOSE

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

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

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

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

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

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

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

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

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

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

2.1.9 produce an annual report for the Board of Directors

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

3 OBJECTIVES

Governance, Risk Management and Internal Control

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

In particular, the committee will review the adequacy of:

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

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

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

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

3.6 policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority.

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

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

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

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

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

External Audit

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

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

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

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

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

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

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

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

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

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

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

Internal Audit

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

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

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

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

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

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

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

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

Other Assurance Functions

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

Counter Fraud

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

Management

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

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

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

Financial Reporting

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

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

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

3.21.2 major judgemental areas;

3.21.3 significant judgements in the preparation of the financial statements;

3.21.4 significant adjustments resulting from the audit;

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

3.21.6 letters of representation;

3.21.7 explanations for significant variances;

3.21.8 unadjusted mis-statements in the financial statements.

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

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

4. MEMBERSHIP AND ATTENDANCE

Membership

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

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

Chair

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

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

Attendees

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

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

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

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

Quorum

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

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

Attendance by Members

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

Attendance by Officers

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

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

Voting

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

5 FREQUENCY OF MEETINGS

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

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

6 AUTHORITY

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

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

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

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

7. SERVICING ARRANGEMENTS

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

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

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

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

8 ACCOUNTABILITY AND REPORTING

8.1 The Committee is accountable to the Board of Directors.

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

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

9 RELATIONSHIPS WITH OTHER COMMITTEES

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

- Information Governance Steering Group
- Information Assurance Board

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

9.2 Alignment with Council of Governor Audit Working Group.

9.3 The Committee will receive Chair reports from the Quality Committee, Finance and Performance Committee and Strategic Workforce Committee as required. To review and consider findings of significant assurance functions and the implications for the governance of the organisation. (As detailed in point 3.16).

10 MONITORING EFFECTIVENESS AND REVIEW

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

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

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

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

11. JOINT COMMITTEES

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

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

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

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

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

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

Reviewed by the Committee: JANUARY 2019

Approved by the Board of Directors:

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE

FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT 18/117

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR FINANCE AND PERFORMANCE COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: MONTH 9 FINANCE REPORT** **APPENDIX 2: MONTH 8 FINANCE REPORT**

BACKGROUND AND EXECUTIVE SUMMARY:

The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan (FRP), delivery of any financial undertakings to NHS Improvement (NHSI) in place, and medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance overseeing financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and the 2018/19 capital plan.
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

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

29 January 2019 Meeting

The Committee reviewed the following matters:

Financial Special Measures (FSM) Update:

1 The Committee received a verbal update from the Director of Finance and Performance on FSM regarding the Trust's proposals for the delivery of the financial plan in 2018/19, as well as 2019/20 and beyond.

1.1 The Trust continues to focus on improving its financial position in relation to having in place a robust financial plan to deliver the 2018/19 plan, as well as developing a deliverable plan for 2019/20;

1.2 Engaging with NHS Improvement (NHSI) to support the delivery of the plan. A meeting is to be held on 21 February with NHSI to discuss the Trust's financial position and the actions taken around improving its financial performance.

Care Group Presentation

2 The Committee received a presentation from the Clinical Support Services (CSS) Care Group, delivered by its Clinical Director and Finance Lead. Key issues discussed for M9 are noted below:

2.1 The Care Group is currently overspent by £2.5m. Pathology direct access and radiology income are above plan, issues continue in therapies with booking templates following the implementation of Allscripts.
2.2 Overall there has been a reduction in agency costs.
2.3 The year to date (YTD) Cost Improvement Programme (CIP) target was met with a total currently of £3.79m against the £5.2m forecast and is on target to be delivered by year end. A challenging target of £5.4m has been set for 2019/20 with aim to ensure schemes are RAG rated green by the end of February.
2.4 Key risks highlighted as noted below:
2.4.1 Impact to CSS as the result of additional beds being opened that have resulted in a cost pressure across CSS and the impact on staff. This is being mitigated by the prioritisation of work.
2.4.2 Workforce issues in relation to vacancies in CT, MRI, nuclear medicine, radiology, and ultrasound. Proactive recruitment continues to appoint to vacant posts and there has been successful recruitment recently in radiology. The Care Group is conscious around the need and importance of retaining staff and attracting candidates to come and work for the Trust.
2.5 The achievements of the Care Group included:
2.5.1 Compliance against the diagnostic DM01 standard in October, November and December 2018.
2.5.2 The reported backlog for CT and MRI is now at its lowest since February 2016.
2.5.3 The delivery of Videofluoscopy and Fibreoptic Endoscopic Evaluation of Swallowing System (FEES) equipment across all sites.
2.5.4 Compliance of the cancer 2 week wait standard in December.
2.5.5 The positive outcome of the Pharmacy and Accident & Emergency (A&E) pilot for web-based environment monitoring and a plan is being developed for roll-out.
2.5.6 Friends and Family Test (FFT) performance at 95% in relation to those who would highly recommend/recommend the Musculoskeletal (MSK) physiotherapy team.
2.5.7 Delivery of the plan to manufacture 100% of bespoke chemotherapy doses over the Christmas period, this has been the first time in five years that this has been achieved.
2.5.8 The Care Group will be exploring the opportunity of providing aseptic manufacturing services to external customers.

Cost Improvement Programmes (CIPs) Update

3 The Committee received and discussed an update against CIPs:

3.1 The CIP forecast for 2018/19 is £30m, in M9 £4m was achieved against a plan of £2.9m, of which was mainly due to non-recurrent CIPs of £1.8m (45%). The Committee emphasised the importance of converting non-recurrent CIPs to recurrent.
3.2 The YTD delivery of CIPs is £21.6m, which is £1.5m ahead of the plan. The main drivers of this over performance are additional pathology income,

reduction in capital charges due to the transfer of assets, additional 2gether Support Solutions (2gether) savings, and property sales.

3.3 Currently the required £30m CIP target indicates £27.2m (91%) RAG rated green. Confirm and challenge sessions will be held with the Care Groups around developing the red/amber schemes to green, as well as closing the gap to achieve the forecast target, and the development of more recurrent schemes to support the Trust achieving its required 2018/29 financial plan. Additional schemes are also being scoped to ensure the £30m target is met. All of the Care Groups have agreed monthly goals to achieve the £30m target and continue to work hard on achieving their individual planned CIPs forecast.

3.4 The CIPs pipeline identified for 2019/20 is currently circa £27m; of which only £5m are green. It is aimed to turn at least £20m schemes RAG rated green by the end of February 2019.

Month 9 Finance Report:

4 The Committee received and discussed the Month 9 (M9) finance report (attached Appendix 1), the following points were noted in relation to the Trust's financial position:

4.1 The generated consolidated deficit in month of £6m, of which is £1.8m behind plan, with a YTD deficit of £64m and is £40.3m behind plan. The main drivers of this deficit in month are the continuing themes in relation to operational pressures that are leading to significant agency spend on Medical and Nursing staff. Although temporary staffing costs have decreased £0.6m in month, the total agency costs YTD is £13.3m more than planned. Elective activity and income are increasingly falling behind the plan based on increasing inpatient elective activity in Q3 and Q4 as well as reducing outpatient activity following the implementation of the new Patient Administration System (PAS). The main specialty areas showing performance behind plan were noted as; Trauma & Orthopaedic (T&O), ENT, Ophthalmology, Pain Management, Dermatology and Gynaecology.

4.2 Non elective work is over performing but this is insufficient to offset the elective shortfall. The Trust needs to ensure improvements in its elective and outpatient activity, as well as effectively utilising its services to ensure maximum productivity, as if these challenges are not resolved this will impact on the delivery of the planned financial forecast. The Performance, Information and Finance Teams are working well together following the implementation of the new Care Group structure.

4.3 As the Trust is in FSM it is measured against its performance excluding technical adjustments. After these are removed the Trust's YTD Income & Expenditure (I&E) deficit to Month 9 (December) was £29.5m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £23m, which is £6.5m worse than the plan.

4.4 The Trust's cash balance as at the end of September was £8.7m and the Trust's total cash borrowing is now £70.7m, which is forecasted to be £81.6m by the year end.

4.5 The Trust Board has agreed to change the Trust's forecast to a £42.2m deficit (consolidated after NHSI adjustments), and as a result risks have been restated in relation to the new forecast. Risks remain at an estimated £4.4m with regards to the revised year end forecast, the main risks are around the delivery of the CIPs target and delivery of the elective activity. The Trust is working on mitigating these risks for the remainder of the year.

Year End Forecast – Elective Activity and Forecast Update on EKHUFT Position and Assessment of Financial Risks/Actions

5 The Committee received and discussed a report on the year-end forecast for elective activity along with an update report on the financial forecast for the Trust and the expected financial outturn for 2018/19. The key elements and risks were noted:

5.1 There is focussed work on driving forward efficiencies and improvements, this includes daily activity logs that are having positive results with increased activity. Following the implementation of PAS work has been undertaken to identify the main areas of under performance and to understand the movements against the plan. The Operational teams are working extremely hard to improve activity performance over the final quarter of the year.
5.2 Nursing workforce gaps are being filled wherever possible by internal nursing staff to reduce the level of agency spend.
5.3 Changes have been made to the pre-admission processes to ensure that this is a much more robust and smoother process.
5.4 The improved data now available providing a clear and robust operational representation of the Trust's activity.
5.5 The Chief Operating Officer (COO) has written to all the Care Groups reiterating the need to review internal processes to identify any potential efficiency savings that can be made.
5.6 The Committee received assurance that the necessary immediate actions had been implemented and that a robust recovery plan is in place and is being progressed in relation to mitigating the elective activity gap and that the plan is achieved by year end. The recovery plan is discussed and monitored weekly by the Executive Management Team (EMT).
5.7 There remains risks associated with the revised forecast, mainly around the delivery of outpatient and elective work, and ensuring a reduction in agency costs and robust control of temporary staffing.

Financial and Operational Risks Review

6 The Committee received and discussed a report on the financial risks. The principal financial risk to the Trust remains as SRR5 – Failure to achieve financial plans as agreed by NHSI under the FSM regime. The Committee noted the key risks:

6.1 There have been no changes to the residual risk scores.
6.2 There has been a change to one target score, in relation to SRR 16 – Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes, which has decreased from 8 (moderate) to 6 (low).
6.3 There were no financial risks for closure.
6.4 There were no new financial risks to be added to the register.

Highlight Report on the National Constitutional Standards: 4 hour Emergency Access Standard, 18 Week Referral to Treatment (RTT) Standard, Cancer Standards and 6 Week Diagnostic Standard (MD01)

7 The FPC received a highlight report on the National Constitutional Standards. The following key areas were discussed and noted in relation to the Trust's operational performance and activity:

7.1 The Emergency Departments (EDs) were significantly challenged during the first two weeks in January around meeting the high demand, performance was also impacted due to lack of capacity in the community.

7.2 Emergency Care performance for the 4 hour target has decreased significantly at 79.36% against the NHSI trajectory of 88.6% compared to the previous month. There were no 12 hour trolley waits, the 60 minute time to treatment decreased from the previous month from 52.7% to 48.7%, reflecting the higher acuity and increased ambulance attendances.

7.3 The ED improvement plan continues to be embedded around improving flow across the sites and ensuring that the winter capacity plan is intrinsically integrated. Daily focus is maintained on internal and external delays to reduce stranded and super stranded patients. The Trust has improved to 37th place from the lowest place the previous year from the position of 2nd last in the Country.

7.4 Performance against the Referral to Treatment (RTT) standard of 72.42% against a trajectory of 81.40%. All specialities failed to meet their trajectory. The total waiting list reported 53,169 patients against trajectory of 38,938, 74 patients are currently waiting over 52 weeks against a trajectory of 150. An RTT recovery plan has been developed around the implementation of urgent actions to improve performance during the last quarter of 2018/19.

7.5 Cancer 62 day performance at 82.21% against a trajectory of 83.12%. The total number of patients on an active cancer pathway at the end of the month was 2,589, there are 8 patients waiting 104 days or more for treatment or potential diagnosis. Improvement plans are in place on all tumour sites and cancer pathways, the actions around these improvement initiatives are beginning to show improvement and are reviewed monthly at the Contract Performance Meeting. The Trust achieved compliance against the 2 week wait (2ww) performance.

7.6 Diagnostics performance was met with a compliance of 99.56% against a trajectory of 99.11%. There were 54 patients who had waited over 6 weeks for their diagnostic procedure. The demand for sleep studies continues and the robust plan developed in response to the increased demand remains to have a positive impact.

7.7 The Committee acknowledged and congratulated the Trust staff for their continued hard work in relation to ensuring performance was moving in the right direction and for the implementation of the actions that were resulting in positive improvements.

Review of Standing Financial Instructions (SFIs)

8 The FPC received and noted the revised SFIs, which had been presented and approved at the January Integrated Audit and Governance Committee (IAGC), the final version will be presented to the Board in March for approval. The key amendments are noted below:

8.1 Changes taking account of the management structure change from Divisions to Care Groups and the setting up of the Trust's wholly owned subsidiary.

8.2 The significant change around the introduction of a £1m contract value limit over which Board approval is required for requisitioning goods and services.

8.3 The Committee requested a couple of minor additional amendments, which have been incorporated in the version presented to the Board for approval that is appended to the IAGC Chair's Report.

Revenue Management Process (Clinical Coding)

9 The FPC received and discussed a report in relation to strengthening the revenue cycle management process following a review of this process in collaboration with the Care Group Clinical Directors and Consultants. The development of this project, which was supported by the Committee will ensure accurate data and provide assurance to the Trust that all activity carried out is recorded and coded accurately, and that the Trust is appropriately re-imbursed for this activity. It will also ensure the safety monitoring of each clinician, nurse and procedure. The Committee will receive an update in three months on progress of the project following its implementation.

Winter Capacity Schemes Briefing Update

10 The FPC received and noted a briefing update on the implementation of the winter capacity plan in relation to efficiently managing access across the Trust and delivery of the internal winter schemes. The key elements are noted below:

10.1 Delivery of the workforce plan providing staffing to the ED Observation Wards and Kings C2 winter ward at William Harvey Hospital (WHH) through a range of managed service agency and substantive recruitment. Recruitment into substantive posts is on-going to enable withdrawal from agency nursing and reduce costs.

10.2 The Observation Ward at Queen Elizabeth the Queen Mother Hospital (QEQMH) received its first patients on the 10 January 2019 and this has been a huge morale boost to the staff working within the Emergency Floor. This ward provides a quiet, calm clinical area for patients to wait for on-going assessment or treatment. It is anticipated that the Observation Ward at WHH will be open during February 2019.

10.3 The Orthopaedic bridging project has been fully implemented on St Lawrence Ward and in the Day Surgery Unit at Kent & Canterbury Hospital (K&CH).

10.4 The ED Rapid Response team has been implemented across the emergency floor and is making an impact on the number of patients who are able to be discharged home with support.

10.5 A training and awareness programme has been implemented to improve the length of stay (LoS).

10.6 Implementation of the Rapid Transfer Service covering all ward areas outside of the emergency floor.

10.7 The model for frailty has been agreed and a Frailty Consultant is available daily to the emergency floor.

Strategic Investment Group (SIG)

11 The FPC received and noted a report from the SIG along with the confirmed minutes. This group is an approval and recommendatory group that focuses on corporate priority business cases.

18 December 2018 Meeting

The Committee reviewed the following matters:

Financial Special Measures (FSM) Update:

12 The Committee received a verbal update from the Director of Finance and Performance on FSM, around the Trust's proposals for the delivery of the financial plan in 2018/19, as well as 2019/20 and beyond. The key areas of focus for the Trust to exit FSM is around driving forward elective activity for the remainder of the financial year to ensure its plan is achieved and providing an explanation of the reasons if the plan is not delivered.

Care Group Presentations

13 The Committee received presentations from the Surgery – Head and Neck, Dermatology and Breast Care Group, as well as the Surgery and Anaesthetics Care Group.

13.1 The Surgery – Head and Neck, Dermatology and Breast Care Group presentation was delivered by its Clinical Director and Finance Lead. Key issues discussed for M8 are noted below:

13.1.1 The Care Group's overall budget of £25m, comprising 35 to 40 consultants, with a significant amount of activity that the majority of which are day cases.

13.1.2 Income was £2.1m below plan.

13.1.3 Elective activity under performance in dermatology, ophthalmology, ENT and maxillofacial surgery, and outsourcing and insourcing plans are in place to recover income. A gap of £300k in the current CIPs plan.

13.1.4 Referrals from primary dental care were slightly lower than projected; referrals from non-primary care were higher due to follow-ups being coded as referrals and this would be corrected; new outpatients were above plan; elective day patients were below plan and the main issues for this are around ophthalmology and ENT; non-elective inpatients activity was much higher than the plan.

13.1.5 Work is progressing well around reducing agency costs whilst ensuring that services are run safely.

13.2 The Surgery and Anaesthetics Care Group presentation was delivered by its Clinical Director and Finance Lead. Key issues discussed for M8 are noted below:

13.2.1 The Care Group is one of the largest in the Trust with a budget of £110m, and is responsible for the bed base, theatres, the supporting service of critical care, and the surgical specialties that use the service.

13.2.2 The current £1.6m adverse to plan, actions are being implemented to recover the plan and achieve its financial forecast but the Care Group acknowledges the significant challenges in achieving this.

13.2.3 Behind plan for elective activity YTD, this has been supported by over performance on non-elective activity. The main drivers for the under performance in electives are orthopaedics and pain services, mainly in day case surgery, as well as inpatients for general surgery, urology and orthopaedics. Critical care has been over plan throughout the year in terms of activity and income. The Care

Group was looking at insourcing and outsourcing activity to mitigate the under performance.

13.2.4 The medical workforce rotas are being reviewed to ensure greater efficiencies through planning rotas six to eight weeks in advance, as well as a theatre efficiency programme.

13.2.5 Weekly meetings are held to review agency usage around reducing agency spend.

Month 8 Finance Report:

14 The Committee received and discussed the Month 8 (M8) finance report (attached Appendix 2), the following points were noted in relation to the Trust's financial position:

14.1 I&E at a deficit of £3.6m, £1.95m adverse to plan.

14.2 YTD I&E deficit of £23.4m v £18.9m deficit plan, adverse to plan of £4.5m.

14.3 Clinical income behind plan in month at £0.8m and £4.9m better than plan YTD.

Business Planning 2019/20 to 2021/22

15 The Committee received and discussed a paper regarding the annual business planning process. Noting the progress made to date and the key areas below:

15.1 Business planning principles.

15.2 Business planning assumptions.

15.3 CIP target of £30m.

15.4 The current draft 2019/20 I&E position.

15.5 The Committee approved the 2019/20 business planning principles and assumptions, and the process and timetable for Trust Board approval of the 2019/20 plan. Final Care Group business plans will be completed by the end of February, and the final business plan signed off by the Board mid-March for submission to NHSI.

Cost Improvement Programmes (CIPs) Update

16 The Committee received and discussed an update against CIPs, noting the key points below:

16.1 The CIP forecast for 2018/19 is £30m, of which £2.8m was achieved in M8 against a plan of £2.9m.

16.2 The YTD delivery of CIPs of £17.6m, which is £0.4m ahead of plan.

16.3 Current RAG ratings for the required £30m CIP programme indicates £27.8m (93%) green, the red/amber schemes remaining are being re-assessed to ensure achievement of the required forecast for 2018/19. Additional schemes are being scoped.

16.4 The CIPs pipeline identified for 2019/20 of circa £27m, with a goal set to identify and work up at least £20m to green RAG rated status by 31 December 2018.

Forecast Update on EKHUFT Position and Assessment of Financial Risks/Actions

17 The Committee received and discussed an update report on the financial forecast for the Trust and the expected financial outturn for 2018/19, noting the key risks:

17.1 The Trust retains its original planned year end position of £29.9m deficit. The current challenges and operational pressures do represent a risk and

the Trust is carrying an estimated £7.3m of risk to the year-end position. This is in relation to expert determination and challenges on income, CIP delivery and activity related costs. The Trust seeks to mitigate these risks as it moves through the year.

17.2 The main drivers are the inability of the Trust to meet the planned elective activity levels and the approval of some unplanned schemes to aid winter performance (e.g. opening wards and observation bays). Operational temporary staff costs are ahead of plan and to date have been covered by additional emergency and A&E income.

Financial and Operational Risks Review

18 The Committee received and discussed a report on the financial risks. The Committee noted the key risks:

18.1 There have been no changes to the residual and target risk scores.

18.2 There were no financial risks for closure.

18.3 There were no new financial risks to be added to the register.

18.4 There has been one new financial risk added to a Care Group risk register; 1510 – Risk of failure to meet financial balance caused by high use of temporary staffing, potential failure to code patients, poor control processes in place, offering of enhanced rate payments. This risk has been added to the Urgent and Emergency Care risk register with a residual risk rating of moderate (9).

18.5 The controls in relation to workforce and agency will be strengthened to reduce the high level of agency spend.

Report on the National Constitutional Standards

19 The FPC received a presentation on the National Constitutional Standards. The following key areas were discussed and noted in relation to the Trust's operational performance and activity:

19.1 Emergency Care performance had decreased at 81.74% against the NHSI trajectory of 89.9%.

19.2 Cancer performance for 2ww had improved at 93.26%, the 31 day standard had also improved at 96.83%, the 62 day standard remained under performing at 71.24% against the NHSI trajectory of 79.01%. Four patients were waiting 104 days or more for treatment.

19.3 Performance against the 18 week RTT standard remained under performing at 72.67% against the NHSI trajectory of 81.84%.

19.4 There were 104 patients waiting over 52 weeks against a trajectory of 125.

Business Planning Update Report 2019/20 to 2021/22

20 The FPC received and noted an update report regarding business planning 2019/20 to 2021/22, outlining the proposed annual business planning process to ensure the Trust has plans in place to deliver its strategy, good quality care and achieve a sustainable financial position acceptable to regulators.

Getting it Right First Time (GIRFT)

21 The FPC received and discussed a report regarding the GIRFT programme and its methodology to improve the quality of clinical outcomes, reduce unwarranted variation and complications, and using data sets to benchmark specialities against national data. This will facilitate sharing of best practice between Trusts and identifying changes that will help improve care and patient outcomes, as well

as delivering efficiencies such as the reduction of unnecessary procedures and cost savings. The GIRFT data and methodology is being reviewed and led by frontline clinicians who are specialist experts who practice and manage services in the areas they are reviewing. The Committee noted the GIRFT programme along with the schedule of specialities planned to be visited in 2018/19. Visits already undertaken include; trauma and orthopaedics, emergency medicine, general surgery, urology, vascular, spinal surgery, ophthalmology, obstetrics and gynaecology, paediatric general surgery, stroke, endocrinology, ear, nose and throat, dentistry, oral and maxillofacial, and diabetes.

Strategic Investment Group (SIG)

22 The FPC received and noted a report from the SIG along with the confirmed minutes. This group is an approval and recommendatory group that focuses on corporate priority business cases.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and approve the FPC report.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Finance Performance Report 2018/19

December 2018

Director of Finance and Performance Management
Philip Cave

We care

Contents and Appendices

Month 09 (December) 2018/19

Contents

Contents	Page
Executive Summary	3
Income and Expenditure Summary	4
Key Highlights	5
Cash Flow	8
Risks and Opportunities	10
Clinical Income	11
Clinical Activity	12
Non Clinical Income	13
Pay	14
Non-Pay	15
Cost Improvement Summary	16
Capital Expenditure	17
Statement of Financial Position	18
Working Capital	19
Care Group Performance	20

Appendices

Appendices	Page
A. Year on Year Analysis	30
B. Cash Flow	31
C. Clinical Income - by Commissioner	32
D. KPIs	33
E. CIP Summary and Plan Phasing	34
F. Debtor Balances	36
G. Pay Analysis - Temporary Staff	38

Executive Summary

Month 09 (December) 2018/19

Executive Summary

The Trust has generated a consolidated deficit in month of £6m (£1.8m behind plan) and a year to date (YTD) deficit of £64m which is £40.3m behind plan. The main drivers of the deficit in month are the continuing themes whereby operational pressures are leading to significant Agency spend on Medical and Nursing staff but Elective activity and income are increasingly falling behind a plan which was based on increasing inpatient elective activity in Q3 and 4 as well as a slowing down of outpatient work following the PAS implementation .The main specialties showing performance behind plan are Trauma & Orthopaedic (T&O), ENT, Ophthalmology, Pain Management, Dermatology and Gynaecology. Whilst non elective work is over performing it is insufficient to make up for the elective shortfall. In addition to these drivers the YTD position is impacted by a £34.3m impairment. Reserves now remaining are very small and the financial position relies on the delivery of increased elective and outpatient activity over the coming three months which, if not delivered, will lead to a failure to deliver the revised financial forecast.
As the Trust is in FSM it is measured against its performance excluding technical adjustments. After these are removed the Trust's YTD I&E deficit to Month 9 (December) was £29.5m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £23m, £6.5m worse than plan. A reconciliation of the various adjustments is presented below.

	This Month			Year to Date		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
EKHUFT Income (inc PSF)	46,809	46,747	(62)	437,374	446,482	9,108
EKHUFT Pay	(30,607)	(31,471)	(864)	(274,137)	(285,766)	(11,629)
EKHUFT Non-Pay	(20,353)	(21,519)	(1,166)	(187,073)	(225,833)	(38,760)
EKHUFT Financial Position (inc PSF)	**(4,151)**	**(6,243)**	**(2,092)**	**(23,836)**	**(65,117)**	**(41,281)**
Subsidiaries Financial Position	16	287	271	95	1,074	979
Consolidated I&E Position (inc PSF)	**(4,135)**	**(5,956)**	**(1,821)**	**(23,741)**	**(64,043)**	**(40,302)**
Impairments/ Donated Assets Adjustment	86	(65)	(151)	767	34,581	33,814
PSF Funding	0	0	0	0	0	0
Consolidated I&E Position (excl PSF)	**(4,049)**	**(6,021)**	**(1,972)**	**(22,974)**	**(29,462)**	**(6,488)**

Trust unconsolidated pay costs in month of £31.5m are £0.4m less than November. Although substantive costs have increased £0.1m as we become more successful at recruitment (net 62 WTE increase in month) temporary staffing costs have decreased £0.6m in month due to a lower levels of Agency and Bank costs for Nursing and Medical staffing. During the Christmas period it is normal for these staffing groups to reduce as workers are less willing to cover the holiday period. This is not therefore expected to be a long term trend. When measured against Budget, pay is over spent by £0.9m. The main driver for the overspend continues to relate to above plan usage of clinical agency and bank staff. All Care Groups contribute to the overspend. The pay spend includes £3.6m year to date and £0.4m year to date of pay awards relating to Agenda for change not previously budgeted for. Agency costs are now £13.3m more than plan YTD driven by operational pressures. Permanent staff costs (including Overtime and waiting list work) are £3m less than plan YTD driven by all staff groups other than HCA's.

Clinical income was behind plan by £1.7m in month. Once the impact of pay awards income funding (£0.4m, not included in the plan) is adjusted the net position in £2.1m less than plan for the month. The YTD position is now £3.2m ahead of plan but once pay awards income funding (YTD £3.7m) and prior year reserve releases (£3m) are removed the net position is £3.5m behind plan. The key drivers remain over performance of non-electives, A&E and ITU offset by under performance in pass through drugs, elective and Outpatient activity. Month on month income has decreased £3.9m as activity in almost all areas, other than A&E, has decreased during the Christmas period. Other income is £1.7m ahead of plan in month (driven by one off gains from property sales and capital goods scheme benefits) and above plan £5.9m YTD driven by the month 9 drivers as well as the SERCO termination payment and the impact of Trust charges to 2Gether which are offset in expenditure by higher non pay charges from the subsidiary.

Against the full year £30m CIP target, including income, £21.6m of CIPS have been delivered YTD against a target of £20.1m, £1.5m ahead of plan. CIPs achieved in Month 9 were £4m and £1m ahead of plan due to the one off benefits of property sales and the capital goods scheme VAT reclaim. Agency and Procurement schemes slightly under delivered in month. CIPs in December amounted to £2.2m recurrent and £1.8m on a non-recurrent basis. The YTD position is recurrent £13.3m and non-recurrent £8.3m.

The Trusts cash balance as at the end of September was £8.7m, which is £4.8m above plan. The Trust's total cash borrowing is now £70.7m and is forecast at £81.6m by the year end.

The Trust Board has agreed to change the Trust forecast to a £42.2m deficit (consolidated after NHSi adjustments). As a result risks have been restated in relation to the new forecast. An estimated £4.4m of risk remains in regard to the revised year end Forecast. The main risks relate to CIP delivery and the delivery of elective activity. The Trust will seek to mitigate these risks as we move through the remainder of the year.

Income and Expenditure A

Overall Income has met plan in Month 9, due largely to low clinical income being offset with Other Income benefiting from VAT reclaims and asset sales. Under delivery of Elective and Outpatient activity is mainly caused by increased activity plans in the second half of the year and lower than planned CIP delivery. Month on Month elective income has decreased £0.9m due to the Christmas break. A significant improvement in monthly elective and out patient activity will be required to deliver the forecast at year end. Elective under activity is being supported by outsourcing to the independent sector. This will improve waiting lists but provides no real financial benefit.
Pay performance is adverse to plan in November by £0.9m and by £11.6m ytd (4.2%). The main driver for the pay overspend in month continues to be above plan usage of agency staff for medical cover. Pay CIPs are adverse to plan in month by £0.5m and by £3.6m ytd. Total expenditure on pay in December was £31.5m, £0.4m lower than in November due to reduced agency staffing
Non Pay expenditure is adverse to plan in December by £1.5m and by £6.3m ytd. This is predominantly due to expenditure procured through 2Gether and phase 2 staffing transfers to the subsidiary which are now accounted for as part of the Operated Healthcare Facility , rather than the various pay and non pay headings as previously planned. The original financial plan did not include the pay to non-pay transfers for 2gether but on consolidation these payments are matched by corresponding adjustments in the 2gether accounts.

Cash G

The Trust's cash balance at the end of December was £8.7m which is £4.8m above plan. The main drivers for the YTD position are as follows:-

- CCG payments are net £7.4m below plan due to the lowering of the contract value .
- HMRC VAT returns are £6.9m below plan
- Other NHS receipts are £5.1m above plan
- Other Income is £12m above plan
- Loans from DHSC are £8.4m above plan
- Unplanned receipts from 2Geather are £17.1m
- Payroll is £4.1m below plan and
- Creditor payments including non pay, agency and capital are £27.6m above plan net.

The Trust borrowed £5.2m cash in month increasing total borrowings to £70.7m. The total expected borrowing by the end of the year will be £81.6m.

Capital Programme A

The Trust has spent £8.8m on capital to December which is £3.3m behind plan. In year the Trust received £6.4m additional capital funding which has used to build 2 observation bays in it's A&E Departments. Originally this was to be mostly spent by the end of November but has now slipped. In addition IT spend is running behind plan. The whole capital plan is being reviewed to ensure full delivery of the revised £23.4m capital programme for 2018/19.

Cost Improvement Programme G

Net CIPs in month were £1m ahead of plan bringing the YTD position to £1.5m ahead of plan at £21.6m of savings YTD. The main variances in month relate to slow delivery of agency reduction and procurement efficiencies whilst one off benefits from overage on the value realised by KCC on assets the Trust had sold to them previously and recognition of a VAT reclaim on the sale of stock to 2hgeather have benefited delivery in month. The forecast is circa £28.6m for the full year driven mainly by shortfalls in Agency reductions and Patient Flow Schemes.

Income and Expenditure Summary

Month 09 (December) 2018/19

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	7,963	6,973	(990)	77,324	69,058	(8,266)	103,209
Non-Electives	13,263	13,250	(13)	121,417	125,561	4,144	161,862
Accident and Emergency	2,106	2,371	265	19,692	21,839	2,147	26,226
Outpatients	6,119	5,139	(980)	60,657	56,779	(3,877)	81,011
High Cost Drugs	4,727	3,975	(752)	41,935	40,372	(1,563)	55,662
Private Patients	21	10	(11)	189	220	31	248
Other NHS Clinical Income	8,797	9,618	820	81,837	92,409	10,573	109,496
Other Clinical Income	154	94	(59)	1,382	1,403	21	1,845
Total Clinical Income	**43,149**	**41,430**	**(1,720)**	**404,431**	**407,641**	**3,210**	**539,558**
Non Clinical Income	3,660	5,317	1,657	32,943	38,841	5,898	44,059
Total Income	**46,809**	**46,747**	**(62)**	**437,374**	**446,482**	**9,108**	**583,617**
Expenditure							
Substantive Staff	(27,601)	(27,643)	(42)	(249,698)	(246,676)	3,022	(326,479)
Bank	(1,111)	(1,367)	(256)	(10,077)	(11,442)	(1,365)	(19,900)
Agency	(1,895)	(2,461)	(566)	(14,362)	(27,648)	(13,286)	(19,431)
Total Pay	**(30,607)**	**(31,471)**	**(864)**	**(274,137)**	**(285,766)**	**(11,629)**	**(365,810)**
Non Pay	(18,115)	(19,576)	(1,461)	(167,155)	(173,430)	(6,275)	(222,146)
Total Expenditure	**(48,722)**	**(51,048)**	**(2,326)**	**(441,292)**	**(459,196)**	**(17,903)**	**(587,956)**
Non-Operating Expenses	(2,238)	(1,942)	295	(19,918)	(52,404)	(32,485)	(26,648)
Income and Expenditure Surplus/(Deficit)	**(4,151)**	**(6,243)**	**(2,092)**	**(23,836)**	**(65,117)**	**(41,281)**	**(30,987)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	43,841	34,728	(9,113)	410,651	407,881	(2,770)	547,857
Non Clinical Income	3,546	11,592	8,046	31,910	43,889	11,979	42,682
Total Income	**47,387**	**46,320**	**(1,067)**	**442,561**	**451,770**	**9,209**	**590,539**
Expenditure						-	
Pay	(30,960)	(33,677)	(2,717)	(277,322)	(297,551)	(20,229)	(370,054)
Non Pay	(18,303)	(17,758)	545	(168,853)	(166,963)	1,890	(224,416)
Total Expenditure	**(49,263)**	**(51,435)**	**(2,172)**	**(446,175)**	**(464,514)**	**(18,339)**	**(594,470)**
Non-Operating Expenses	(2,259)	(841)	1,418	(20,127)	(51,299)	(31,172)	(26,924)
Income and Expenditure Surplus/(Deficit)	**(4,135)**	**(5,956)**	**(1,821)**	**(23,741)**	**(64,043)**	**(40,302)**	**(30,855)**

Clinical Income

Income from Commissioners in month was behind plan. Non elective income remains higher than planned YTD, while elective income is showing a large negative variance due to a phased increase in plan as the CIP schemes were expected to start and lower than normal run rates recorded. The majority of the adverse variances are contained within Electives, Outpatients and Non-PbR. A reduction in outpatient attendances was expected in September and following the implementation of the new PAS system, but this now appears to have continued into Quarter 3. Clinical Income contains £0.4m funding received in month to cover the pay awards which is included under "Other NHS Clinical Income" and for which there is no clinical income plan.

There remains a small amount of uncertainty around the financial impact of 2017-18 Expert Determination challenges on 2018-19 baseline as both commissioners and the Trust work through the implications of the way some of our activity is recorded. The Trust is holding a small provision against this risk.

NHSE Contracts are behind plan in month by £278k. Rechargeable expenditure such as high cost drugs, devices and haemophilia blood products under performed by £850k in month across all contracts. The Trust contract with NHSE includes £4.1m of QIPP expectation with the Trust agreeing to work with NHSE to implement cost savings where possible, however, the risk against non achievement sits with the commissioner.

Non Clinical Income and Expenditure

Non clinical income is favourable to plan by £1.7m in December and by £5.9m ytd. Income CIPs are favourable to plan in December and by £2.2m ytd. The variance in month predominantly relates to estimated income for KCC property sales overage, capital goods scheme benefits and profits on the disposal of assets totalling £1.4m. Unplanned income for goods and services provided to 2gether accounts for £0.2m of the favourable variance in month.

Total expenditure is adverse to plan by £2.3m in December and £17.9m ytd. In month, pay is overspent by £0.9m again mainly driven by temporary staffing spend, although actual spend on medical agency staff fell by £0.5m in December when compared to November. Non pay is overspent by £1.5m in December, mainly relating to supplies and services general which is £1.6m adverse to plan due to phase two staffing transfers to the subsidiary and IHSS contract catch up costs totalling 1.5m.

The expenditure run rate fell by £0.2m when compared to November, with pay spend reducing by £0.4m (mainly medical agency) and non pay increasing by £0.3m. Reductions in spend on drugs, premises and external commissioning totalling £1.1m are offset by increases in non clinical supplies (mainly IHSS contract), education and training and clinical negligence (additional rebate received in November) totalling £1.3m.

Key Highlights

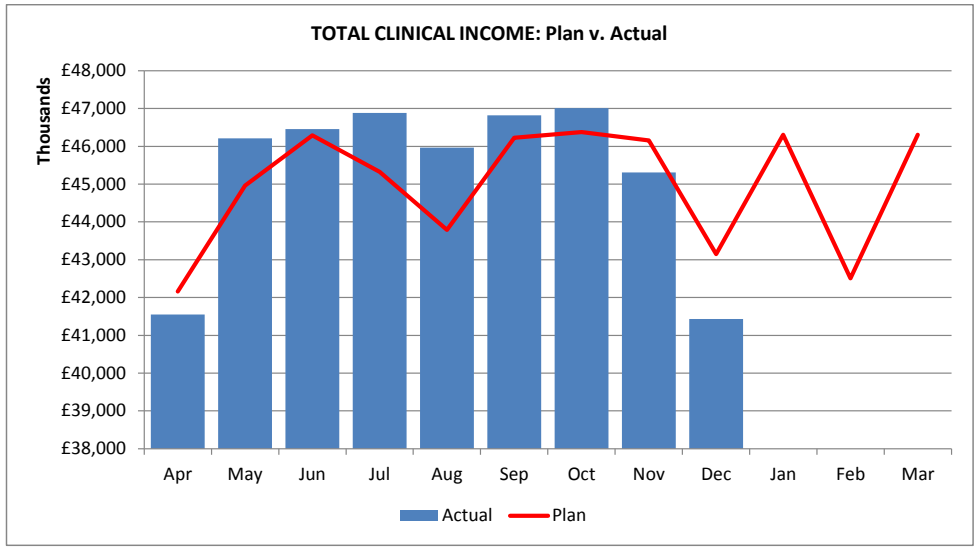
Month 09 (December) 2018/19

CLINICAL INCOME

Clinical income is under plan in December by £1.7m. Non-Elective income is on plan, while Elective income is under planned levels by £1.0m due to increased activity plans in the second half of the year. There was also the expectation that CIP targets would be achieved. Outpatients are under performing by £1.0m. Non-Elective casemix has reduced post PAS implementation and the teams at WHH and QEQM are investigating the recording of treatment and investigations to ensure all diagnostics are captured. A&E Income is also ahead of plan in month by 12.5% driven by activity increases. Much of the Elective CIPs are held centrally and services are finding it difficult to meet these income targets each month. Higher than planned levels of regular day attenders continue which is generating a lower case mix variance resulting in lower average tariffs within Electives.

ACTIVITY

A&E demand is ahead of plan by 6% this month. This over performance follows on from the last quarter and continues to improve against recent trends which was driven by the temporary transfer of some ED specialties from KCH to WHH and QEQM. Non-elective activity has performed on plan in month. The commissioners have increased the provision of care packages with a view to returning patients home more quickly and as part of their QIPP schemes are investing in preventing patients with Pneumonia from coming to the hospital where they can be treated at home. Outpatient activity is behind plan in month and YTD. Elective activity is 11.5% behind plan in month.



COMMISSIONER ANALYSIS

Activity plans reflected commissioner QIPP schemes to the value of £3.1m YTD. Any new commissioner QIPP schemes will be added to the contracts via a contract variation once the Trust is satisfied that the schemes are achievable in the timeframes set out. GP referrals were 1.6% ahead of plan in December. Many of our outpatient services are now listing at 13 weeks and beyond, but continued focus on reducing 52 week waiters is producing positive results.

The Trust has agreed an April and May closedown position with East Kent CCGs and both parties had committed to a financial reconciliation and closedown of Q1 by the 1st October 2018. However, EK CCGs have subsequently challenged the Q1 outturn and it has not yet been possible to enact the closedown. Negotiations are ongoing. The Trust does not foresee any risk to our reported position.

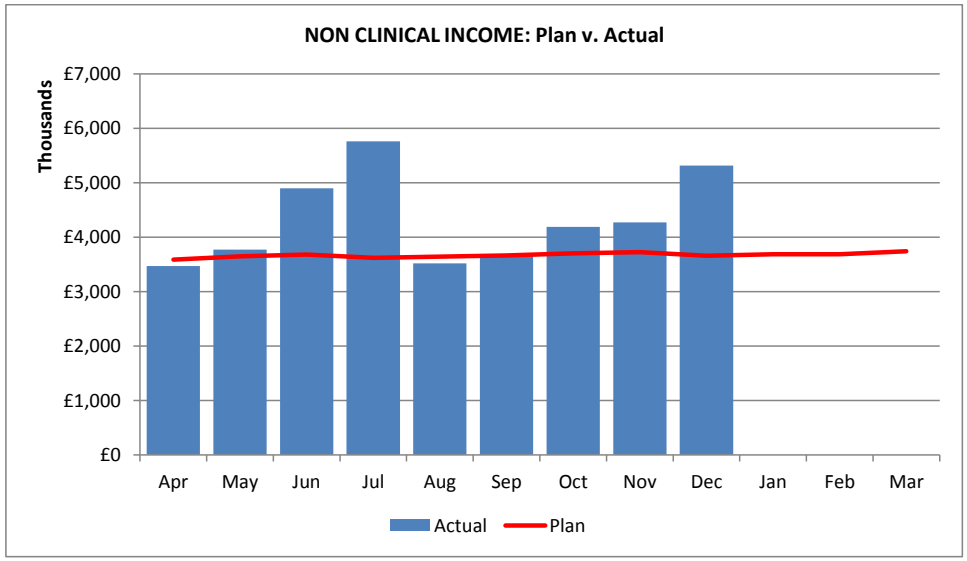
Key Highlights

Month 09 (December) 2018/19

NON CLINICAL INCOME

Non clinical income is favourable to plan by £1.7m in December and by £5.9m ytd. Income CIPs are marginally favourable to plan in December and by £2.2m ytd.

The variance in month predominantly relates to estimated income for KCC property sales overage, capital goods scheme benefits and profits on the disposal of assets totalling £1.4m. Unplanned income for goods and services provided to 2gether accounts for £0.2m of the favourable variance in month. Other main headlines for the favourable performance ytd are income received from Serco following early exit from the contract of £2.1m, goods and services provided to the subsidiary in previous months of £1.3m and income relating to the PAS project of £0.6m.

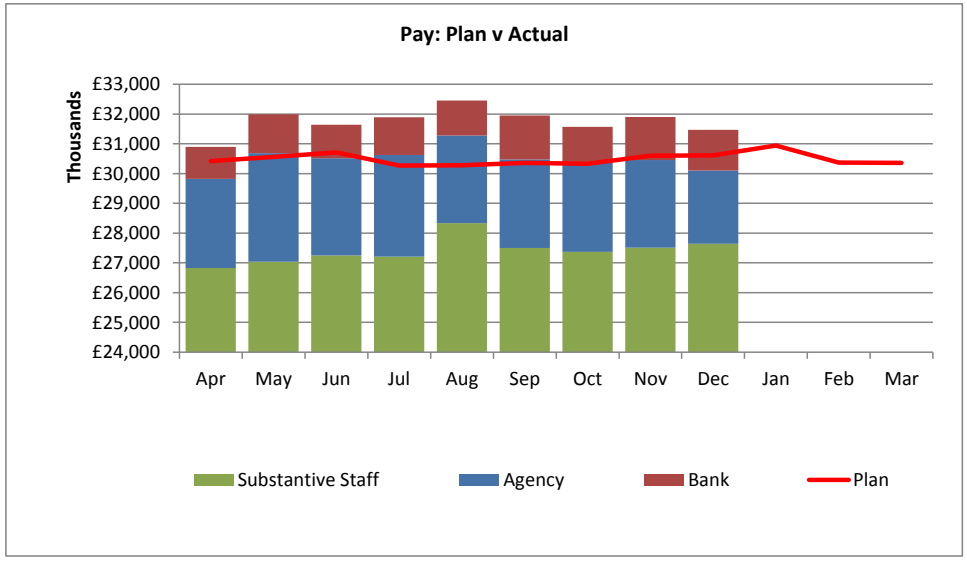


PAY

Pay performance is adverse to plan in December by £0.9m and by £11.6m ytd (4.24%). Pay CIPs are adverse to plan in month by £0.5m and by £3.6m ytd. The estimated AfC pay award excess impact not included in the base plan (funded in-year by the DOH in Clinical Income) is c£0.4m in month and £3.7m ytd.

Total expenditure on pay in December was £31.5m, £0.4m lower than in November with all of the reduction relating to expenditure on medical agency staff, predominantly in General and Specialist Medicine and Surgery and Anaesthetics Care Groups.

The main driver for the pay overspend in month and ytd continues to relate to above plan usage of agency staff totalling £0.6m in month and £13.3m ytd.



Key Highlights

Month 09 (December) 2018/19

NON-PAY

Non Pay expenditure is adverse to plan in December by £1.5m and by £6.3m (3.75%) ytd. Non pay CIP schemes are adverse to plan in total by £0.4m in month and by £6.0m ytd.

The main expenditure heading driving the overspend in December is supplies and services non clinical which (excluding the effect of pass through expenditure from the subsidiary) is £1.6m adverse to plan. Phase two staffing transfers to the subsidiary and unachieved CIP targets account for £1.0m of the adverse variance and a catch up from prior periods in the reporting of IHSS contract costs via the subsidiary has resulted in an overspend on the OHF contract of £0.5m. A favourable variance on drug spend of £0.9m is offset by overspend on clinical supplies totalling £0.7m.

Non pay actual expenditure in December increased by £0.3m when compared to November. Reductions in spend on drugs, premises and external commissioning totalling £1.1m are offset by increases in non clinical supplies (including IHSS contract), education and training and clinical negligence (additional rebate received in November) totalling £1.3m.

DEBT

Total invoiced debtors have decreased from the opening position of £28.5m by £8.2m to £20.3m. The largest debtors at 31st December were East Kent CCGs £5.2m, East Kent Medical Services £2.2m and 2gether support solutions £1.7m

CAPITAL

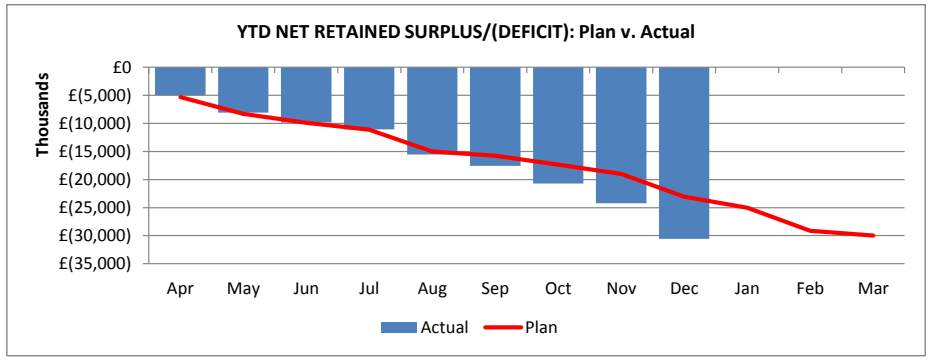
Total YTD expenditure for Mth 9 2018/19 is £3.3m below plan mainly driven by slower than planned delivery of the observation bays.

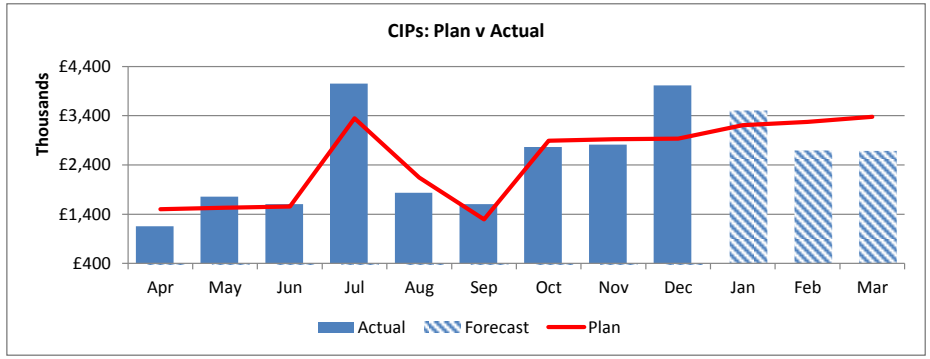
EBITDA

The Trust is reporting a year to date deficit EBITDA of £12.7m

CASH

The closing cash balance for the Trust as at 31st December was £8.7m





FINANCING

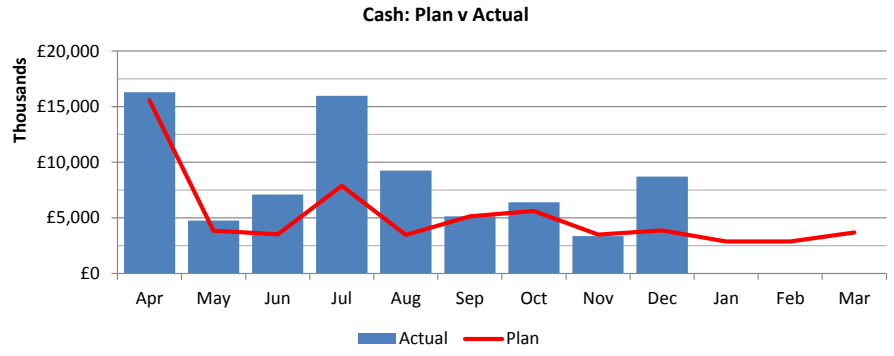
£1.5m of interest was incurred in respect of the drawings against working capital facilities to 31st December 2018.

CIPS

The target for the year is £30m. The Trust is maintaining confirm and challenge meetings. As at the time of reporting, c.95% of schemes were 'green' rated . The major focus is on delivering 18/19 schemes and progressing 'red' and 'amber' schemes to 'green'. Care Groups, supported by the PMO, are being asked to work up schemes for 2019/20.

Cash Flow

Month 09 (December) 2018/19



Unconsolidated Cash balance was £8.7m at the end of December 2018, £4.8m above plan.

Total receipts in December 2018 were £11.7m above plan

- Receipts from East Kent CCGs were £0.9m below plan for Main Contract
- Receipt of £13.3m from 2gether for VAT elements of Sale of Assets and Stocks. £0.7m received for October and November Loan invoices.
- Vat reclaim was £10.0m below plan in the month due to a payment to HMRC of £9.4m.
- Receipt of £6.5m for Capital PDC
- Loan received in December of £5.2m, £0.9m above plan
- Other receipts are £1.2m over plan
- Total Payments in December 2018 were £6.7m above plan
- Monthly payroll was £0.2m below plan
- Creditor payments inc Capital were £0.8m above plan
- Payments to 2gether(prev Serco) were £6.1m above plan

YTD cash receipts are £28.4m above plan

- East Kent CCGs are net £7.4m below plan. Payments against contract are £9.7m below plan due to the reduction of their contract value. Payments for overperformance are £2.3m above plan
- Other NHS receipts are £6.1m above plan, which includes £3.8m AfC funding from DoH
- HMRC VAT returns are £6.9m below plan
- STF receipt was £1.4m above plan
- Loans from DHSC £8.4m above plan
- Receipts from 2gether £17.1m above plan
- Other receipts are £10.6m above plan; which includes £2.5m received from Serco and £6.5m capital PDC
- YTD cash payments are £23.5m above plan
- Payroll is £4.1m below plan
- Creditor Payments including Capital are £27.6m above plan

2018/19 Forecast

- The forecast includes restrictions on creditor payment runs throughout the year to ensure that a positive cash balance is maintained
- The impact of 2gether Support Solutions operating fully has been reflected in the Payroll and Creditors payments forecast. Additional changes to the forecast may still be made once the full effects are known.

Provider Sustainability Funding (Formerly Sustainability and Transformation Funding)

The Trust received £5.6m incentive Provider and Sustainability Funding (PSF) relating to 2017/18 in July 2018.
As a result of the Trust not agreeing to a control total, the Trust is not eligible for any PSF funding in 2018/19.

Working Capital Facility

Loan Schedule	Loan Value £'000	Facility Type	Repayment date	Interest rate	Total Interest if full term £'000
2016/17 Received	22,736	ISRWF	17/05/2021	3.5%	3,688
2017/18 Received	23,492	ISUCL	2020/21	3.5%	2,485
Apr' 2018 (Received)	2,234	ISUCL	2021/22	3.5%	323
July' 2018 (Received)	3,410	ISUCL	2021/22	3.5%	359
Aug' 2018 (Received)	3,708	ISUCL	2021/22	3.5%	391
Sept' 2018 (Received)	5,103	ISUCL	2021/22	3.5%	538
Nov' 2018 (Received)	4,869	ISUCL	2021/22	3.5%	515
Dec' 2018 (Received)	5,207	ISUCL	2021/22	3.5%	548
Jan' 2018 (Forecast)	2,037	ISUCL	TBA	TBA	TBA
Feb' 2018 (Forecast)	2,192	ISUCL	TBA	TBA	TBA
March' 2018 (Forecast)	6,661	ISUCL	TBA	TBA	TBA

Planned 18/19 Loan was £27.4m in line with the plan pre technical deficit but on current forecast this will be exceeded.
Future Loans have been rephased due to changes in the forecast

Creditor Management

- Creditor management continued to be applied throughout December 18. The Trust is close to the limit in restricting creditor payments and still being able to receive essential goods and services. At the end of December 2018 the Trust was recording 69 creditor days (Calculated as invoiced creditors at 30th November/ Forecast non pay expenditure x 365)
- The Trust has been flagged in the national press as one of the slowest paying Trusts in the country.

- ISRWF Single Currency Interim Revolving Working Capital Support Facility
- ISUCL Uncommitted Single Currency Interim Revenue Support - this facility replaces the ISRWF as the Trust is in Financial special measures and has a variable interest rate

Income and Expenditure Forecast

Month 09 (December) 2018/19

Unconsolidated

£000	Annual Plan	Forecast	Var.
Income			
Clinical Income	539,558	546,980	7,422
Non Clinical Income	44,059	50,515	6,456
Total Income	**583,617**	**597,495**	**13,878**
Expenditure			
Pay	(365,552)	(383,421)	(17,868)
Non Pay	(222,404)	(234,631)	(12,227)
Total Expenditure	**(587,956)**	**(618,051)**	**(30,095)**
Non-Operating Expenses	(26,648)	(58,050)	(31,402)
Income and Expenditure Surplus/(Deficit)	**(30,987)**	**(78,606)**	**(47,618)**
Add back all I&E impairments/(reversals)	500	34,205	33,705
Remove capital donations/grants I&E impact	525	546	21
Surplus/(Deficit) after technical adjustments	**(29,962)**	**(43,854)**	**(13,892)**

Consolidated

£000	Annual Plan	Forecast	Var.
Income			
Clinical Income	547,857	557,307	9,450
Non Clinical Income	42,682	46,880	4,198
Total Income	**590,539**	**604,187**	**13,648**
Expenditure			
Pay	(370,054)	(401,502)	(31,448)
Non Pay	(224,416)	(223,356)	1,060
Total Expenditure	**(594,470)**	**(624,858)**	**(30,388)**
Non-Operating Expenses	(26,924)	(56,241)	(29,317)
Income and Expenditure Surplus/(Deficit)	**(30,855)**	**(76,911)**	**(46,056)**
Add back all I&E impairments/(reversals)	500	34,205	33,705
Remove capital donations/grants I&E impact	525	546	21
Surplus/(Deficit) after technical adjustments	**(29,830)**	**(42,160)**	**(12,330)**

The Trust's consolidated year end forecast has been amended to a deficit of £42.1m, which has been reported to NHSi following a worsening of the I&E position in Q3. When compared against a deficit control total equivalent (no PSF assumed) of £29.9m, this is £12.2m adverse to plan.

The forecast represented here is the most likely scenario of the Trust but some risks still exist in relation to CIP and elective activity delivery

CIPS of £30.5m have been assumed to support the delivery of the 18-19 forecast.

The unconsolidated forecast for impairments remains unchanged for non-operating expenses. This assessment is subject to review. However, as this forms part of NHSi technical adjustments, the impact is removed and reflected in the adjusted deficit forecast.

The income forecast included is based on the Trusts Activity forecast at the end of November and this is currently under review.

Expenditure includes revised part year effect estimates for business cases approved to support the Winter plan, reflecting expected start dates and likely spend

Work will continue to evaluate the forecast in 'best', 'likely' and 'worst' case scenarios considering current trends, progress against approved investments and identified risks

Risks and Opportunities

Month 09 (December) 2018/19

Risk/Opp	Area	Description	Narrative	Full Year (Risk)/Opp £000	Probability	Impact £,000
Risk	Clinical Income	Failure to deliver Planned activity	Organisation is running well behind planned activity levels which are required to meet the financial Forecast	(6,000)	50%	(3,000)
Risk	CIP Delivery	Red and Amber Schemes to be fully developed	Schemes which do not yet have a fully finalised plans have a higher risk of non delivery	(2,800)	50%	(1,400)
			Total Risk			(4,400)
			Total Opportunity			
			NET (RISK)/OPPORTUNITY			(4,400)

Some risks have been realised and are now included in the Forecast, only remaining risks are shown in the table.

Clinical Income

Month 09 (December) 2018/19

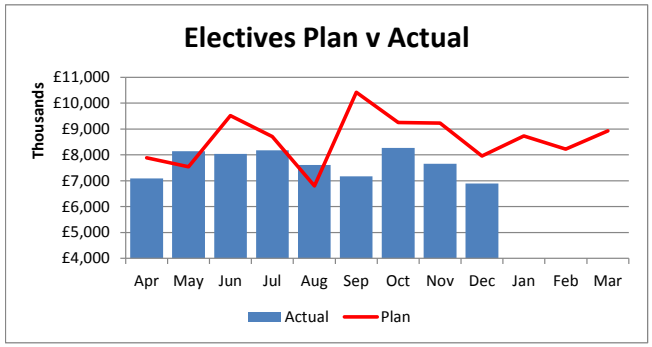
£000	This Month Plan	This Month Actual	This Month Variance		Year to Date Plan	Year to Date Actual	Year to Date Variance		Annual Plan
Electives	7,963	6,896	(1,067)	(13.4%)	77,324	69,058	(8,266)	(10.7%)	103,209
Non-Electives	13,263	13,812	549	4.1%	121,417	125,561	4,144	3.4%	161,862
Accident and Emergency	2,106	2,369	263	12.5%	19,692	21,839	2,147	10.9%	26,226
Outpatients	6,119	5,232	(887)	(14.5%)	60,656	56,779	(3,877)	(6.4%)	81,011
High Cost Drugs	4,727	4,005	(722)	(15.3%)	41,935	40,372	(1,563)	(3.7%)	55,662
Private Patients	21	10	(11)	(53.1%)	189	220	31	16.5%	248
Other NHS Clinical	8,797	9,519	722	8.2%	81,836	92,411	10,574	12.9%	109,496
Other Clinical	154	94	(59)	(38.6%)	1,382	1,403	21	1.5%	1,845
Prior Month Adjustment		(508)	(508)	0.0%		()	()	0.0%	
Total	**43,149**	**41,430**	**(1,719)**	(4.0%)	**404,431**	**407,642**	**3,211**	0.8%	**539,558**
				Adverse				Favourable	

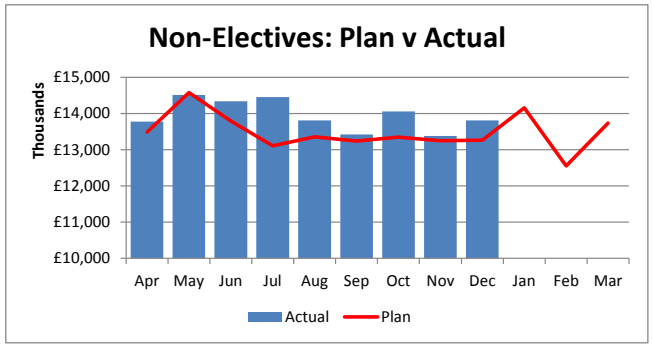
Income has performed under plan in December, due largely to underperformances within Elective Spells, Outpatient activity and Non-PbR. This is partially offset by £0.4m unplanned income to fund Agenda for Change pay awards, while Non-Electives, A&E, and Other NHS Areas also over performed in month.

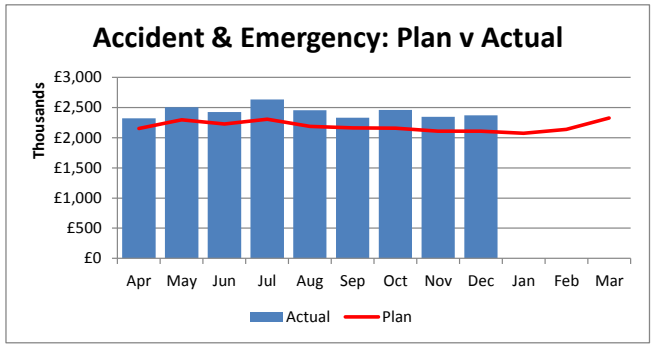
Elective inpatients and Day cases under performed in month by £1.0m as the Elective plan phasing was increased above run-rate incorporating the planned CIP schemes for the second half of the year. The main areas behind plan were T&O, ENT, Ophthalmology, Pain Management, Dermatology and Gynaecology. To mitigate the risk of non achievement, plans for using Independent Sector organisations for the rest of the year are as follows: 18 Week Support in Gastroenterology, Chaucer, One Ashford, SHS and Spencer wing for Trauma & Orthopaedics, DMC to continue to deliver Dermatology activity, Insourcing for Ear, Nose & Throat patients, HBS and Spencer Wing for Ophthalmology outpatient activity and Spencer Wing to help waiting times for Rheumatology Outpatient first attendances. The installation of the two Theatres Pods has been completed at Canterbury, and became operational in December.
Non-Electives were on plan in December.

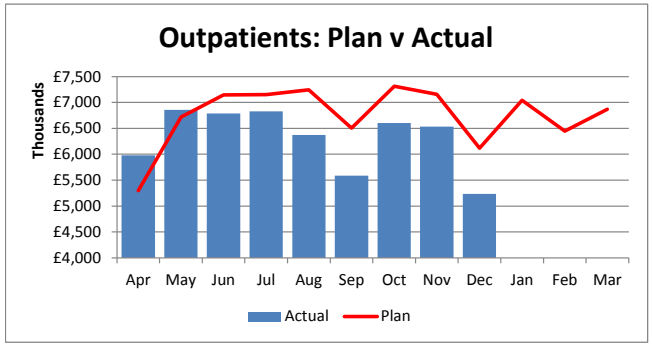
Other NHS Clinical activity is also ahead of plan due to an amount received to cover the increased pay award costs of £0.4m in the month.

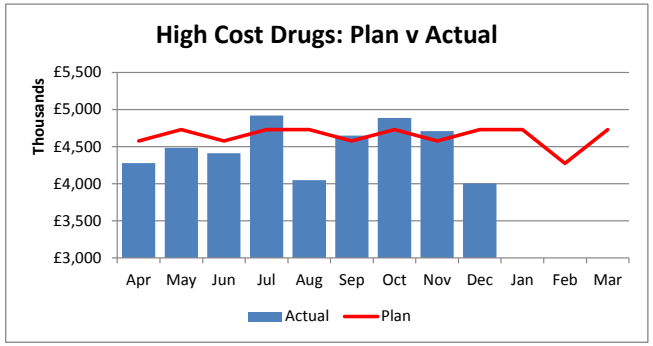
Rechargeable income is behind plan in month with Drugs and Devices £850k below plan. This does not impact the bottom line as there is a corresponding decrease in expenditure.

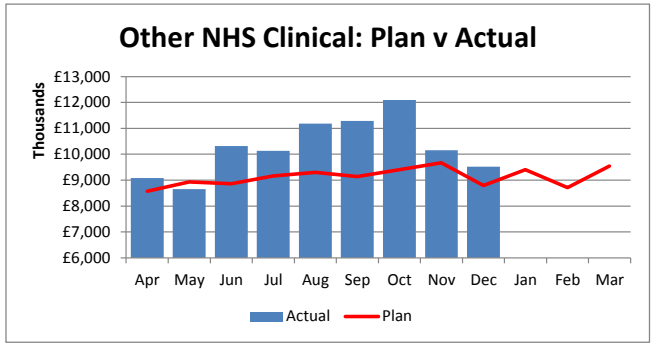












Clinical Activity

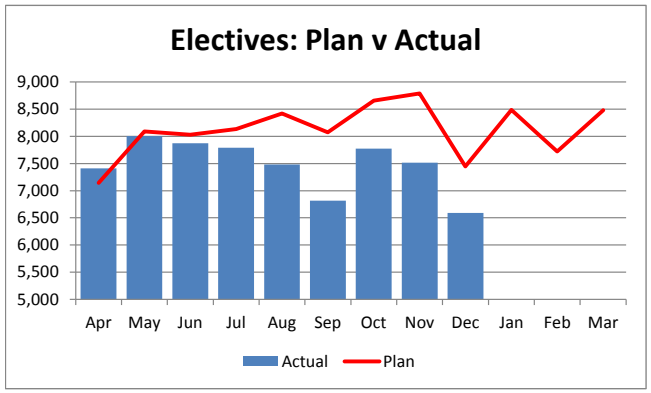
Month 09 (December) 2018/19

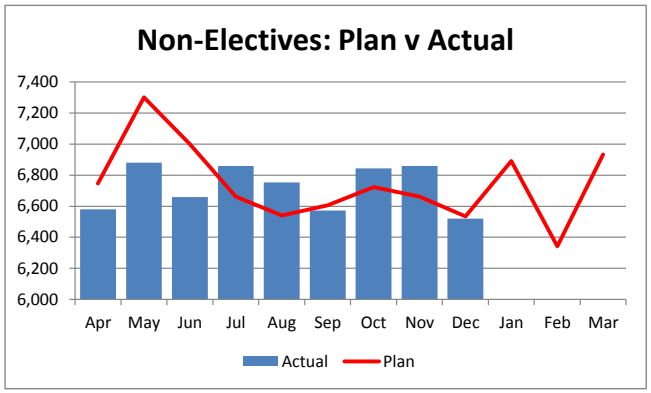
Activity Units	This Month Plan	This Month Actual	This Month Variance		Year to Date Plan	Year to Date Actual	Year to Date Variance		Annual Plan
Electives	7,449	6,591	(858)	(11.5%)	72,789	67,259	(5,530)	(7.6%)	97,477
Non-Electives	6,534	6,520	(14)	(0.2%)	60,777	60,526	(251)	(0.4%)	80,942
Accident & Emergency	16,940	18,022	1,082	6.4%	158,479	166,074	7,595	4.8%	211,076
Outpatients	59,815	51,203	(8,612)	(14.4%)	600,177	566,314	(33,863)	(5.6%)	802,917
Other NHS Clinical	360,517	429,625	69,108	19.2%	4,043,053	4,281,866	238,813	5.9%	5,397,116
Total	**90,738**	**82,336**	**(8,402)**	(9.3%)	**892,222**	**860,173**	**(32,049)**	(3.6%)	**1,192,412**
				Adverse				Adverse	

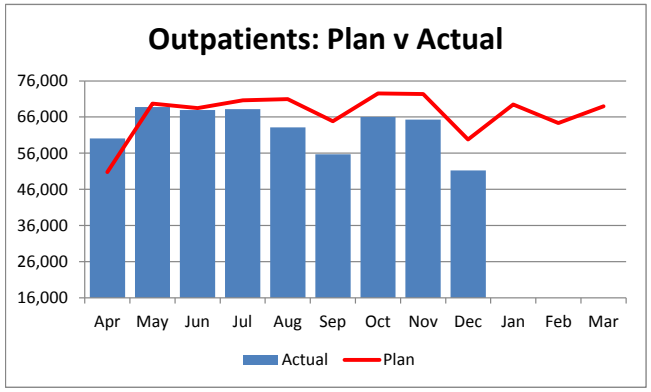
Within Elective activity (11.5% under plan in total), Inpatient activity was 9% under plan largely due to General Medicine (by 116). Day case activity was 19% under plan (T&O 189, Pain Management 186, Dermatology 216, General Surgery 78, ENT 93, Neurology 82 and Rheumatology 72). This is partially offset by continued activity over performance in Regular day attenders of 42%.

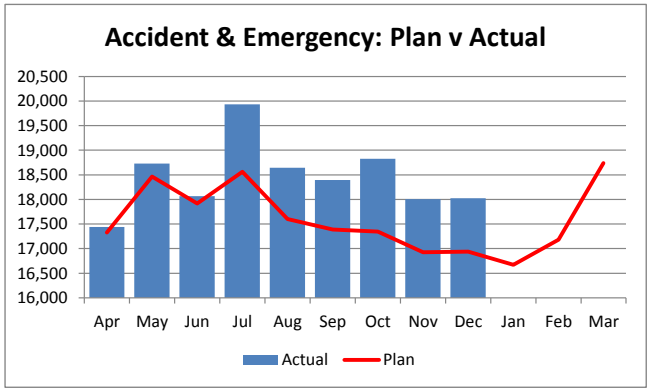
Outpatient activity under performed in month by 14% across new and follow up attendances, many areas were behind plan such as: Urology, General Surgery, T&O, ENT, Ophthalmology, Pain Management, General Medicine, Gastroenterology, Dermatology, Gynaecology, Respiratory Medicine, Diabetic Medicine, Neurology, Rheumatology, Paediatrics, Clinical Oncology, Orthoptics, Occupational Therapy and Physiotherapy, while the only notable over performing specialties were Cardiology and Oral Surgery.

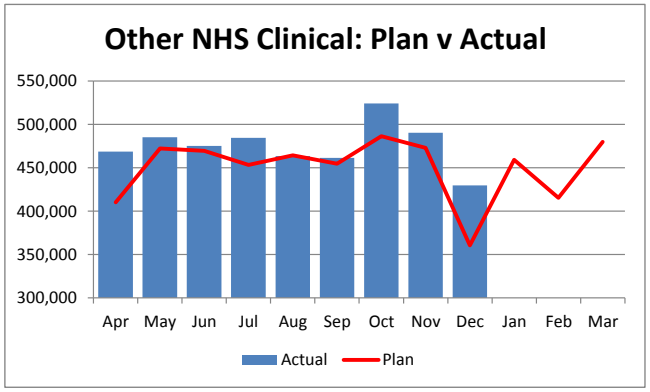
Most specialties reduced activity in September in order to ensure the smooth implementation of the new PAS system, however the run rates since then are lower than the previous M1-5 run rate. This is being investigated by the Care groups, one issue though is the cashing up of Outpatient clinics with 331 not being cashed up in November, in time to charge Commissioners.







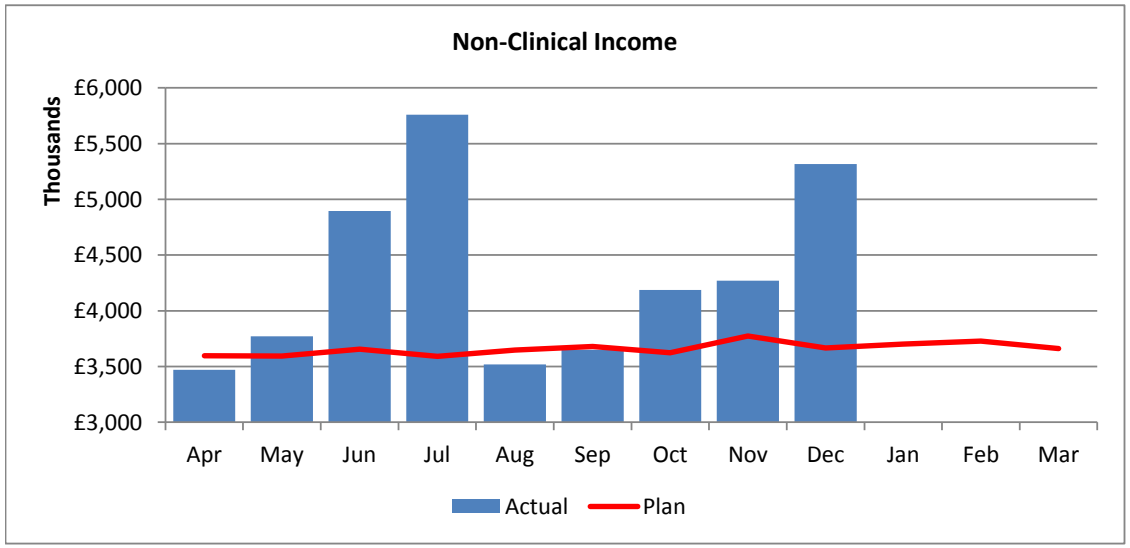




Non Clinical Income

Month 09 (December) 2018/19

Non-Clinical Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,429	1,575	146	12,864	14,207	1,343	17,150
Research and development	223	210	(13)	2,007	2,024	17	2,673
Education and Training	1,269	1,270	1	11,421	11,513	92	15,233
Car Parking income	389	391	2	3,513	3,672	159	4,766
Staff accommodation rental	205	202	(3)	1,828	1,737	(91)	2,494
Property rental (not lease income)	1	1		10	9	(1)	13
Cash donations / grants for the purchase of capital assets	41	209	168	377	369	(8)	500
Charitable and other contributions to expenditure	12	12	()	108	108	()	145
Other	91	1,448	1,357	815	5,203	4,388	1,085
Total	**3,660**	**5,317**	**1,657**	**32,943**	**38,841**	**5,898**	**44,059**
			45.28%			17.90%	
			Favourable			Favourable	



Non clinical income is favourable to plan by £1.7m in December and by £5.9m ytd. Income CIPs are marginally favourable to plan in December and by £2.2m ytd.

The variance in month predominantly relates to estimated income for KCC property sales overage, capital goods scheme benefits and profits on the disposal of assets totalling £1.4m. Unplanned income for goods and services provided to 2gether accounts for £0.2m of the favourable variance in month.

The majority of the over performance ytd relates to income received from Serco following early exit from the contract of £2.1m, goods and services provided to the subsidiary of £1.5m, income relating to the PAS project of £0.6m and benefits in month 9 detailed above totalling £1.4m. A favourable performance on car parking and education and training income totalling £0.3m is offset by and underperformance on staff accommodation income of £0.1m.

Pay

Month 09 (December) 2018/19

Pay Expenditure	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,115	1,041	74	(8,085)	(8,434)	(349)	(73,140)	(72,941)	199	(97,531)
Nurses and Midwives	2,436	2,101	335	(7,647)	(7,771)	(124)	(69,178)	(68,529)	649	(92,248)
Scientific, Therapeutic and Technical	1,400	1,361	38	(4,507)	(4,366)	141	(40,770)	(39,048)	1,723	(54,367)
Admin and Clerical	1,440	1,279	161	(2,858)	(2,675)	183	(25,852)	(24,532)	1,320	(34,474)
Other Pay	1,441	1,346	95	(3,967)	(3,856)	110	(35,892)	(37,084)	(1,192)	(47,859)
Permanent Staff Total	**7,832**	**7,129**	**702**	**(27,063)**	**(27,102)**	**(39)**	**(244,832)**	**(242,133)**	**2,699**	**(326,479)**
Waiting List Payments										
Medical and Dental	0	0	0	(226)	(172)	54	(2,042)	(2,101)	(60)	(2,723)
Waiting List Payments Total	**0**	**0**	**0**	**(226)**	**(172)**	**54**	**(2,042)**	**(2,101)**	**(60)**	**(2,723)**
Medical Locums/Short Sessions										
Medical and Dental	1	28	(27)	(312)	(369)	(56)	(2,824)	(2,441)	383	(3,766)
Medical Locums/Short Sessions Total	**1**	**28**	**(27)**	**(312)**	**(369)**	**(56)**	**(2,824)**	**(2,441)**	**383**	**(3,766)**
Substantive	**7,832**	**7,157**	**675**	**(27,601)**	**(27,643)**	**(42)**	**(249,698)**	**(246,676)**	**3,022**	**(332,968)**
Bank										
Medical and Dental	0	23	(23)	(468)	(372)	97	(4,249)	(2,913)	1,336	(5,654)
Nurses and Midwives	0	84	(84)	(248)	(352)	(104)	(2,247)	(3,024)	(777)	(2,990)
Scientific, Therapeutic and Technical	1	4	(3)	(12)	(18)	(6)	(110)	(181)	(71)	(147)
Admin and Clerical	0	57	(57)	(94)	(153)	(59)	(852)	(1,490)	(638)	(1,133)
Other Pay	0	179	(179)	(289)	(473)	(184)	(2,620)	(3,834)	(1,214)	(3,487)
Bank Total	**1**	**347**	**(346)**	**(1,111)**	**(1,367)**	**(256)**	**(10,077)**	**(11,442)**	**(1,365)**	**(13,411)**
Agency										
Medical and Dental	38	121	(83)	(869)	(1,480)	(611)	(6,582)	(15,334)	(8,752)	(8,906)
Nurses and Midwives	0	154	(154)	(556)	(757)	(201)	(4,216)	(8,463)	(4,247)	(5,704)
Scientific, Therapeutic and Technical	0	19	(19)	(63)	(120)	(57)	(480)	(2,057)	(1,577)	(650)
Admin and Clerical	0	2	(2)	(7)	(11)	(4)	(54)	(162)	(109)	(73)
Other Pay	0	10	(10)	(54)	(53)		(407)	(1,008)	(602)	(550)
Agency Total	**38**	**306**	**(268)**	**(1,549)**	**(2,422)**	**(873)**	**(11,739)**	**(27,025)**	**(15,285)**	**(15,883)**
Direct Engagement - Agency										
Medical and Dental	0	3	(3)	(346)	(39)	307	(2,623)	(623)	1,999	(3,548)
Direct Engagement - Agency Total	**0**	**3**	**(3)**	**(346)**	**(39)**	**307**	**(2,623)**	**(623)**	**1,999**	**(3,548)**
Agency	**38**	**308**	**(270)**	**(1,895)**	**(2,461)**	**(566)**	**(14,362)**	**(27,648)**	**(13,286)**	**(19,431)**
Total	**7,871**	**7,813**	**58**	**(30,607)**	**(31,471)**	**(864)**	**(274,137)**	**(285,766)**	**(11,629)**	**(365,810)**
						-2.82%			-4.24%	
						Adverse			Adverse	

Pay performance is adverse to plan in December by £0.9m and by £11.6m ytd (4.24%). Pay CIPs are adverse to plan in month by £0.5m and by £3.6m ytd. The estimated AfC pay award excess impact not included in the base plan (funded in-year by the DOH in Clinical Income) is c£0.4m in month and £3.7m ytd.

Total expenditure on pay in December was £31.5m, £0.4m lower than in November with all of the reduction relating to expenditure on medical agency staff.

Substantive staff expenditure is marginally adverse to plan in December and favourable to plan by £2.7m ytd. Expenditure on substantive medical and dental staff is overspent in month by £0.3m, continuing the adverse trend in the last quarter of 2018. Expenditure on permanent nursing staff is adverse to plan in December by £0.1m, offset by underspends on all other staffing groups. All substantive staffing groups remain underspent ytd except other staff which are £1.2m overspend ytd, predominantly relating to expenditure on HCAs as previously reported.

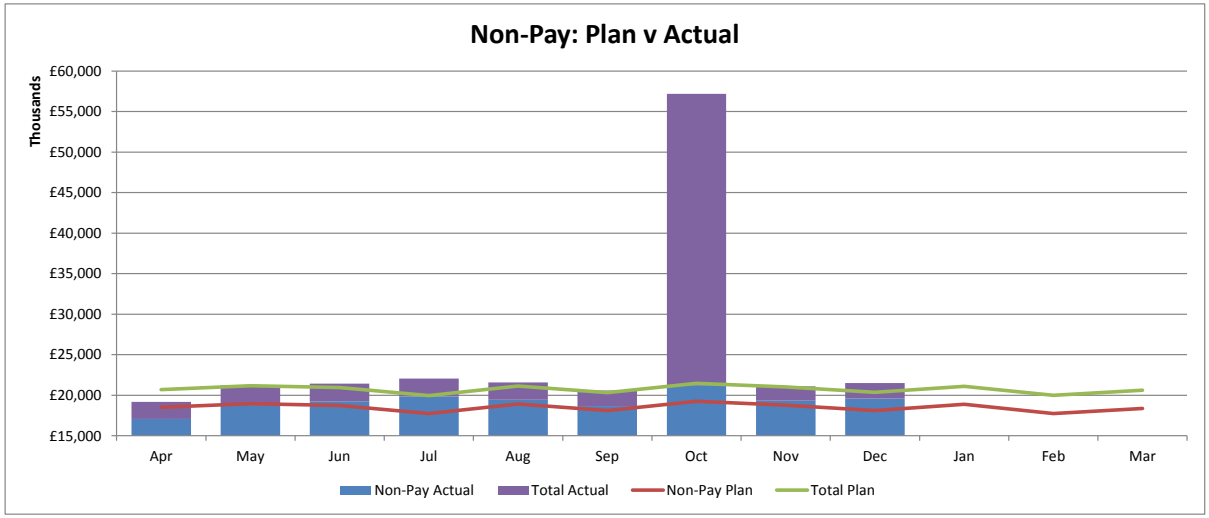
Expenditure on bank staff is adverse to plan by £0.3m in month and by £1.4m ytd. All staffing groups are overspending against plan on bank staff in month and ytd except medical staffing which is favourable to plan by £0.1m in December and by £1.3m ytd. Actual expenditure on bank staff in December reduced by less than £0.1m when compared to expenditure in November.

Expenditure on agency staff is adverse to plan in December by £0.9m, offset by a favourable performance on directly engaged agency medical staff of £0.3m. Ytd the overall agency variance stands at £13.3m adverse to plan with overspends in all staffing groups. All Care Groups contribute to the overspend, and CIP schemes are behind plan by £0.3m in December and by £2.5m ytd in this category. Expenditure on agency staff fell by £0.5m in December, all relating to medical staff. Excluding the effect of prior month cost transfers between General and Specialist Medicine and Urgent and Emergency Care in November, the expenditure reduction on agency medical staff in December relates predominantly to the General and Specialist Medicine and Surgery and Anaesthetics Care Groups, suggesting the availability of staff in these areas fell over the Christmas period.

Non-Pay

Month 09 (December) 2018/19

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(5,750)	(4,899)	851	(51,121)	(48,294)	2,827	(67,802)
Clinical Supplies and Services - Clinical	(4,833)	(2,517)	2,316	(50,028)	(43,066)	6,962	(66,208)
Supplies and Services - Non-Clinical	(2,152)	(7,673)	(5,521)	(16,107)	(32,730)	(16,623)	(22,245)
Purchase of Healthcare	(761)	(797)	(36)	(6,855)	(7,812)	(957)	(9,138)
Education & Training	(246)	(167)	79	(2,214)	(1,350)	864	(2,951)
Consultancy	(72)	(46)	26	(648)	(687)	(39)	(861)
Premises	(1,718)	(829)	889	(15,542)	(15,142)	400	(20,552)
Clinical Negligence	(1,697)	(1,730)	(33)	(16,245)	(15,567)	678	(21,336)
Transport	(323)	(273)	50	(2,907)	(2,686)	221	(3,877)
Establishment	(273)	(295)	(22)	(2,479)	(2,748)	(269)	(3,296)
Other	(290)	(351)	(61)	(3,009)	(3,348)	(339)	(3,880)
Total Non-Pay Expenditure	**(18,115)**	**(19,576)**	**(1,461)**	**(167,155)**	**(173,430)**	**(6,275)**	**(222,146)**
Depreciation & Amortisation-Owned Assets	(1,517)	(1,183)	334	(13,651)	(12,786)	865	(18,201)
Impairment Losses	(42)	(73)	(31)	(375)	(34,205)	(33,830)	(500)
Profit/Loss on Asset Disposals	(10)		10	(90)	1	91	(120)
PDC Dividend	(501)	(429)	72	(4,510)	(3,862)	648	(6,013)
Interest Receivable	9	216	207	83	758	676	110
Interest Payable	(177)	(470)	(293)	(1,370)	(2,307)	(937)	(1,917)
Other Non-Operating Expenses	(1)	(3)	(3)	(5)	(3)	2	(7)
Total Non-Operating Expenditure	**(2,238)**	**(1,942)**	**295**	**(19,918)**	**(52,404)**	**(32,485)**	**(26,648)**
Total Expenditure	**(20,353)**	**(21,519)**	**(1,166)**	**(187,073)**	**(225,833)**	**(38,760)**	**(248,794)**



Non Pay expenditure is adverse to plan in December by £1.5m and by £6.3m (3.75%) ytd. Non pay CIP schemes are adverse to plan in total by £0.4m in month and by £6.0m ytd.

Drug expenditure is favourable to plan by £0.9m in month and favourable to plan by £2.8m ytd. Pass through drugs account for all of the favourable position in month and are favourable to plan by £1.7m ytd, offset by an adverse position on clinical income. All other drugs are marginally adverse to plan in month and favourable to plan by £1.1m ytd. CIP schemes remain at £0.2m favourable to plan ytd.

Clinical supplies are favourable to plan in month by £2.3m and by £7.0m ytd. This favourable variance is offset by an overspend in Supplies and Services - General relating to pass through expenditure on consumable items purchased via the Operated Healthcare Facility (OHF). Including the £3.0m in month and £8.5m ytd of actual OHF pass through expenditure relating to clinical supplies, purchases are adverse to the Trust's original plan by £0.7m in month and adverse to plan by £1.5m ytd. Slippage on CIP schemes accounts for all of the overspend ytd.

Expenditure on supplies and services non clinical is adverse to plan in December by £5.5m and by £16.6m ytd. £3.9m of the total overspend in month (£10.8 ytd) relates to all pass-through costs (mainly clinical supplies and premises costs), now procured via the OHF provided by 2gether. Removing the effect of all pass through costs, expenditure on non clinical supplies is adverse to plan by £1.6m in month and by £5.9m ytd. In month, the implementation of phase two staffing transfer to the subsidiary and an adverse performance against CIP targets accounts for £1.0m of the variance. The OHF contract is overspent in month by £0.5m due to an understatement of IHSS invoices in previous periods. In addition to the IHSS movement, ytd underperformance on CIPs of £4.1m accounts for the majority of the remaining variance, including £2.1m from Serco planned as non clinical supplies but realised as non clinical income.

The underspend shown on Premises costs is offset by pass through costs of £0.8m leaving a marginal surplus in month.

Non pay actual expenditure in December increased by £0.3m when compared to November. Reductions in spend on drugs, premises and external commissioning totalling £1.1m are offset by increases in non clinical supplies (mainly IHSS contract), education and training and clinical negligence (additional rebate received in November) totalling £1.3m.

Non Operating Expenditure YTD is £38.8m above plan. The Trust has incurred £1.5m interest charges in respect of the £70.8m cumulative facility utilised to date. Impairment losses of £34.2m in respect of the 5 year cyclical valuation have been recognised.

Cost Improvement Summary

Month 09 (December) 2018/19

Delivery Summary

Programme Themes £000	This Month Plan	This Month Actual	This Month Variance	Year to Date Plan	Year to Date Actual	Year to Date Variance	Forecast Outturn	Forecast Variance
Patient Flow/LOS	167	-	(167)	500	-	(500)	-	(1,000)
Agency	450	388	(62)	3,759	2,752	(1,006)	3,579	(1,838)
Workforce *	20	155	136	111	438	327	538	368
Procurement	207	142	(65)	1,360	697	(663)	1,098	(884)
Medicines Value	88	118	30	550	1,171	621	1,502	631
Division Schemes **	1,753	1,751	(2)	10,948	12,515	1,567	18,122	1,538
Sub-total	**2,684**	**2,555**	**(130)**	**17,227**	**17,573**	**346**	**24,840**	**(1,185)**
Central	252	1,461	1,209	2,912	4,027	1,115	3,807	(168)
Grand Total	**2,937**	**4,016**	**1,079**	**20,139**	**21,601**	**1,462**	**28,647**	**(1,353)**

*** Smaller divisional schemes not allocated to a work stream*

Delivered £000

Month	Target	Actual
April	1,504	1,155
May	1,534	1,758
June	1,553	1,604
July	3,349	4,054
August	2,148	1,835
September	1,295	1,603
October	2,894	2,766
November	2,925	2,811
December	2,937	4,016
January	3,205	
February	3,276	
March	3,379	
	30,000	**21,601**
		72.0%

CIPs

The CIPs Plan of £30.0m is net of the cost of delivery. CIPs achieved in M09 were £4.0m against a plan of £2.9m. Medicines Value and workforce over performed in month and YTD supported by Central schemes. Agency, Procurement and Patient Flow are adverse in month and YTD. CIPs in December amounted to £2.2m recurrent and £1.8m on a non-recurrent basis. The YTD position is recurrent £13.3m and non-recurrent £8.3m.

Capital Expenditure

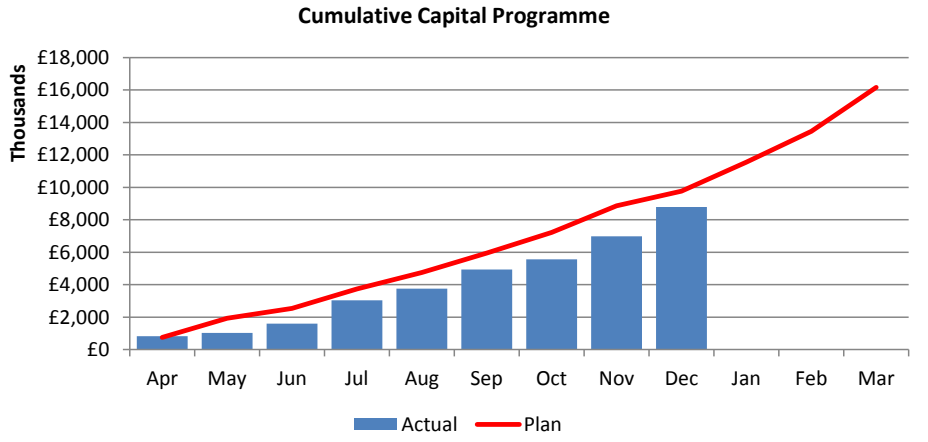
Month 09 (December) 2018/19

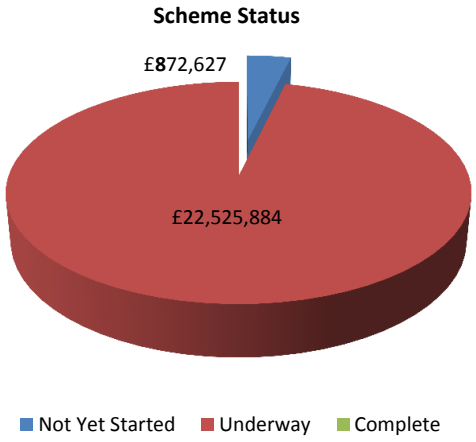
Capital Programme	Annual	To Date		
£000	Plan	Plan	Actual	Variance
Dementia Village	974	270	246	24
A&E Observation Area	6,400	1,464	1,464	0
Clinical Strategy Plans	200	174	136	38
Orthopaedic Modular Theatres	2,066	2,066	737	1,329
CT/CT SPECT Replacement	212	31	39	(8)
Invest To Save Schemes	39			
Medical Devices Group	3,082	1,700	1,844	(144)
Patent Environment Investment Committ	2,788	2,047	1,392	655
Information Development Group	2,000	1,690	1,715	(25)
Other Equipment Schemes	402	402	69	333
Other Building Schemes	70	70	5	65
Other IT Schemes	2,593	2,109	1,562	547
All Other Schemes	2,573	100	(5)	105
VAT Reclaim			(419)	419
Total	23,399	12,123	8,786	3,337

- Total expenditure at Mth 9 (Q3) 2018/19 is 27.5% below plan. The main reason for the shortfall is the late approval of Observation Bay expenditure by NHSi meaning the A&E improvement programme was delayed. The bays are expected to open in early January 2019, with the rest of the agreed works completed by the end of March 2019.

- The current capital forecast outturn position for 2018/19 is £23m, a small underspend of £0.4m (1.8%). The capital plan has been re-prioritised to recognise forecast slippage on the CT SPECT replacement scheme and to accommodate internal funding for the transfer of Elective Orthopaedics activity to K&C as part of the Trust's winter plan. In addition, the Trust is in receipt of capital funding bids of over £7.3m from both NHSI and Interreg to support additional schemes such as the Observation Bays at WHH and QEQM.

- Work is underway, but still to be completed, on understanding the flow of VAT within the additional schemes Q4 spend through the Trust Operated Healthcare Facility (OHF). In addition, there is an emergent potential patient safety issue that the Trust may need to address current year that may absorb this underspend.





Statement of Financial Position

Month 09 (December) 2018/19

£000	Opening	To Date	Movement
Non-Current Assets	**270,767**	**327,192**	**56,426 ▲**
Current Assets			
Inventories	8,949	3,849	(5,100) ▼
Trade and Other Receivables	39,034	46,254	7,220 ▲
Assets Held For Sale			-
Cash and Cash Equivalents	7,157	8,706	1,549 ▲
Total Current Assets	**55,139**	**58,808**	**3,669 ▲**
Current Liabilities			
Payables	(39,536)	(41,595)	(2,059) ▲
Accruals and Deferred Income	(26,013)	(30,438)	(4,425) ▲
Provisions	(884)	(835)	49 ▼
Net Current Assets	**(11,294)**	**(14,059)**	**(2,766) ▼**
Non Current Liabilities			
Provisions	(3,203)	(3,094)	109 ▼
Long Term Debt	(46,228)	(164,222)	(117,994) ▲
Total Assets Employed	**210,042**	**145,817**	**(64,225) ▼**
Financed by Taxpayers Equity			
Public Dividend Capital	191,687	198,169	6,482 ▲
Retained Earnings	(41,167)	(105,619)	(64,451) ▼
Revaluation Reserve	59,523	53,267	(6,256) ▼
Total Taxpayers' Equity	**210,042**	**145,817**	**(64,225) ▼**

Non Current asset values reflect in year additions of £9.1m (including donated assets) less depreciation charges of £12.8m a revaluation that resulted in our asset values being reduced by £41m. Non Current assets also includes the loan and equity that finances 2gether Support Solutions c.£99.3m

Trust closing cash balances for December was £4.8m above revised plan at £8m. See cash report for further details.

Trade and other receivables have increased from the 2018/19 opening position by £7.2m. Invoiced debtors have decreased from the opening position of £28.5m by £8.2m to £20.3m at the end of December, The 2gether debtor in respect of balance of sale of stock was £1.7m of the invoiced debtor balance.

Accruals and Deferred Income have increased by 4.4m since the opening position. Of the £30.4m balance, £21.6m relates to Accruals and £8.8m is Deferred Income of which £2.8m relates to a notional profit on sale of assets to 2gether that has been eliminated on consolidation.

The long term debt entry reflects drawings against working capital facilities. Total drawing to date £70.8m see cash report for details. The balance of £47.1 relates to the long term finance lease debtor with 2gether.

Retained earnings reflects the year to date deficit which includes impairments of £34.2m.

Working Capital

Month 09 (December) 2018/19

Creditors

Invoiced creditors have decreased by £5.1m from the opening position to £28.4m. 48% relates to current invoices with 16% or £4.7m over 90 days.

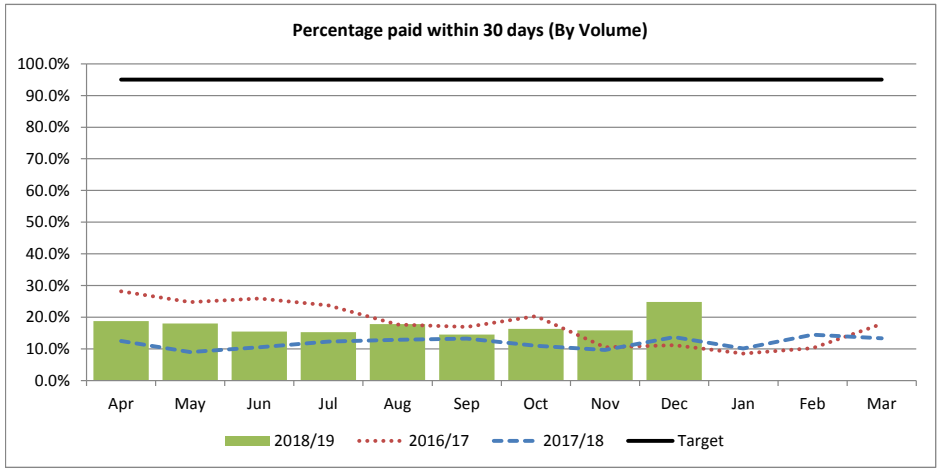
Over 90 days NHS creditors have decreased by £415k in Month.

- Maidstone & Tunbridge Wells NHS Trust (RWF) - £335k
- Medway NHS Foundation Trust (RPA) - £90k

YTD the Trust has paid 66.2% of NHS and 49.5% of non NHS invoices by value to 30 days. The average payment terms are 47 days.

Better Payment Practice Code

	Year to Date		This Month	
	Non NHS Creditor Invoices	NHS Creditor Invoices	Non NHS Creditor Invoices	NHS Creditor Invoices
By Value £000				
0 - 30 days	(141,735)	(21,454)	(18,926)	(2,353)
30+ days	(144,769)	(10,942)	(14,283)	(2,051)
By Volume				
0 - 30 days	13,070	229	1,544	30
30+ days	61,821	2,027	4,496	288
% by Value £	49.5%	66.2%	57.0%	53.4%
% by Volume	17.5%	10.2%	25.6%	9.4%
Target	95.0%	95.0%	95.0%	95.0%



Debtors

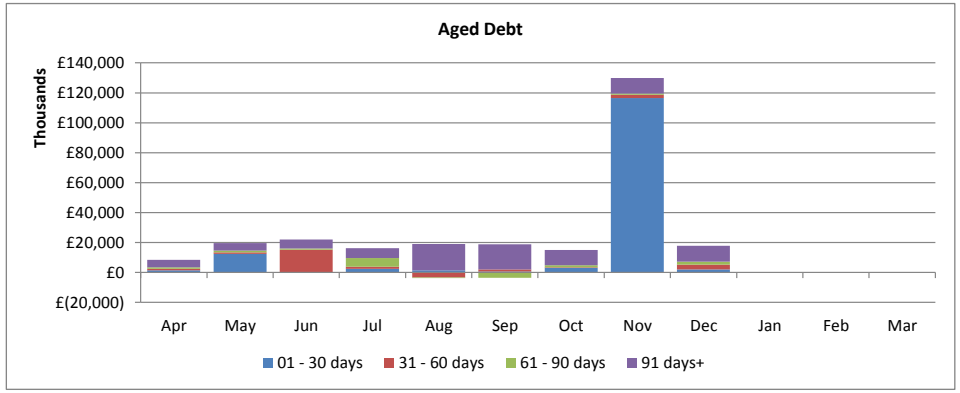
Total invoiced debtors have decreased from the opening position of £28.5m by £8.2m to £20.3m.
At 31st December there were 6 debtors owing over £1m.

- 2gether Support Solutions have an outstanding balance on a the sale of Stocks of £1.7m
- East Kent CCGs owing: South Kent Coast CCG £1.1m, Canterbury & Coastal CCG £1.6m, Ashford CCG £1.1m and Thanet CCG £1.4m. (outstanding invoices for 1718 and 1819 overperformance)
- East Kent Medical Services £2.2m

The debtors team are focussing on collection of all other debt to support the Trust cash position.

Aged Debt

£000	Current	01 - 30 days	31 - 60 days	61 - 90 days	91 days+	Total
Apr	12,651	1,397	1,073	974	4,911	8,354
May	925	12,478	1,013	1,216	5,018	19,725
Jun	527	39	15,136	845	5,989	22,009
Jul	2,660	2,515	1,255	5,771	6,687	16,228
Aug	1,382	1,455	(3,278)	(530)	17,545	15,192
Sep	4,338	556	1,550	(3,524)	16,703	15,285
Oct	120,626	3,059	337	1,492	10,244	15,131
Nov	3,356	116,458	2,283	765	10,466	129,972
Dec	2,540	2,074	3,083	2,111	10,534	17,803
Jan	0	0	0	0	0	0
Feb	0	0	0	0	0	0
Mar	0	0	0	0	0	0
		12%	17%	12%	59%	



Care Group Performance

Month 09 (December) 2018/19

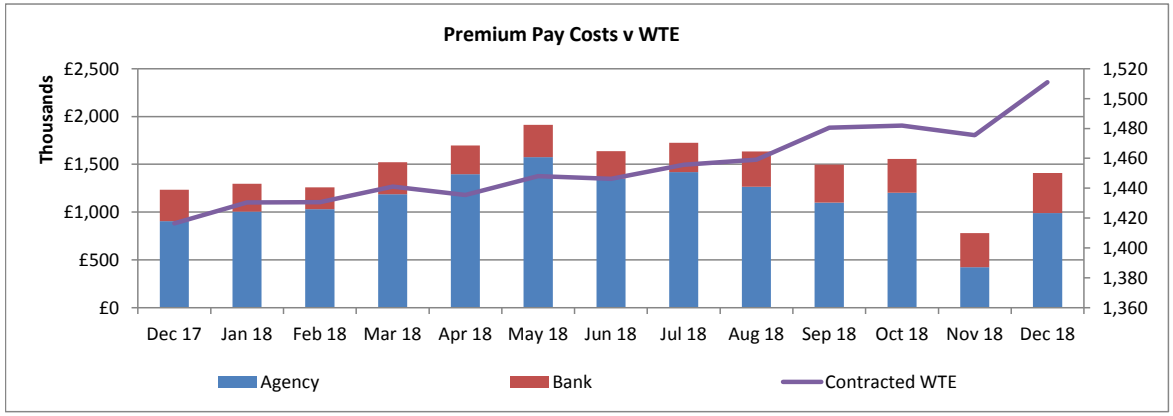
Year to Date Actual £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
General and Specialist Medicine	16,136	67,924	0	17,212	6,984	66	17,437	589	(63,912)	(23,504)	38,931
Urgent and Emergency Care	62	4,383	21,839		61	0	1,076	23	(27,640)	(3,306)	(3,502)
Surgery and Anaesthetics	33,422	28,800	0	11,096	218	59	10,748	1,349	(64,145)	(23,209)	(1,662)
Surgery - Head and neck, Breast Surgery and Dermatology	11,196	1,394	0	15,357	4,741	37	538	99	(11,349)	(7,910)	14,102
Clinical Support	484	30	0	3,076	12,011	53	26,504	4,626	(46,781)	(35,692)	(35,688)
Cancer Services	3,333	144	0	4,379	15,879		6,405	635	(5,710)	(18,735)	6,329
Women's and Children's Services	4,426	22,816	0	5,658	228	2	22,228	792	(36,864)	(3,385)	15,901
Clinical Total	**69,058**	**125,491**	**21,839**	**56,779**	**40,122**	**218**	**84,935**	**8,114**	**(256,402)**	**(115,742)**	**34,412**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	9,065	(8,409)	(34,873)	(34,218)
Corporate	0	0	0	0	0	0	0	13,325	(18,716)	(23,041)	(28,432)
Care Group Total	**69,058**	**125,491**	**21,839**	**56,779**	**40,122**	**218**	**84,935**	**30,504**	**(283,527)**	**(173,656)**	**(28,237)**
Central		70	0	0	250	3	8,878	8,337	(2,239)	227	15,526
							EBITDA				**(12,712)**
							Capital Charges and Interest			(52,404)	(52,404)
							Income and Expenditure Surplus/(Deficit)				(65,116)

Year to Date Variance to Plan £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
General and Specialist Medicine	(1,333)	3,172	0	(1,429)	(275)		(1,046)	100	(1,005)	(914)	(2,729)
Urgent and Emergency Care	60	250	2,101	()	40	0	123	(22)	(4,231)	(354)	(2,032)
Surgery and Anaesthetics	(6,011)	1,410	0	(1,423)	(94)	49	2,045	(115)	(4,672)	(300)	(9,112)
Surgery - Head and neck, Breast Surgery and Dermatology	(2,391)	245	0	(369)	(769)	(4)	525	()	(71)	277	(2,557)
Clinical Support	2	21	0	(129)	400	(15)	565	433	(1,582)	(2,280)	(2,585)
Cancer Services	499	(158)	0	129	(611)		56	(99)	(72)	579	322
Women's and Children's Services	(622)	(916)	0	(563)	(70)		(1,123)	(14)	(1,900)	446	(4,761)
Clinical Total	**(9,796)**	**4,025**	**2,101**	**(3,784)**	**(1,379)**	**31**	**1,146**	**284**	**(13,533)**	**(2,547)**	**(23,453)**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	754	173	(1,499)	(572)
Corporate	0	0	0	0	0	0	0	(29)	337	(270)	39
Care Group Total	**(9,796)**	**4,025**	**2,101**	**(3,784)**	**(1,379)**	**31**	**1,146**	**1,009**	**(13,024)**	**(4,316)**	**(23,987)**
Central	1,530	119	46	(93)	(184)		9,449	4,889	1,395	(1,959)	15,193
							EBITDA				**(8,794)**
							Capital Charges and Interest			(32,485)	(32,485)
							Income and Expenditure Surplus/(Deficit)				(41,279)

General and Specialist Medicine

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,780	1,500	(279)	17,469	16,136	(1,333)
Non-Electives	7,131	7,282	151	64,752	67,924	3,172
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,880	1,593	(288)	18,641	17,212	(1,429)
High Cost Drugs	807	757	(50)	7,259	6,984	(275)
Private Patients	7	3	(4)	66	66	
Other NHS Clinical	2,138	1,817	(321)	18,302	17,311	(991)
Other Clinical	20	1	(19)	181	126	(55)
Prior Month Adjustment	0	(23)	(23)	0	0	0
Total Clinical Income	**13,762**	**12,930**	**(833)**	**126,669**	**125,759**	**(910)**
Non Clinical Income	53	45	(8)	489	589	100
Total Income	**13,815**	**12,974**	**(841)**	**127,158**	**126,348**	**(810)**
Expenditure						
Substantive Staff	(5,563)	(5,812)	(249)	(51,890)	(50,060)	1,830
Bank	(327)	(422)	(95)	(2,926)	(3,128)	(202)
Agency	(941)	(988)	(48)	(8,091)	(10,724)	(2,633)
Total Pay	**(6,831)**	**(7,223)**	**(392)**	**(62,907)**	**(63,912)**	**(1,005)**
Non Pay	(2,414)	(2,468)	(54)	(22,590)	(23,504)	(914)
Total Expenditure	**(9,244)**	**(9,691)**	**(446)**	**(85,497)**	**(87,416)**	**(1,919)**
Contribution	**4,571**	**3,284**	**(1,287)**	**41,660**	**38,931**	**(2,729)**



The Care Group is £1.3m adverse in December and £2.7m adverse YTD.

Income was £0.8m adverse to plan in December and is £0.8m adverse YTD. Electives and Outpatients were significantly behind plan whilst the impact of activity recording for the new PAS is still under investigation in this area, at a combined position of £0.6m adverse. NEL activity whilst over plan by £0.2m, is a lower favourable performance than previous months. Income CIPs including Bowel Screening and IBD are not yet delivering.

Pay overspent by £0.4m in December of which £0.3m is Medical staff, with 20 wte used in excess of budget (in Gen Med). Agency spend reduced by £0.1m this month, attributable to the recruitment and subsequent Agency reduction of Neurology Consultants. Junior Doctor Agency reduced by £0.06m due to a conversion to Medical Bank. Nursing Agency increased by £0.07m due to the opening of Kings C2 Ward which followed Business Case approval.

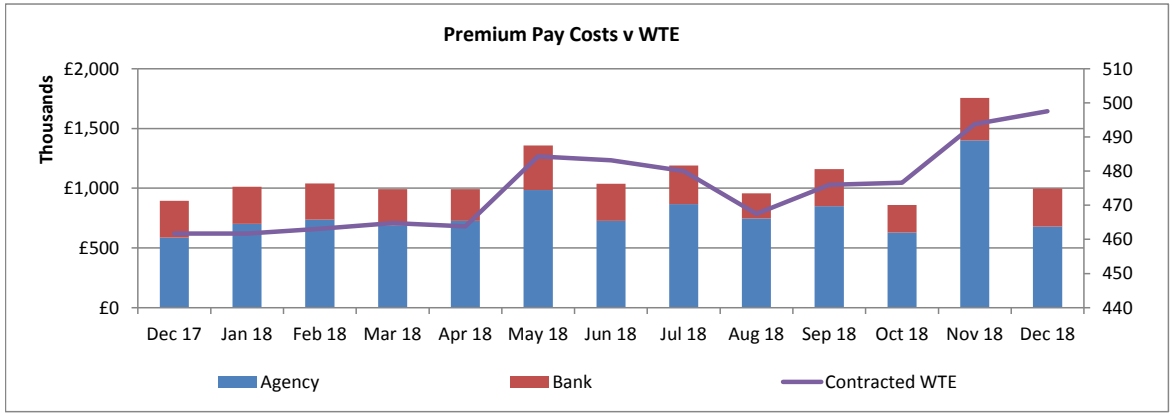
The non-pay run rate is consistent with October as expected, November spiked by £0.1m due to stock take issues on Cardiology. The slight overspend this month includes the outliers recharge of £0.16m therefore other non-pay is net underspent .

CIPs fell short of the monthly target due to non-delivery of 18 Weeks, Bowel Cancer Business Case and Patient Flow 3 schemes however this was backfilled non-recurrently through A&C vacancies.

Urgent and Emergency Care

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives		9	9	2	62	60
Non-Electives	384	613	229	4,133	4,383	250
Accident & Emergency	2,111	2,369	258	19,738	21,839	2,101
Outpatients						()
High Cost Drugs	2	2	()	21	61	40
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	106	76	(30)	953	1,076	123
Prior Month Adjustment	0	(16)	(16)	0	()	()
Total Clinical Income	**2,604**	**3,053**	**450**	**24,847**	**27,421**	**2,574**
Non Clinical Income	5	9	4	45	23	(22)
Total Income	**2,609**	**3,062**	**453**	**24,892**	**27,444**	**2,552**
Expenditure						
Substantive Staff	(2,398)	(2,040)	358	(19,833)	(17,334)	2,498
Bank	(285)	(317)	(32)	(2,511)	(2,699)	(187)
Agency	(62)	(680)	(618)	(1,065)	(7,607)	(6,542)
Total Pay	**(2,745)**	**(3,038)**	**(293)**	**(23,410)**	**(27,640)**	**(4,231)**
Non Pay	(290)	(350)	(60)	(2,952)	(3,306)	(354)
Total Expenditure	**(3,036)**	**(3,388)**	**(352)**	**(26,362)**	**(30,947)**	**(4,585)**
Contribution	**(427)**	**(326)**	**101**	**(1,470)**	**(3,502)**	**(2,032)**



Income is significantly above plan, reflecting the higher than planned attendances which have been in evidence throughout the year. Non elective income is also significantly above plan in month. Other Clinical Income is under performing due to fewer CRU (Compensation Recovery Unit) receipts. This income fluctuates significantly and the possibility of accruing receipts in future is being investigated.

Pay was overspent by £0.3m in month and reflects savings shortfalls and an increase in temporary staffing expenditure compared to last year. Agency decreased by £0.7m from November to December. This was expected because retrospective acute consultant agency costs were transferred from the GSM Care Group last month. Nursing agency was stable at £370k in the month, an improvement of £130k on the average for the year to date, but expenditure is still significantly higher than last year.

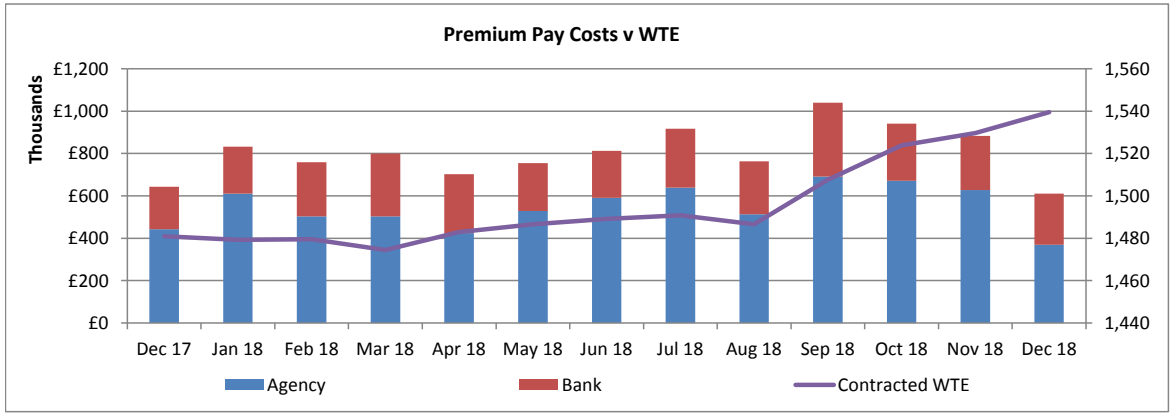
Non-pay was overspent by £60k. This is due to a mixture of small overspends on consumables, drugs, recruitment fees, security services and computer equipment. The majority of these issues reflect the higher number of attendances going through A&E.

The annual CIP target for the Care Group is £2.5m and is mainly focused on agency reduction plans. Currently performance is £0.9m adverse to plan and is forecast to be £1.4m adverse at year end. The Care Group is investigating what measures can be taken both recurrently and non-recurrently to help address the gap.

Surgery and Anaesthetics

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	4,468	3,458	(1,009)	39,433	33,422	(6,011)
Non-Electives	2,973	3,208	235	27,390	28,800	1,410
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,274	1,079	(195)	12,519	11,096	(1,423)
High Cost Drugs	35	18	(16)	312	218	(94)
Private Patients	1	0	(1)	10	59	49
Other NHS Clinical	1,082	1,162	80	8,629	10,654	2,025
Other Clinical	8	6	(2)	74	94	20
Prior Month Adjustment	0	(121)	(121)	0		
Total Clinical Income	**9,841**	**8,811**	**(1,030)**	**88,368**	**84,343**	**(4,025)**
Non Clinical Income	172	119	(53)	1,464	1,349	(115)
Total Income	**10,013**	**8,930**	**(1,083)**	**89,832**	**85,692**	**(4,139)**
Expenditure						
Substantive Staff	(6,067)	(6,386)	(318)	(54,100)	(56,720)	(2,620)
Bank	(214)	(240)	(27)	(1,885)	(2,370)	(485)
Agency	(386)	(370)	16	(3,488)	(5,055)	(1,567)
Total Pay	**(6,667)**	**(6,996)**	**(329)**	**(59,473)**	**(64,145)**	**(4,672)**
Non Pay	(2,632)	(2,518)	114	(22,909)	(23,209)	(300)
Total Expenditure	**(9,300)**	**(9,514)**	**(214)**	**(82,382)**	**(87,354)**	**(4,972)**
Contribution	**714**	**(584)**	**(1,298)**	**7,450**	**(1,662)**	**(9,112)**



The Care Group is £1.3m adverse to plan in month and £9.1m adverse YTD.

Below plan elective income (£6.0m) is mostly due to underperformance in Orthopaedics (£2.2m), and unachieved CIPs (£2.8m). Orthopaedic activity has been significantly impacted by reduced capacity issues, i.e. beds and Independent sector. However with the set up of the new Elective Orthopaedic Centre in November, the production plan forecasts that the Orthopaedic elective plan will now over achieve each month. Although Elective CIP plans were not achieved, this was offset from savings realised by ITU and Non Elective over performances.

Non-Elective income is above plan (£1.4m) with high levels of General Surgery activity.

Outpatient performance is adverse (£1.4m), with Orthopaedics (£0.7m) the largest YTD which is mostly due to the greater than anticipated impact of the Virtual Fracture Clinics. Urology (£0.3m), General Surgery (£0.2m) and Pain services (£0.2m) are also under performing.

Other NHS Clinical Income is favourable mostly due to ITU (£2.0m).

Pay is adverse with the continuation of high medical agency costs for middle grade vacancies in General Surgery, Urology, Vascular and also additional support for the ED's. Interviews and appointments have been made, and the delays on VISAs for foreign nationals is slowly unblocking. Nursing agency is still high at WHH for ITU and bedding of patients overnight in the Day Surgery Unit. These have contributed to an unmet CIP Pay target (£1.2m), which has instead been met through Income. ITU nursing recruitment from the approved business case is progressing well, whilst the SEAU and Hospital at Home services cases are awaiting review and approval of funding.

Non Pay is adverse (£300k) YTD with underspend on Independent Sector usage (£349k) for Orthopaedic services more than offset by Clinical Supplies overspend (£755k) and CIP underachievement (£698k).

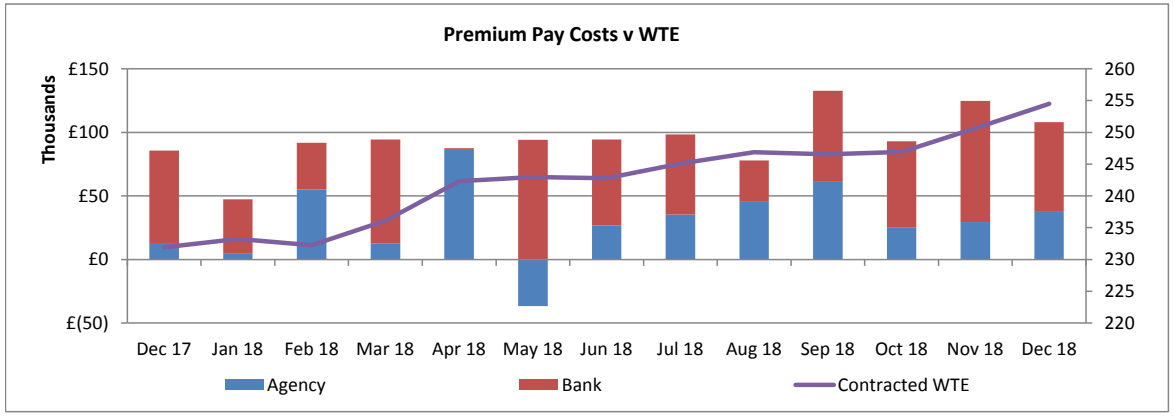
Included in the above expenditure is approximately £730k for medical patient outliers in the first six months, with no additional income. This has equated to the loss on average of 24 Surgical beds per day. Also incurred is £868k supporting the Winter/ED plan.

CIPs YTD target of £3.9m is underachieved by £0.9m.

Surgery - Head and neck, Breast Surgery and Dermatology

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,380	1,056	(324)	13,586	11,196	(2,391)
Non-Electives	112	147	35	1,149	1,394	245
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,571	1,388	(184)	15,726	15,357	(369)
High Cost Drugs	612	439	(174)	5,510	4,741	(769)
Private Patients	5	2	(2)	41	37	(4)
Other NHS Clinical	(16)	70	86	(24)	525	549
Other Clinical	4	5	1	36	13	(24)
Prior Month Adjustment	0	(897)	(897)	0	0	0
Total Clinical Income	**3,669**	**2,210**	**(1,459)**	**36,025**	**33,262**	**(2,762)**
Non Clinical Income	11	11	()	100	99	()
Total Income	**3,680**	**2,221**	**(1,459)**	**36,124**	**33,362**	**(2,763)**
Expenditure						
Substantive Staff	(1,194)	(1,182)	12	(10,494)	(10,475)	19
Bank	(56)	(71)	(15)	(498)	(563)	(65)
Agency	(28)	(37)	(9)	(286)	(311)	(25)
Total Pay	**(1,278)**	**(1,290)**	**(12)**	**(11,278)**	**(11,349)**	**(71)**
Non Pay	(884)	(646)	237	(8,187)	(7,910)	277
Total Expenditure	**(2,162)**	**(1,936)**	**225**	**(19,465)**	**(19,259)**	**206**
Contribution	**1,518**	**284**	**(1,234)**	**16,659**	**14,102**	**(2,557)**



The Care Group is £1.2m adverse to plan in month, mostly due to the recoding of £0.9m Audiology income to the Clinical Support Services Care Group. YTD the Care Group is £2.6m adverse.

Below plan elective income (£2.4m) is mostly due to underperformances in Dermatology (£0.7m), Ophthalmology (£0.6m) & ENT (£0.4m), together with unachieved CIPs (£0.5m). Dermatology activity is offset by over performance in outpatients and the release of a risk provision (related to the outcome of the expert determination negotiation). Elective CIP underachievement is partially offset by savings realised by Non Elective over performances.

Non-Elective income is above plan (£0.2m) with high levels of Maxillo Facial activity.

Outpatient performance is adverse (£369k), with underperformances in ENT (£258k) & Ophthalmology (£195k) partly offset with an overperformance in Dermatology (£124k). Forecast production plans for all specialties, apart from ENT, indicate monthly over performances which will deliver the year end plan.

High Cost Drugs under performance (£769k) is solely in relation to Ophthalmology AMD patients, and is offset with an underspend in expenditure.

Other NHS Clinical Income is favourable (£549k) mostly due to the Dermatology risk provision.

Pay is slightly adverse YTD (£71k). Medical agency costs have reduced significantly with ENT remaining the sole specialty requiring agency cover. However the prior months high usage of Medical agency has contributed to an unmet CIP Pay target (£96k).

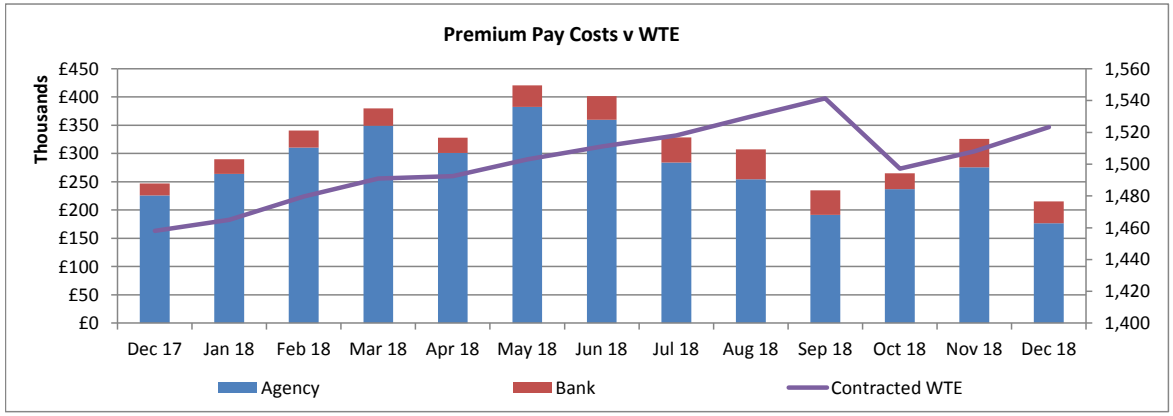
Non Pay is favourable (£277k) YTD, however the underspend on Drugs (£906k) is offset by the High cost drugs income under recovery and above planned usage (£679k) of Ophthalmology insourcing services. This was originally only planned to be utilised for the first five months, but is now required until the end of the financial year.

CIPs YTD target of £0.8m is underachieved by £0.3m.

Clinical Support

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	50	52	2	482	484	2
Non-Electives		9	9	9	30	21
Accident & Emergency	0	0	0	0	0	0
Outpatients	317	219	(97)	3,205	3,076	(129)
High Cost Drugs	1,290	1,179	(111)	11,610	12,011	400
Private Patients	8	4	(3)	68	53	(15)
Other NHS Clinical	2,631	2,809	178	25,940	26,504	564
Other Clinical	0	0	0	0		
Prior Month Adjustment	0	929	929	0	()	()
Total Clinical Income	**4,295**	**5,201**	**906**	**41,314**	**42,159**	**845**
Non Clinical Income	458	606	148	4,193	4,626	433
Total Income	**4,753**	**5,807**	**1,054**	**45,508**	**46,785**	**1,277**
Expenditure						
Substantive Staff	(4,893)	(4,969)	(76)	(43,505)	(43,954)	(449)
Bank	(23)	(39)	(16)	(214)	(364)	(150)
Agency	(75)	(177)	(102)	(1,481)	(2,463)	(982)
Total Pay	**(4,991)**	**(5,185)**	**(194)**	**(45,200)**	**(46,781)**	**(1,582)**
Non Pay	(3,715)	(4,004)	(288)	(33,411)	(35,692)	(2,280)
Total Expenditure	**(8,706)**	**(9,188)**	**(482)**	**(78,611)**	**(82,473)**	**(3,862)**
Contribution	**(3,953)**	**(3,381)**	**572**	**(33,103)**	**(35,688)**	**(2,585)**



The Clinical Support Care group held its favourable income position in December, despite a reduction in Homecare pass-through drugs costs.

The Audiology Income has now been transferred into the Care Group causing a swing in month (£1m). Pathology income is currently estimated to be over plan particularly for direct access. Clinical Biochemistry direct access is still significantly above plan and Microbiology and Haematology are also above plan to a lesser extent. There has also been an increase in income from Private Hospitals for laboratory services provided, therefore the income plan has been increased and the benefit shown as CIP (income) achieved. Radiology and Interventional Radiology income were above plan in December.

Homecare drugs were below plan (£0.1m) in December reflecting the fewer working days, however the year to date position is £0.4m above plan.

As forecast, Therapies income trend continued below plan with a drop in activity in Physiotherapy and Occupational Therapy, this has been driven by the implementation of Allscripts which has caused issues with the booking templates. A third party was engaged to help resolve this issue.

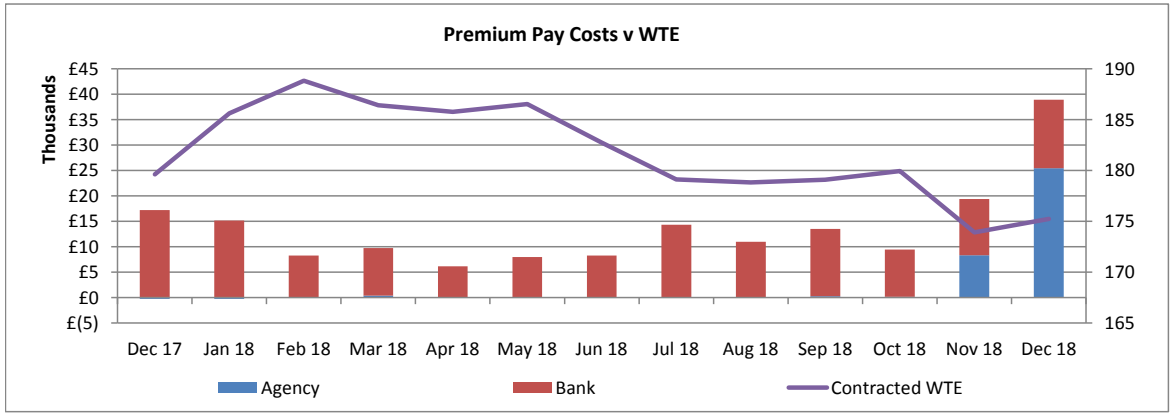
Pay is lower than last month, in all departments except Radiology and infection control. The largest reduction was Pathology which was unusually high last month due to backdated consultant's payments for Private hospital work. Agency cost also reduced this month - in Pathology, Therapies and Pharmacy but increased slightly in Radiology.

The overspend on Non-pay continues in Radiology on outsourced cardiac CT, CT & MRI imaging and reporting. Maintenance contracts are overspent in EME (£0.2m YTD). This needs a closer analysis to determine the cause of the increase e.g. higher prices, more aged maintenance reliant equipment or more new pieces of equipment requiring new contract cover. Referred pathology diagnostic tests to other organisations are also presenting a cost pressure.
The Care Group is exceeding its CIP target, (£3.9m achieved) and is forecast to achieve £5.2m in total this year.

Cancer Services

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	346	355	9	2,834	3,333	499
Non-Electives	30	40	10	302	144	(158)
Accident & Emergency	0	0	0	0	0	0
Outpatients	438	426	(11)	4,250	4,379	129
High Cost Drugs	1,832	1,558	(275)	16,490	15,879	(611)
Private Patients		0	()			
Other NHS Clinical	686	652	(34)	6,348	6,402	54
Other Clinical		1	1		3	2
Prior Month Adjustment	0	9	9	0		
Total Clinical Income	**3,332**	**3,041**	**(291)**	**30,224**	**30,139**	**(85)**
Non Clinical Income	79	53	(27)	734	635	(99)
Total Income	**3,411**	**3,094**	**(318)**	**30,959**	**30,774**	**(184)**
Expenditure						
Substantive Staff	(614)	(618)	(4)	(5,530)	(5,581)	(51)
Bank	(12)	(13)	(1)	(108)	(95)	13
Agency	0	(25)	(25)	0	(34)	(34)
Total Pay	**(626)**	**(657)**	**(31)**	**(5,638)**	**(5,710)**	**(72)**
Non Pay	(2,171)	(1,875)	296	(19,314)	(18,735)	579
Total Expenditure	**(2,796)**	**(2,532)**	**265**	**(24,951)**	**(24,445)**	**506**
Contribution	**615**	**562**	**(53)**	**6,007**	**6,329**	**322**



Income was below plan in the CCHH Care Group this month. This was mainly due to less spend and recharge of high cost drugs than anticipated (£0.3m). There was also, this was also reflected in Chemotherapy income which is behind plan in month. Electives remain above plan year to date for Daycases and regular day admissions reflecting the weekend working now at the Canterbury site. There is a plan to roll this out to the other 2 main sites in the near future.

Non Clinical Income is under plan but is currently understated by the December Macmillan funding which will partially reduce the deficit.

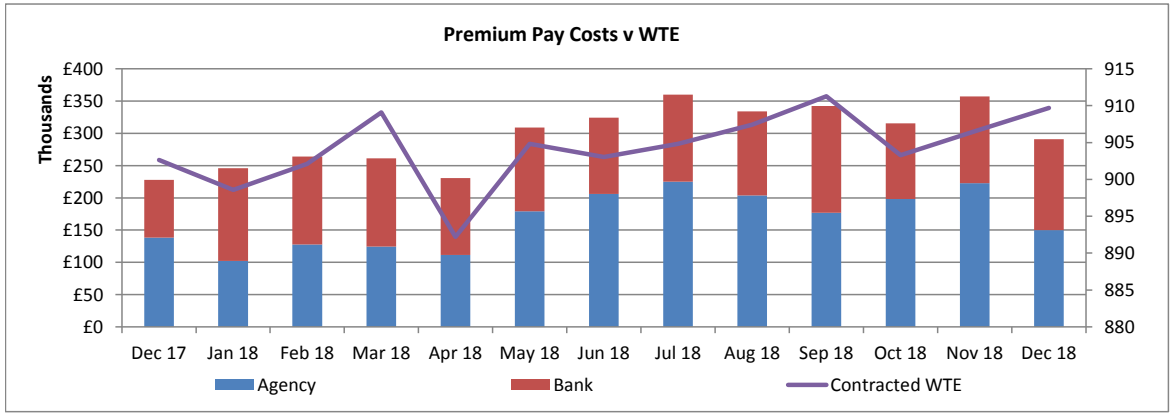
Pay is overspent this month due to management staff agency costs. This cost pressure is now ceased. The year to date overspend on substantive staff includes a reduction in overall vacancy factor across the Care Group.

Non-pay is underspent overall, mainly on drugs expenditure which is £0.6m underspent year to date. Computer Hardware purchases across the care group are also causing a adverse position. There is also an unmet savings target within Non-pay, even though overall the CCHH savings target is being met and exceeded through the Saturday working initiative.

Women's and Children's Services

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	518	465	(53)	5,048	4,426	(622)
Non-Electives	2,639	2,443	(195)	23,731	22,816	(916)
Accident & Emergency	0	0	0	0	0	0
Outpatients	628	526	(102)	6,221	5,658	(563)
High Cost Drugs	33	34	1	298	228	(70)
Private Patients		0	()	2	2	
Other NHS Clinical	2,372	2,417	45	23,187	22,170	(1,016)
Other Clinical	18	5	(13)	164	58	(106)
Prior Month Adjustment	0	(303)	(303)	0	()	()
Total Clinical Income	**6,208**	**5,588**	**(620)**	**58,651**	**55,358**	**(3,293)**
Non Clinical Income	91	86	(4)	806	792	(14)
Total Income	**6,299**	**5,675**	**(624)**	**59,457**	**56,150**	**(3,306)**
Expenditure						
Substantive Staff	(3,692)	(3,811)	(120)	(33,214)	(34,000)	(786)
Bank	(103)	(141)	(38)	(928)	(1,190)	(262)
Agency	(109)	(150)	(40)	(822)	(1,674)	(852)
Total Pay	**(3,905)**	**(4,102)**	**(198)**	**(34,964)**	**(36,864)**	**(1,900)**
Non Pay	(428)	(370)	58	(3,831)	(3,385)	446
Total Expenditure	**(4,333)**	**(4,473)**	**(140)**	**(38,794)**	**(40,249)**	**(1,455)**
Contribution	**1,966**	**1,202**	**(763)**	**20,662**	**15,901**	**(4,761)**



Elective income is significantly adverse to plan in month and cumulatively. This reflects continued gynaecology underperformance. Work is focused on addressing efficiency and capacity problems. There has been significant success in reducing waiting time breaches and improving productivity, but overall activity continues to fall below the plan.

Non-elective performance deteriorated markedly in December, predominantly within Paediatrics. This is due to the reclassification of a tranche of activity previously, incorrectly coded as non-electives, to a lower tariff under ward attenders. Births income also continues to perform below plan and this is consistent with lower levels seen throughout the year to date.

Overall outpatient income was significantly below plan in month. This continues to be driven by underperformance in both gynaecology and paediatrics. Some gynaecology capacity has been switched in order to focus on elective activity/breach avoidance. Paediatrics are investigating the viability of employing NHS locum resource to help recover the position.

The year to date adverse performance in the 'Other NHS Clinical' category is driven by lower than planned activity in NICU/SCBU and the maternity pathway. Both areas have struggled to reach planned levels over the year to date. However income in both areas picked up in December with both performing ahead of plan.

Overall pay was significantly overspent in December and year to date. Savings shortfalls (£100k in month) are a key driver. Temporary pay costs are also, on average, £80k a month higher than last year with junior/middle grade vacancies/sickness/maternity leave being particular issues. Recruitment into middle/junior grade roles and into midwifery has led to recent improvements-Agency costs were £40k lower this month than the monthly average for the year.

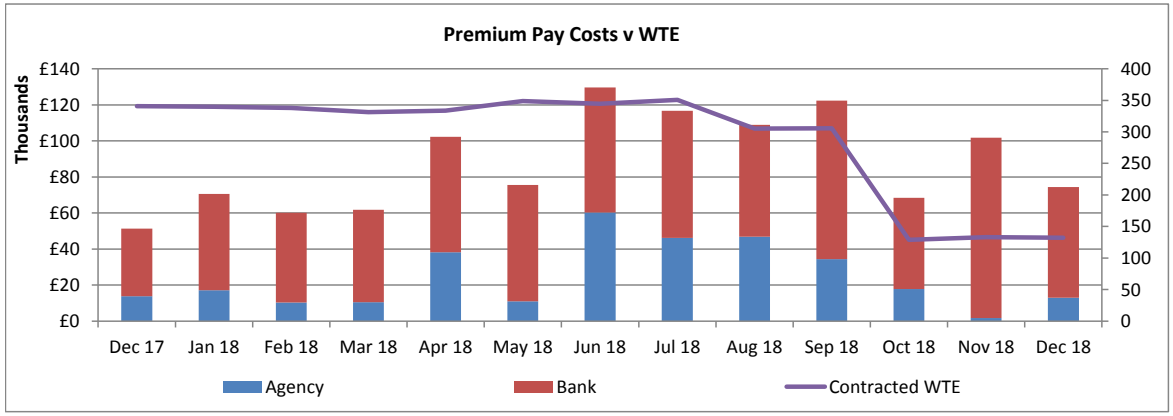
Non-pay is underspent due to the receipt a CNST incentive bonus. This has offset overspends relating to clinical supplies and computer equipment.

Overall CIP performance is above plan year to date, however a deficit of £100k is forecast due to the phasing of schemes in the second half of the year. The recurrent shortfall is £1.0m. The Care Group is investigating what further measures can be taken to improve recurrent performance.

Strategic Development and Capital Planning

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	0	0	0	0	0	0
Non-Electives	0	0	0	0	0	0
Accident & Emergency	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0
High Cost Drugs	0	0	0	0	0	0
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	0	0	0	0	0	0
Prior Month Adjustment	0	0	0	0	0	0
Total Clinical Income	**0**	**0**	**0**	**0**	**0**	**0**
Non Clinical Income	941	957	17	8,311	9,065	754
Total Income	**941**	**957**	**17**	**8,311**	**9,065**	**754**
Expenditure						
Substantive Staff	(457)	(471)	(13)	(7,961)	(7,509)	452
Bank	(41)	(61)	(20)	(447)	(630)	(183)
Agency	(1)	(13)	(12)	(174)	(270)	(96)
Total Pay	**(499)**	**(545)**	**(46)**	**(8,582)**	**(8,409)**	**173**
Non Pay	(4,403)	(4,892)	(489)	(33,374)	(34,873)	(1,499)
Total Expenditure	**(4,902)**	**(5,437)**	**(534)**	**(41,956)**	**(43,282)**	**(1,326)**
Contribution	**(3,962)**	**(4,479)**	**(518)**	**(33,645)**	**(34,218)**	**(572)**



The position as at month 9 is £(572)k adverse. Income is £754k favourable YTD, pay £173k favourable YTD and non-pay £(1.5)m adverse YTD. The variance between Income & Expenditure is due to invoices raised to 2gether following transfer.

After adjusting for PAS/SaCP, income is £77k favourable in month and £814k favourable

The position in month is mostly due to £98k of expenditure that has been invoiced to 2gether; £18k of income is for 2gether NHSP bank/agency staff and £8k for car parking. The rest is for various Facilities/Estates contracts that relate to October onwards; these are offset by expenditure. In addition there is £11k over-achievement on accommodation income in month.
The position YTD is mostly attributable to car parking £249k favourable YTD, laundry, external utility recharges, accommodation and income for 2gether recharges - as indicated above.

Pay is favourable £173k YTD and adverse £(46)k in month; £(12)k in month and £(28)k YTD is due to PAS OT worked; the PAS OT is being offset by income.
£(18)k of the adverse position in month is due to 2gether NHSP agency/bank expenditure, which is offset by income. The YTD position is due to vacancies earlier in the year, most of which have transferred to 2gether in October. The vacancy rate has diminished to under 1% compared to 10% in previous months, the reduction in contracted WTE can be seen on the graph below.

Non Pay is adverse £(489)k in month and £(1.5)m YTD.
The position is offset by income from 2gether equating to £72k in month and £524k YTD. Therefore after adjusting for this the actual position in month is £(417)k adverse in month and adverse £(975)k YTD.

The adverse position in month is due to the fact that there was an unknown delay in the novation of the IHSS contract to 2gether. A revised provision of £400k was made for the IHSS contract costs for October to December and the budget needs to be revised.

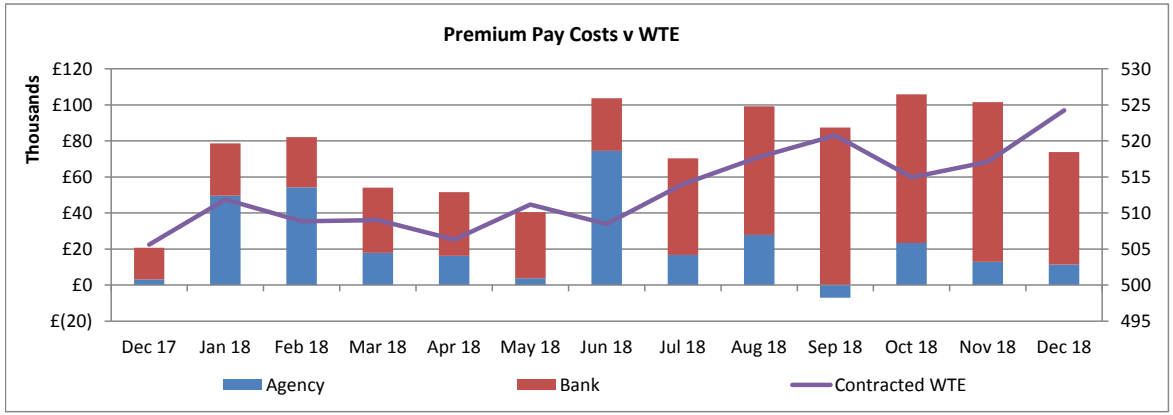
As previously reported, YTD adverse variances are due to waste £(65)k, laundry adverse on non pay but this is offset by income, utilities £(133)k still o/s issues around billing / rates raised as a cost pressure and escalated with Procurement.

In addition to this, £(173)k adverse variance YTD shows subjectively under non pay on the CIP report due to profiling . Savings are £(47)k adverse YTD against plan. Those o/s are the procurement work plan schemes details awaited from procurement. All of the schemes are continually being monitored. Forecast savings to be achieved in full.

Corporate

Month 09 (December) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	0	0	0	0	0	0
Non-Electives	0	0	0	0	0	0
Accident & Emergency	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0
High Cost Drugs	0	0	0	0	0	0
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	0	0	0	0	0	0
Prior Month Adjustment	0	0	0	0	0	0
Total Clinical Income	**0**	**0**	**0**	**0**	**0**	**0**
Non Clinical Income	1,473	1,471	(2)	13,354	13,325	(29)
Total Income	**1,473**	**1,471**	**(2)**	**13,354**	**13,325**	**(29)**
Expenditure						
Substantive Staff	(2,123)	(2,032)	91	(19,025)	(17,989)	1,035
Bank	(5)	(62)	(58)	(28)	(547)	(519)
Agency	0	(11)	(11)	0	(179)	(179)
Total Pay	**(2,127)**	**(2,105)**	**22**	**(19,053)**	**(18,716)**	**337**
Non Pay	(2,486)	(2,624)	(138)	(22,771)	(23,041)	(270)
Total Expenditure	**(4,613)**	**(4,729)**	**(116)**	**(41,824)**	**(41,757)**	**67**
Contribution	**(3,140)**	**(3,258)**	**(117)**	**(28,471)**	**(28,432)**	**39**



The position is £39k favourable as at Month 9 of which £224k is PGME/Library.

Income is adverse £(2k) in month and £(29)k YTD. Finance and Performance adverse £(24)k YTD, £(19)k is due to a discontinued provision for reference costing support. £(15)k YTD is adverse in Comms due to advertising income not achieving. These are partly offset by Chaplaincy and Health Education England income in the Resourcing Team.

Pay is favourable £22k in month and favourable £337k YTD. The current vacancy rate is just over 40 WTE.
The largest adverse variance in month and YTD is within the CQ&PS directorate, which due to additional cost centres being situated here and in addition to this higher costs being incurred following the implementation of the Care Group structure. This is offset by pay underspends in the rest of the Corporate Care Group.
The percentage vacancy rates, budgeted against contracted, are on average 6% in each directorate.

Each directorate has incurred temporary staff costs, these are the material areas: Finance (temporary PMO staff, clinical coders and Information Team), CQ&PS (Ops Management, Patient Experience and Waiting List Offices at WHH and QEQM), HR (HR Systems & HR Management) and Trust Board. The majority of the cost for the use of temporary/bank staff is being funded by the existing vacancies within each dept, the PMO posts have now recruited into substantial posts.

Non pay is adverse £(138)k in month and £(270)k YTD.
The position in month is mostly due to £(99)k expenditure being incurred relating to PAS waiting list shift validation on Finance Management Report, HR border agency permits adverse £(39)k in the month and £(17)k adverse on the Trust Management report due to fees for governance assessment and Board development. These are partly offset by a small underspend on PGME/Library.
The position YTD is mainly due to overspend on Trust Management, which consists of: recruitment fees for exec posts, management consultancy, transcription services for committee minutes and refurbishment costs of £(40)k.

Additionally, HR border agency permits adverse £(115)k YTD, this cost pressure was raised last financial year due to the costs trebling. Finance Senior Mgt report is adverse YTD due to asset valuation fees (Cushman and Wakefield Debenham Tie Leung Ltd and QE Facilities Ltd), PAS related waiting list shift validation costs and settlement discount ceased from Month 5 £(55)k adverse YTD, again this is to be raised as a cost pressure for 19/20.
HR, Finance and Performance and Trust Board overspends are partly offset by CQ&PS and PGME/Library underspends.

Year on Year Analysis

Month 09 (December) 2018/19

	Year to Date	Prior Year to Date	Year on Year	
	Actual	Actual	Variance	Variance %
Income				
Electives	69,058	67,387	1,671	2.5%
Non-Electives	125,561	118,909	6,652	5.6%
Accident and Emergency	21,839	19,636	2,203	11.2%
Outpatients	56,779	57,758	(978)	(1.7%)
High Cost Drugs	40,372	41,239	(867)	(2.1%)
Private Patients	220	184	36	19.6%
Other NHS Clinical Income	92,409	87,378	5,032	5.8%
Other Clinical Income	1,403	1,411	(9)	(0.6%)
Total Clinical Income	**407,641**	**393,902**	13,739	3.5%
Non Clinical Income	38,841	41,058	(2,216)	(5.4%)
Total Income	**446,482**	**434,959**	11,523	2.6%
Expenditure				
Substantive Staff	(237,937)	(224,700)	(13,236)	(5.9%)
Overtime	(4,227)	(3,804)	(423)	(11.1%)
Waiting List Payments	(2,101)	(1,586)	(516)	(32.5%)
Medical Locums/Short Sessions	(2,441)	(2,555)	114	4.5%
Bank	(11,412)	(9,962)	(1,450)	(14.6%)
Agency	(27,025)	(14,617)	(12,408)	(84.9%)
Direct Engagement - Agency	(623)	(2,888)	2,265	78.4%
Total Pay	**(285,766)**	**(260,112)**	(25,654)	(9.9%)
Non-Pay				
Drugs	(48,294)	(50,238)	1,944	3.9%
Clinical Supplies and Services - Clinical	(43,066)	(51,631)	8,565	16.6%
Supplies and Services - Non-Clinical	(32,730)	(15,800)	(16,930)	(107.1%)
Purchase of Healthcare	(7,812)	(5,914)	(1,899)	(32.1%)
Education & Training	(1,350)	(1,882)	532	28.3%
Consultancy	(687)	(500)	(186)	(37.2%)
Premises	(15,142)	(14,278)	(864)	(6.0%)
Clinical Negligence	(15,567)	(16,084)	517	3.2%
Transport	(2,686)	(2,788)	102	3.7%
Establishment	(2,748)	(2,701)	(48)	(1.8%)
Other	(3,348)	(5,027)	1,679	33.4%
Total Non-Pay	**(173,430)**	**(166,843)**	(6,587)	(3.9%)
Total Expenditure	**(459,196)**	**(426,955)**	(32,241)	(7.6%)
EBITDA	**(12,713)**	**8,004**	(20,718)	(258.8%)
Non-Operating Expenses	(52,818)	(19,004)	(33,814)	(177.9%)
Income and Expenditure Surplus/(Deficit)	**(65,531)**	**(11,000)**	(54,532)	(495.8%)

Clinical Income

- Non Elective income and A&E Activity is higher
- Other NHS Clinical Activity in the current year includes the 2018/19 pay award.

Non Clinical Income

- No PSF income 18-19 but £3.2m in 17-18
- PAS Project income 18-19
- Serco contract early exit fee £2.1m 18-19
- Recharges to 2gether Support Solutions as part of OHF set up arrangements £0.5m 18-19
- Non recurrent benefits £1.3m 18-19

Pay

- Pay inflation, incl AfC and Medical Pay Award
- Consultant Job Plan and Junior Doctors roll out.
- No RMO usage in this period 17-18.
- No A&E Improvement costs in this period 17-18.
- Divisional run rate increases to support activity and operational requirements including use of TFS Nurse Agency.
- Subjective impact of staff transferring to Operated Healthcare Facility

Non Pay

- Drugs - lower expenditure on rechargeable between years.
- Clinical Supplies - inflation and activity related cost of delivery.
- Purchase of Healthcare - increased use of insourcing companies
- Premises - PAS project costs 18-19 and Estates non pay profile prior to transfer to Operated Healthcare Facility
- Subjective impact of Operated Healthcare Facility from pay to non pay and across categories within non pay.

Cash Flow

Month 09 (December) 2018/19

Year to Date		This Month			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual		Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast
7,157	**Opening Bank Balance**	3,493	3,368	(125)	7,157	16,287	4,760	7,090	15,985	9,247	5,129	6,416	3,368	8,708	2,178	2,891
55,656	Ashford CCG	5,919	5,770	(149)	7,445	5,494	7,891	5,771	5,775	5,770	5,968	5,773	5,770	5,773	5,770	5,770
89,961	C4G	9,844	9,619	(226)	10,918	9,344	11,531	9,619	9,622	9,621	10,019	9,669	9,619	9,619	9,619	9,619
102,491	South Kent Coast CCG	11,105	10,832	(274)	12,809	10,529	12,943	11,220	10,846	10,829	12,745	9,740	10,832	10,437	10,827	10,827
70,887	Thanet CCG	8,048	7,835	(213)	8,180	7,824	8,233	7,195	7,835	7,835	7,839	8,110	7,835	7,835	7,835	7,835
576	Additional Income											576				
544	Dartford, Gravesham & Swanley CCG	38	152	114	38	38	38	63	92	45	38	39	152	38	38	38
1,675	Medway CCG	164	174	9	263	165	190	174	173	180	182	174	174	164	164	164
2,168	Swale CCG	306	330	24	306	306	299	323	304			301	330	306	306	306
3,851	West Kent CCG	449	429	(21)	377	377	531	427	428	427	428	427	429	452	449	449
73,298	NHS England	8,059	8,304	245	8,082	7,728	8,453	7,346	9,707	7,657	8,006	8,013	8,304	8,059	8,059	8,059
29,381	All Other NHS Organisations	1,160	2,232	1,072	5,317	1,119	801	5,645	2,866	2,447	6,396	2,560	2,232	1,188	6,368	1,423
0	Capital Receipts															
36,987	All Other Receipts	1,710	11,892	10,182	2,664	2,277	2,274	3,976	2,866	1,672	4,389	4,976	11,892	5,718	3,455	3,892
5,603	Provider Sustainability Fund							5,603								
24,531	Working Capital Facility	4,276	5,207	931	2,234			3,410	3,708	5,103		4,869	5,207	2,037	2,192	6,661
	Working Capital Facility Repaid															
	Permanent Loan															
497,609	**Total Receipts**	**51,078**	**62,774**	**11,696**	**58,633**	**45,202**	**53,184**	**60,772**	**54,222**	**51,585**	**56,010**	**55,226**	**62,774**	**51,625**	**55,082**	**55,042**
	Payments															
(245,599)	Monthly Payroll inc NI & Super	(27,710)	(27,520)	189	(26,383)	(26,617)	(26,681)	(27,120)	(28,165)	(28,308)	(27,351)	(27,453)	(27,520)	(27,224)	(27,268)	(27,118)
(237,963)	Creditor Payment Run	(21,310)	(29,547)	(8,237)	(21,600)	(27,605)	(23,054)	(24,445)	(31,892)	(23,180)	(26,586)	(30,054)	(29,547)	(28,974)	(22,704)	(20,186)
(8,949)	Capital Payments	(1,642)	(337)	1,305	(1,503)	(2,508)	(1,085)	(312)	(848)	(861)	(729)	(767)	(337)	(1,895)	(4,187)	(3,225)
(2,634)	PDC Dividend Payment									(2,634)						(3,007)
(914)	Interest Payments	(30)	(30)		(18)		(34)		(55)	(719)	(57)		(30)	(61)	(210)	(704)
(496,059)	**Total Payments**	**(50,692)**	**(57,435)**	**(6,743)**	**(49,503)**	**(56,730)**	**(50,854)**	**(51,877)**	**(60,960)**	**(55,703)**	**(54,723)**	**(58,274)**	**(57,435)**	**(58,154)**	**(54,369)**	**(54,240)**
1,551	**Total Movement In Bank Balance**	**386**	**5,339**	**4,953**	**9,130**	**(11,527)**	**2,330**	**8,895**	**(6,738)**	**(4,118)**	**1,287**	**(3,048)**	**5,339**	**(6,530)**	**713**	**802**
8,708	**Closing Bank Balance**	**3,879**	**8,708**	**4,828**	**16,287**	**4,760**	**7,090**	**15,985**	**9,247**	**5,129**	**6,416**	**3,368**	**8,708**	**2,178**	**2,891**	**3,693**
	Plan				15,584	3,861	3,529	7,882	3,470	5,153	5,618	3,493	3,879	2,890	2,890	3,693
	Variance				704	899	3,561	8,102	5,777	(25)	798	(125)	4,828	(712)		

Clinical Income - by Commissioner

Month 09 (December) 2018/19

	This Month £000			Year to Date £000			Annual £000
Commissioner	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**
NHS Ashford CCG	5,477	5,780	303	51,914	54,852	2,938	69,236
NHS Canterbury & Coastal CCG	9,085	9,101	16	86,396	88,644	2,248	115,422
NHS South Kent Coast CCG	10,136	10,201	64	97,329	99,386	2,057	129,925
NHS Thanet CCG	7,520	7,586	66	70,426	71,573	1,147	94,021
East Kent CCGs	32,218	32,667	449	306,065	314,455	8,390	408,603
NCA - England	365	316	(48)	3,647	3,822	175	4,686
NHS England - Armed Forces	10	9	(1)	123	136	13	159
NHS England - Specialised Services	6,530	6,400	(130)	59,701	60,291	591	79,165
NHS England - Health In Justice	10	7	(3)	87	65	(22)	116
NHS England - Secondary Dentistry	499	523	24	4,824	4,880	56	6,429
NHS England - Public Health	684	564	(120)	5,759	5,036	(724)	7,811
Kings	22	25	3	198	198		264
NCA - Wales	12	3	(9)	107	84	(23)	142
NCA - Northern Ireland				4	7	4	5
NCA - Scotland	2	1		17	15	(2)	22
Other Trusts	149	176	26	1,345	1,774	429	1,793
East Kent Overseas	(2)	19	21	4	469	465	
NHS Dartford, Gravesham & Swanley CCG	34	37	3	381	320	(60)	455
NHS Medway CCG	178	179	1	1,608	1,597	(12)	2,075
NHS Swale CCG	271	268	(3)	2,806	2,602	(204)	3,643
NHS West Kent CCG	356	527	171	3,875	4,408	533	5,122
Other Organisations	1,561	84	(1,477)	11,625	2,478	(9,146)	16,059
Cancer Drugs Fund	251	143	(107)	2,255	2,195	(60)	3,007
Adjust Prior Month Reported Position		(508)	(508)		()		
Prior year Income		(11)	(11)		2,808	2,808	
Local Authority					1	1	
Total	43,149	41,430	(1,719)	404,431	407,642	3,212	539,558

East Kent Commissioner contracts are all over performing YTD and in month. NHSE Specialised Services is also ahead of Contract YTD but has an under performance in month for the second month running. The Cancer Drugs Fund is showing an underperformance YTD for the first time this year. West Kent CCG is ahead of Contract YTD, while the North Kent CCGs are collectively behind Contract despite an improving position in recent months. Other Organisations include provisions for risks along with the planned CIP schemes and £3.7m YTD unplanned income to fund AfC pay awards.

EK CCGs continue to materially challenge Trust data on a monthly basis, however through joint discussions they are reducing. In July £2m of patient level data queries were received, of which only a handful of challenges were accepted with minimal financial impact. The monthly challenges have since reduced to more reasonable levels and Commissioners are working with the Trust to improve the processes of their Commissioning Support Unit which originally triggered the large increase in numbers of challenges.

The Expert Determination items from 17-18 that roll into 18-19 are being actively progressed. The unbundled radiology challenge has now been resolved with a credit to commissioners for 17-18 of £1.5m. The Unbundled Radiology and Dermatology activity reporting have now been amended to comply with the rulings. There are no material contracting issues with any of our other Commissioners.

KPIs

Month 09 (December) 2018/19

		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Clinical Income	**Plan**	42,848	45,649	46,985	46,015	44,480	46,915	47,069	46,849	43,841	47,000	43,204	47,002
Consolidated	**Actual**	42,369	47,016	47,467	47,702	46,857	47,609	47,860	46,273	34,728			
	Variance	-479	1,367	482	1,687	2,377	694	791	-576	-9,113			
	Quarterly rolling average spend	43,089	44,782	45,617	47,395	47,342	47,389	47,442	47,247	42,954			
Other Income	**Plan**	3,475	3,534	3,566	3,508	3,529	3,552	3,587	3,613	3,546	3,574	3,570	3,628
Consolidated	**Actual**	3,329	3,588	4,824	5,604	3,633	3,691	4,173	3,455	11,592			
	Variance	-146	54	1,258	2,096	104	139	586	-158	8,046			
	Quarterly rolling average spend	5,875	6,087	3,914	4,672	4,687	4,309	3,832	3,773	6,407			
Pay	**Plan**	-30,772	-30,911	-31,066	-30,623	-30,634	-30,717	-30,686	-30,953	-30,960	-31,294	-30,721	-30,717
Consolidated	**Actual**	-31,253	-32,237	-32,156	-32,254	-34,168	-33,635	-33,878	-34,293	-33,677			
	Variance	-481	-1,326	-1,090	-1,631	-3,534	-2,918	-3,192	-3,340	-2,717			
	Quarterly rolling average spend	-31,203	-31,818	-31,882	-32,216	-32,859	-33,352	-33,894	-33,935	-33,949			
Non Pay Operating Expenses	**Plan**	-18,693	-19,143	-18,927	-17,936	-19,125	-18,308	-19,439	-18,979	-18,303	-19,074	-17,944	-18,545
Consolidated	**Actual**	-17,358	-19,394	-19,634	-20,118	-18,502	-17,558	-19,430	-17,211	-17,758			
	Variance	1,335	-251	-707	-2,182	623	750	9	1,768	545			
	Quarterly rolling average spend	-19,920	-20,168	-18,795	-19,715	-19,418	-18,726	-18,497	-18,066	-18,133			
Non Operating	**Plan**	-2,228	-2,228	-2,228	-2,229	-2,235	-2,238	-2,236	-2,246	-2,259	-2,257	-2,260	-2,280
Consolidated	**Actual**	-2,118	-2,214	-2,179	-2,213	-2,176	-1,949	-35,884	-1,725	-841			
	Variance	110	14	49	16	59	289	-33,648	521	1,418			
	Quarterly rolling average spend	-1,942	-1,971	-2,170	-2,202	-2,189	-2,113	-13,336	-13,186	-12,817			
Agency	**Plan**	-1,849	-1,702	-1,617	-1,552	-1,460	-1,450	-1,432	-1,292	-1,289	-1,278	-1,279	-1,258
Unconsolidated	**Actual**	-3,186	-3,921	-3,264	-3,411	-2,949	-2,983	-2,996	-2,945	-2,461			
	Variance	-1,337	-2,219	-1,647	-1,859	-1,489	-1,533	-1,564	-1,653	-1,172			
	Quarterly rolling average spend	-3,237	-3,484	-3,457	-3,532	-3,208	-3,114	-2,976	-2,975	-2,801			
CIPS	**Plan**	1,502	1,534	1,553	3,357	2,156	1,295	2,895	2,925	2,937	3,205	3,276	3,379
Unconsolidated	**Actual**	1,155	1,758	1,629	4,081	1,777	1,598	2,763	2,811	4,016			
	Variance	-348	224	75	723	-378	303	-132	-113	1,079			
Cash	**Plan**	15,584	3,861	3,529	7,882	3,470	5,153	5,618	3,493	3,879	2,890	2,890	3,693
Unconsolidated	**Actual**	16,287	4,762	7,090	15,985	9,247	5,129	6,406	3,368	8,708			
	Variance	704	901	3,561	8,102	5,777	-25	789	-125	4,828			

Cost Improvement Summary

Month 09 (December) 2018/19

Planned Summary	2018 - 2019			Target Variance	
Programme Care Groups £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Clinical Support		4,159	3,733	3,726	(426)	(433)
General & Specialist Medicine		4,321	3,834	3,834	(487)	(487)
Urgent & Emergency Care		2,477	1,083	1,083	(1,395)	(1,395)
Surgery & Anaesthetics		6,075	4,390	4,188	(1,685)	(1,887)
Surgery - Head and neck, Breast Surgery and Dermatology		1,137	795	782	(342)	(355)
Women's & Children's		2,913	2,825	2,825	(88)	(88)
Cancer		567	869	869	302	302
Corporate		71	382	382	311	311
SD&CP		1,300	1,299	1,247	(1)	(53)
Procurement		2,693	1,668	1,646	(1,025)	(1,047)
Medicines Value		871	1,502	1,502	631	631
Sub-total		**26,584**	**22,381**	**22,084**	**(4,203)**	**(4,500)**
Central		3,416	6,266	6,266	2,850	2,850
Grand Total		**30,000**	**28,647**	**28,350**	**(1,353)**	**(1,650)**

Planned Summary	2018 - 2019			Target Variance	
Programme Themes £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Patient Flow/LOS		1,000	-	-	(1,000)	(1,000)
Agency		5,417	3,579	3,579	(1,838)	(1,838)
Workforce *		170	538	538	368	368
Procurement		1,982	1,098	1,076	(884)	(906)
Medicines Value		871	1,502	1,502	631	631
Division Schemes **		16,584	18,122	17,848	1,538	1,264
Sub-total		**26,025**	**24,840**	**24,543**	**(1,185)**	**(1,482)**
Central		3,975	3,807	3,807	(168)	(168)
Grand Total		**30,000**	**28,647**	**28,350**	**(1,353)**	**(1,650)**

Cost Improvement Phasing

Month 09 (December) 2018/19

Work stream Gross £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	-	-	-	-	167	167	167	167	167	167	1,000
Agency	368	382	378	422	414	467	420	456	450	530	567	560	5,417
Workforce	2	2	2	4	20	20	20	20	20	20	20	20	170
Procurement	50	69	87	129	199	206	207	207	207	207	208	208	1,982
Medicines Value	30	45	50	55	66	68	70	79	88	98	108	116	871
Clinical Support Services	184	165	166	251	248	251	250	246	243	271	269	270	2,817
General & Specialist Medicine	59	59	58	134	127	(42)	260	259	258	261	261	261	1,956
Urgent & Emergency Care	1	1	1	1	1	1	1	1	1	1	1	1	8
Surgery & Anaesthetics	322	290	305	394	394	394	611	611	611	698	723	723	6,075
Surgery - Head and neck, Breast Sur	65	98	83	90	89	56	91	90	90	86	86	86	1,012
Women's & Children's	173	175	173	221	219	(434)	382	379	375	372	372	372	2,778
Cancer Services	52	51	54	61	56	(68)	62	61	60	60	60	60	567
Corporate - Other	6	6	6	6	6	6	6	6	6	6	6	6	71
SD&CP	108	109	108	108	108	108	108	108	108	108	108	107	1,300
Sub-total	**1,420**	**1,451**	**1,470**	**1,878**	**1,947**	**1,033**	**2,654**	**2,689**	**2,684**	**2,885**	**2,956**	**2,957**	**26,025**
Central	83	83	83	1,471	200	262	240	235	252	320	320	422	3,975
Grand Total	**1,504**	**1,534**	**1,553**	**3,349**	**2,148**	**1,295**	**2,894**	**2,925**	**2,937**	**3,205**	**3,276**	**3,379**	**30,000**

Workstream RAG adj £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	-	-	-	-	-	-	-	-	-	-	-
Agency	434	275	352	308	236	206	260	295	388	234	301	292	3,579
Workforce	22	53	2	25	44	44	44	46	155	33	33	33	538
Procurement	35	44	59	106	54	52	82	123	142	127	127	125	1,076
Medicines Value	42	57	109	222	194	161	102	167	118	103	110	117	1,502
Clinical Support	157	184	234	330	357	144	161	276	268	289	288	289	2,978
General & Specialist Medicine	1	67	87	100	255	207	171	126	222	229	222	222	1,910
Urgent & Emergency Care	-	-	-	80	20	20	20	20	20	20	20	20	240
Surgery & Anaesthetics	132	583	366	445	302	260	369	367	214	383	383	383	4,188
Surgery - Head and neck, Breast Sur	9	94	64	82	41	11	54	86	73	82	93	93	782
Women's & Children's	89	82	131	184	164	482	174	469	359	190	228	258	2,810
Cancer Services	113	110	84	51	89	3	71	50	73	78	73	73	869
Corporate - Other	-	11	7	7	7	7	754	407	407	406	406	406	2,824
SD&CP	20	198	108	113	172	105	120	95	116	92	92	15	1,247
Sub-total	**1,055**	**1,758**	**1,604**	**2,054**	**1,935**	**1,703**	**2,383**	**2,528**	**2,555**	**2,266**	**2,378**	**2,326**	**24,543**
Central	100	-	-	2,000	(100)	(100)	383	284	1,461	(190)	(34)	4	3,807
Grand Total	**1,155**	**1,758**	**1,604**	**4,054**	**1,835**	**1,603**	**2,766**	**2,811**	**4,016**	**2,077**	**2,343**	**2,330**	**28,350**

Debtor Balances

Month 09 (December) 2018/19

Debtor	Top ten debtor balances outstanding as at 31/12/2018						Creditor balance as at 31/12/2018	Notes
	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total		
76480-2GETHER SUPPORT SOLUTIONS LTD	70,458	589,859	1,801,616	53,413	0	2,515,346	2,659,475	£1.7m stocks paid in January
51136-EAST KENT MEDICAL SERVICES	127,011	183,488	5,120	275,031	1,562,778	2,153,427	858,949	Reciprocal payment arrangement in place
61865-NHS CANTERBURY AND COASTAL CCG	4,134	130,936	133,385	280,834	1,089,852	1,639,140	74,762	£1.0m 1718 overperformance, £0.3m 1819 overperformance
62033-NHS THANET CCG	2,030	10,350	133,859	399,869	890,768	1,436,877	80,522	£0.9m 1718 overperformance, £0.4m 1819 overperformance
61818-NHS ASHFORD CCG	3,083	5,957	6,291	441,478	690,762	1,147,571	57,352	£0.6m 1718 overperformance, £0.4m 1819 overperformance
62003-NHS SOUTH KENT COAST CCG	8,103	13,581	348,441	9,696	738,903	1,118,724	111,527	£1.0m 1718 overperformance
51708-MEDWAY NHS FOUNDATION TRUST	137,831	6,020	51,174	6,854	698,882	900,761	1,103,294	Trust creditor balance with MTW is larger than the debtor balance. Difference being reduced as invoices are authorised
62048-NHS WEST KENT CCG	14,554	10,345	18,346	8,564	782,436	834,245		16/17 overperformance in dispute
50010-MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	215,313	146,642	56,795	32,270	367,756	818,775	1,142,367	Trust creditor balance with MTW is larger than the debtor balance. Difference being reduced as invoices are authorised
62138-NHS ENGLAND SOUTH EAST COMMISSIONING HUB (14G)	73,900	73,900	0	147,800	517,301	812,902		Unpaid Hep C Drugs invoices
Other Govn.	1,620,553	500,195	400,718	396,229	1,981,222	4,898,918		
Other Non Govn.	278,079	388,036	127,697	59,366	1,212,853	2,066,030		
	2,555,048	2,059,310	3,083,441	2,111,403	10,533,512	20,342,714	6,088,247	

Creditor Balances

Month 09 (December) 2018/19

Unpaid at last Payment Run

Supplier Name	Total
Other Creditors	2,000
NHS Professionals Ltd	821
Abbott Laboratories Ltd	299
Alcura UK Ltd	265
Novartis Pharmaceuticals UK Ltd	226
NHS Supply Chain 8HD71 - Stock	178
Maidstone & Tunbridge Wells NHS Trust (RWF)	162
NES Holdings (UK) Ltd	148
Bayer PLC	120
Beckman Coulter UK Ltd	117
HealthNet Homecare (UK) Ltd	98
Total	**4,434**

At the last payment run of the period we had a total of £14.m of invoices authorised and ready for payment.

Of the £14.m, £10.4m was released leaving £4.4m unpaid due to low liquidity.

Aged Creditors now stands at £28.4m.

The Accounts Payable team prioritises key suppliers and those threatening to restrict supplies.

Top Ten Aged Creditor

Supplier Name	Current	1-30	31-60	60-90	90 +	Total
Other Creditors	6,513	4,757	777	455	2,834	15,336
NHS Professionals Ltd	2,265	1,753	4	2	22	4,046
2gether Support Solutions Ltd	2,214	66	219	149	11	2,659
Maidstone & Tunbridge Wells NHS Trust (RWF)	519	310	18	34	263	1,142
Medway NHS Foundation Trust (RPA)	160	150	203	117	474	1,103
NES Holdings (UK) Ltd	285	321	205	164	16	991
East Kent Medical Services Ltd T/a The Spencer Wing		189			1,048	859
Healthcare At Home Ltd	573	23	15		0	611
AAH Pharmaceuticals LTD	482	89	0		0	571
Novartis Pharmaceuticals UK Ltd	307	263				570
Alcura UK Ltd	250	265				515
Total	**13,569**	**7,807**	**1,440**	**920**	**4,668**	**28,405**

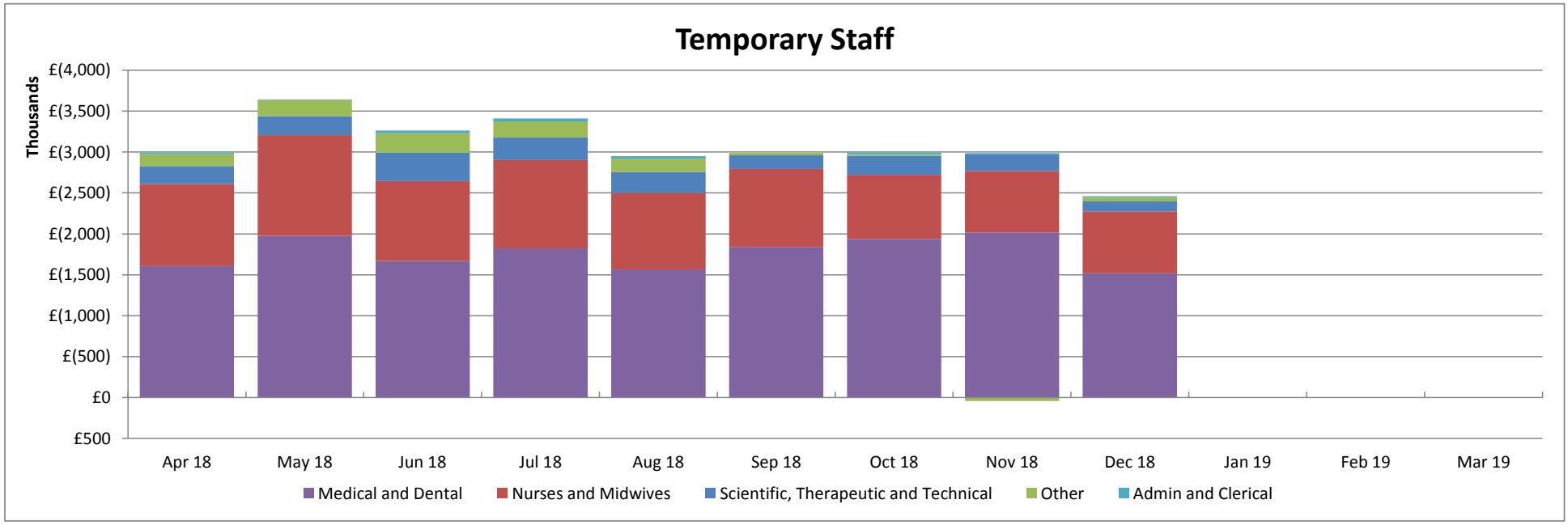
Aged Creditor By Reason

Reason Description	Current	1-30	31-60	60-90	90 +	Total
Current	13,569					13,569
Cash Flow		4,426	7			4,434
Waiting on a GRN		1,291	738	496	1,175	3,700
Not Recorded		2,369	228	210	192	3,000
Disputed		529	99	92	1,838	1,500
Creditor Debit Balance					1,004	1,004
Waiting on Authorisation		168	325	6	226	713
Price Query		54	29	36	87	206
Purchase Order Value Exceeded		9	12	90	80	191
Order Raised after Invoice Received		17	1	4	63	86
Other		0			2	2
Total	**13,569**	**7,807**	**1,440**	**920**	**4,668**	**28,405**

Pay Analysis - Temporary Staff

Month 09 (December) 2018/19

In Month £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medical and Dental	**(1,608)**	**(1,976)**	**(1,670)**	**(1,822)**	**(1,567)**	**(1,841)**	**(1,938)**	**(2,017)**	**(1,519)**			
Agency	(1,476)	(2,079)	(1,571)	(1,702)	(1,515)	(1,741)	(1,765)	(2,006)	(1,480)			
Direct Engagement	(132)	103	(99)	(121)	(51)	(100)	(173)	(11)	(39)			
Scientific, Therapeutic and Technical	**(217)**	**(231)**	**(348)**	**(275)**	**(257)**	**(168)**	**(234)**	**(207)**	**(120)**			
Agency	(217)	(231)	(348)	(275)	(257)	(168)	(234)	(207)	(120)			
Nurses and Midwives	**(1,002)**	**(1,230)**	**(974)**	**(1,080)**	**(933)**	**(951)**	**(784)**	**(751)**	**(757)**			
Agency	(1,002)	(1,230)	(974)	(1,080)	(933)	(951)	(784)	(751)	(757)			
Admin and Clerical	**(18)**	**(6)**	**(33)**	**(36)**	**(28)**	**7**	**(23)**	**(13)**	**(11)**			
Agency	(18)	(6)	(33)	(36)	(28)	7	(23)	(13)	(11)			
Other	**(150)**	**(201)**	**(239)**	**(198)**	**(164)**	**(29)**	**(17)**	**43**	**(53)**			
Agency	(150)	(201)	(239)	(198)	(164)	(29)	(17)	43	(53)			
Total	**(2,995)**	**(3,637)**	**(3,231)**	**(3,375)**	**(2,921)**	**(2,990)**	**(2,973)**	**(2,933)**	**(2,450)**			



Pay Analysis - Temporary Staff

Month 09 (December) 2018/19

Temporary Staff Actual £m	M & D	N & M	PAMS	A&C Other	Total	Variance v 2018/19	Variance v 2017/18
General and Specialist Medicine	0.69	0.28	0.02		0.99	(0.20)	0.16
Urgent and Emergency Care	0.31	0.37			0.68	(0.17)	0.16
Surgery and Anaesthetics	0.28	0.08	0.01		0.37	(0.19)	(0.07)
Surgery - Head and neck, Breast Surgery and Dermatol	0.03				0.04		0.02
Clinical Support Services	0.09		0.09		0.18	(0.10)	(0.06)
Cancer Services				0.03	0.03	0.02	0.03
Women's and Children's Services	0.10	0.03		0.02	0.15	(0.04)	0.02
Strategic Development and Capital Planning				0.01	0.01	(0.02)	
Corporate				0.01	0.01	(0.01)	(0.01)
Central	0.01				0.01	0.08	0.06
Total	**1.51**	**0.76**	**0.12**	**0.07**	**2.46**	**(0.63)**	**0.31**
Variance v 2018/19 average	(0.25)	(0.18)	(0.11)	(0.07)	(0.61)		
Variance v 2017/18 average	0.17	0.15	(0.03)		0.29		

Temporary Staff Year to Date £m	M & D	N & M	PAMS	A&C Other	Total	Average per Month
General and Specialist Medicine	7.23	2.70	0.23	0.57	10.72	1.19
Urgent and Emergency Care	3.23	4.24		0.14	7.61	0.85
Surgery and Anaesthetics	3.62	1.16	0.27		5.06	0.56
Surgery - Head and neck, Breast Surgery and Dermatol	0.29	0.02			0.31	0.04
Clinical Support Services	0.88		1.58	0.01	2.46	0.27
Cancer Services				0.03	0.03	
Women's and Children's Services	1.33	0.31		0.04	1.67	0.19
Strategic Development and Capital Planning				0.27	0.27	0.03
Corporate		0.01		0.18	0.18	0.02
Central	(0.61)	0.03	(0.02)	(0.06)	(0.67)	(0.07)
Total	**15.97**	**8.47**	**2.06**	**1.18**	**27.68**	**3.08**
Average per month	1.77	0.94	0.23	0.13	3.07	

Finance Performance Report 2018/19

November 2018

Director of Finance and Performance Management
Philip Cave

Contents and Appendices

Month 08 (November) 2018/19

Contents

	Page
Executive Summary	3
Income and Expenditure Summary	4
Key Highlights	5
Cash Flow	8
Risks and Opportunities	10
Clinical Income	11
Clinical Activity	12
Non Clinical Income	13
Pay	14
Non-Pay	15
Cost Improvement Summary	16
Capital Expenditure	17
Statement of Financial Position	18
Working Capital	19
Care Group Performance	20

Appendices

	Page
A. Year on Year Analysis	30
B. Cash Flow	31
C. Clinical Income - by Commissioner	32
D. KPIs	33
E. CIP Summary and Plan Phasing	34
F. Debtor Balances	36
G. Pay Analysis - Temporary Staff	38

Executive Summary

Month 08 (November) 2018/19

Executive Summary

The Trust has generated a consolidated deficit in month of £3.5m and a year to date (YTD) deficit of £58.1m which is £38.5m behind plan. The main drivers of the deficit in month are the continuing themes whereby operational pressures are leading to significant Agency spend on Medical and Nursing staff but Elective activity and income are increasingly falling behind plan. This is mainly driven by low elective work in Surgery (Trauma & Orthopaedic (T&O) did not start as planned) and General and Specialist Services (Respiratory, Neurology and Bowel Scope Business Case (BC)). Whilst non elective work is over performing it is insufficient to make up for the elective shortfall. In addition to these driver the YTD position is impacted by a £34.3m impairment. Reserves now remaining are very small and the plan assumes increased elective activity over the coming four months which, if not delivered, will lead to a failure to deliver the financial plan.

As the Trust is in FSM it is measured against its performance excluding technical adjustments. After these are removed the Trust's YTD I&E deficit to Month 8 (November) was £23.4m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £18.9m, £4.5m worse than plan. A reconciliation of the various adjustments is presented below.

	This Month			Year to Date		
£'000	Plan	Actual	Variance	Plan	Actual	Variance
EKHUFT Income (inc PSF)	49,885	49,581	(304)	390,565	399,735	9,170
EKHUFT Pay	(30,599)	(31,897)	(1,298)	(243,530)	(254,295)	(10,765)
EKHUFT Non-Pay	(21,013)	(21,095)	(82)	(166,720)	(204,314)	(37,594)
EKHUFT Financial Position (inc PSF)	**(1,727)**	**(3,412)**	**(1,685)**	**(19,685)**	**(58,874)**	**(39,189)**
Subsidiaries Financial Position	11	(89)	(100)	79	787	708
Consolidated I&E Position (inc PSF)	**(1,716)**	**(3,501)**	**(1,785)**	**(19,606)**	**(58,087)**	**(38,481)**
Impairments/ Donated Assets Adjustment	85	(101)	(186)	681	34,646	33,965
PSF Funding	0	0	0	0	0	0
Consolidated I&E Position (excl PSF)	**(1,631)**	**(3,602)**	**(1,971)**	**(18,925)**	**(23,441)**	**(4,516)**

Trust unconsolidated pay costs in month of £31.9m are £0.3m more than October. Temporary staffing costs have increased £0.2m in month due to a increases in bank costs mainly driven by increased medical staffing. When measured against Budget, pay is over spent by £1.3m. The main driver for the overspend continues to relate to above plan usage of clinical agency and bank staff. All Care Groups contribute to the overspend. Agency spend is reduced a little (£0.1M) at £2.9m in month . Agency costs are now £12.7m more than plan YTD driven by operational pressures. Permanent staff costs (including Overtime and waiting list work) are £3.1m less than plan YTD driven by all staff groups other than HCA's.

Clinical income was behind plan by £0.8 in month. Once the impact of pay awards income funding (£0.4m, not included in the plan) is adjusted the net position in £1.2m less than plan for the month. The YTD position is now £4.9m ahead of plan but once pay awards income funding (YTD £3.3m) and prior year reserve releases (£3m) are removed the net position is £1.4m less than plan. The key drivers to activity remain over performance of non-electives, A&E and ITU offset by under performance in Elective and Outpatient activity. Once all adjustments are removed the month on month Income has increased £1m as activity in Electives increased a little. Other income is £0.5m ahead of plan in month and above plan £4.2m YTD driven mainly by the SERCO termination payment and the impact of Trust charges to 2Gether which are offset in expenditure by higher non pay charges from the subsidiary.

Against the full year £30m CIP target, including income, £17.6m of CIPS have been delivered YTD against a target of £17.2m, £0.4m ahead of plan. CIPs achieved in Month 8 were £2.8m (the same as month 7) and £0.1m behind plan. Agency and Patient flow schemes slightly under delivered in month. CIPs in November amounted to £2.5m recurrent and £0.3m on a non-recurrent basis. The YTD position is recurrent £11.4m and non-recurrent £6.2m.

The Trusts cash balance as at the end of September was £3.4m, which is £0.1m below plan. The Trust's total cash borrowing is now £65.5m and is forecast at £81.6m by the year end.

The Trust carries and estimated £7.2m of risk to the year end position. The main risks relate to CIP delivery, activity related costs and increasingly low elective activity. The Trust will seek to mitigate these risks as we move through the year.

Income and Expenditure A

Income has performed under plan in Month 8, due largely to under delivery of Elective and Outpatient activity caused by increased activity plans in the second half of the year and lower than planned CIP delivery. Month on Month elective income has increased a small amount but will required significant improvement to deliver plan. Non-Electives, A&E, High Cost Drugs and Other NHS Areas over performed in month. Non-Electives over performance in month is driven by Obstetrics, General Surgery and General Medicine.

Pay performance is adverse to plan in November by £1.3m and by £10.8m ytd (4.2%). The main driver for the pay overspend in month continues to be above plan usage of agency staff for medical cover. Pay CIPs are adverse to plan in month by £0.7m and by £3.1m ytd. Total expenditure on pay in November was £31.9m, £0.3m higher than in October.

Non Pay expenditure is adverse to plan in November by £0.5m and by £4.8m (3.2%) ytd. This is predominantly due to expenditure procured through 2Gether and phase 2 staffing transfers to the subsidiary which are now accounted for as part of the Operated Healthcare Facility , rather than the various pay and non pay headings as previously planned. The original financial plan did not include the pay to non-pay transfers for 2gether but on consolidation these payments are matched

Cash G

The Trust's cash balance at the end of June was £3.4m which is £0.1m below plan. The main drivers for the YTD position are as follows:-

- CCG payments are net £6.5m below plan due to the lowering of the contract value .
- HMRC VAT returns are £3.1m above plan
- Other Income is £9.5m above plan; £2.5m from Serco on other income, STF funding of £1.4m and £3.3m of AfC funding from the DoH and other receipts £2.3m
- Loans from DHSC are £7.5m above plan
- unplanned receipts from 2Geather are £3.1m
- Payroll is £3.9m below plan and
- Creditor payments including non pay, agency and capital are £20.7m above plan net.

The Trust borrowed £4.9m cash in month increasing total borrowings to £65.5m. The total expected borrowing by the end of the year will be £81.6m.

Capital Programme A

The Trust has spent £7m on capital to November which is £5.7m behind plan. In year the Trust received £6.4m additional capital funding which it is using to build 2 observation bays in it's A&E Departments. Originally this was to be mostly spent by the end of November but has now slipped to January, hence the Trust now being behind plan. The whole capital plan is being reviewed to ensure full delivery of the revised £23.4m capital programme for 2018/19.

Cost Improvement Programme G

Net CIPs in month were £0.1m behind plan bringing the YTD position to £0.4m ahead of plan at £17.6m of savings YTD. The main variances in month relate to slow delivery of agency reduction, procurement and Patient Flow/LOS efficiencies whilst Workforce and Medicine schemes over delivered slightly. The forecast is circa £29.3m for the full year driven mainly by divisional schemes.

Income and Expenditure Summary

Month 08 (November) 2018/19

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	9,227	7,652	(1,574)	69,361	62,085	(7,276)	103,209
Non-Electives	13,246	13,921	676	108,154	112,311	4,157	161,862
Accident and Emergency	2,106	2,389	283	17,586	19,468	1,882	26,226
Outpatients	7,157	6,672	(485)	54,538	51,641	(2,897)	81,011
High Cost Drugs	4,575	4,617	42	37,208	36,397	(811)	55,662
Private Patients	21	21		168	210	42	248
Other NHS Clinical Income	9,674	9,768	95	73,039	82,792	9,752	109,496
Other Clinical Income	154	269	116	1,228	1,308	80	1,845
Total Clinical Income	**46,158**	**45,311**	**(847)**	**361,282**	**366,211**	**4,929**	**539,558**
Non Clinical Income	3,727	4,270	543	29,283	33,524	4,241	44,059
Total Income	**49,885**	**49,581**	**(304)**	**390,565**	**399,735**	**9,170**	**583,617**
Expenditure							
Substantive Staff	(27,599)	(27,510)	89	(222,097)	(219,033)	3,064	(326,479)
Bank	(1,111)	(1,442)	(331)	(8,966)	(10,075)	(1,108)	(19,900)
Agency	(1,889)	(2,945)	(1,056)	(12,467)	(25,187)	(12,720)	(19,431)
Total Pay	**(30,599)**	**(31,897)**	**(1,298)**	**(243,530)**	**(254,295)**	**(10,765)**	**(365,810)**
Non Pay	(18,791)	(19,321)	(530)	(149,040)	(153,853)	(4,813)	(222,146)
Total Expenditure	**(49,390)**	**(51,219)**	**(1,829)**	**(392,570)**	**(408,148)**	**(15,578)**	**(587,956)**
Non-Operating Expenses	(2,222)	(1,774)	448	(17,680)	(50,461)	(32,781)	(26,648)
Income and Expenditure Surplus/(Deficit)	**(1,727)**	**(3,412)**	**(1,685)**	**(19,685)**	**(58,874)**	**(39,189)**	**(30,987)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	46,849	46,273	(576)	366,810	373,153	6,343	547,857
Non Clinical Income	3,613	3,455	(158)	28,364	32,297	3,933	42,682
Total Income	**50,462**	**49,728**	**(734)**	**395,174**	**405,450**	**10,276**	**590,539**
Expenditure						-	
Pay	(30,953)	(34,293)	(3,340)	(246,362)	(263,874)	(17,512)	(370,054)
Non Pay	(18,979)	(17,211)	1,768	(150,550)	(149,205)	1,345	(224,416)
Total Expenditure	**(49,932)**	**(51,504)**	**(1,572)**	**(396,912)**	**(413,079)**	**(16,167)**	**(594,470)**
Non-Operating Expenses	(2,246)	(1,725)	521	(17,868)	(50,458)	(32,590)	(26,924)
Income and Expenditure Surplus/(Deficit)	**(1,716)**	**(3,501)**	**(1,785)**	**(19,606)**	**(58,087)**	**(38,481)**	**(30,855)**

Clinical Income

Income from Commissioners in month was behind plan. Non elective income remains higher than planned, while elective income is showing a large negative variance due to a phased increase in plan as the CIP schemes were expected to start and lower than normal run rates recorded. The majority of the adverse variances are contained within Electives, Outpatients and Non-PbR. The reduction in outpatient attendances was put in place in order to ensure the smooth implementation of the PAS system in September, however this appears to have continued into October and November. The largest increase in income is £0.4m funding received in month to cover the pay awards which is included under "Other NHS Clinical Income" and for which there is no clinical income plan.

There remains a small amount of uncertainty around the financial impact of 2017-18 Expert Determination challenges on 2018-19 baseline as both commissioners and the Trust work through the implications of the way some of our activity is recorded. The Trust is holding a small provision against this risk.

NHSE Contracts are behind plan in month by £145k. Rechargeable expenditure such as high cost drugs, devices and haemophilia blood products over performed by £58k in month across all contracts. The Trust contract with NHSE includes £4.1m of QIPP expectation with the Trust agreeing to work with NHSE to implement cost savings where possible, however, the risk against non achievement sits with the commissioner.

Non Clinical Income and Expenditure

Non clinical income is favourable to plan by £0.5m in November and by £4.2m ytd. The variance in month relates to unplanned income for goods and services provided to 2gether Support Solutions of £0.3m and income relating to the sale of equipment to 2gether Support Solutions of £0.5m, offset by an adverse performance against plan on pathology lab testing for other organisations of £0.2m.

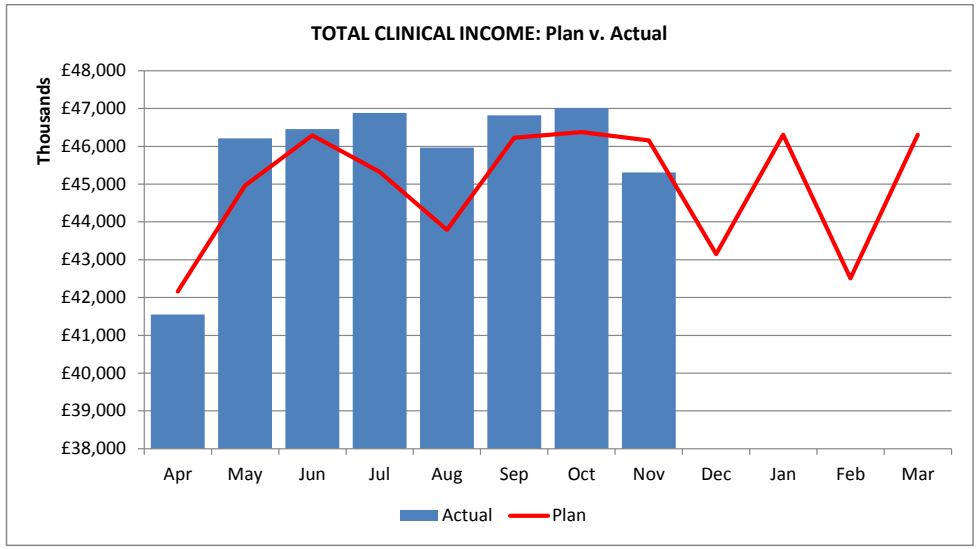
Total expenditure is adverse to plan by £1.8m in November and £15.6m ytd. In month, pay is overspent by £1.3m again mainly driven by temporary staffing spend, predominantly medical and nursing staff, which is £1.0m adverse to plan.
Non pay is overspent by £0.5m in November, mainly relating to supplies and services general which is £0.8m adverse to plan due to phase two staffing transfers to the subsidiary and associated pay costs being recharged to the Trust via the Operated Healthcare Facility. This is offset by an underspend in month of £0.2m on clinical supplies. The expenditure run rate fell by £1.9m when compared to October, with reductions in all non pay headings except drugs which increased marginally. The main headlines are reduced establishment and premises costs of £0.4m, reduced spend on supplies and services £0.4m, a further rebate from the CNST maternity incentive scheme resulting in reduced cost of £0.3m, reduced spend in E&T (mainly SIFT funding) £0.3m and reduced consultancy fees of £0.2m.

Key Highlights

Month 08 (November) 2018/19

CLINICAL INCOME

Clinical income is under plan in November by £0.8m. Non-Elective income is ahead of plan (£0.7m), while Elective income is under planned levels by £1.7m due to increased activity plans in the second half of the year. There was also the expectation that CIP targets would be achieved. Outpatients are under performing by £0.5m. Non-Elective income remains high due to higher than planned activity in month, however the casemix has reduced post PAS implementation and the teams at WHH and QEQM are investigating the recording of treatment and investigations to ensure all diagnostics are captured. A&E Income is also ahead of plan in month by 11% driven by activity increases. Much of the Elective CIPs are held centrally and services are finding it difficult to meet these income targets each month. Higher than planned levels of regular day attenders continue which is generating a lower case mix variance resulting in lower average tariffs within Electives.



ACTIVITY

A&E demand is ahead of plan by 6% this month. This over performance follows on from the last quarter and continues to improve against recent trends which was driven by the temporary transfer of some ED specialties from KCH to WHH and QEQM. Non-elective activity has performed above plan in month. The commissioners have increased the provision of care packages with a view to returning patients home more quickly and as part of their QIPP schemes are investing in preventing patients with Pneumonia from coming to the hospital where they can be treated at home. Outpatient activity is behind plan in month and YTD. Elective activity is 14% behind plan in month.

COMMISSIONER ANALYSIS

Activity plans reflected commissioner QIPP schemes to the value of £2.7m YTD. Any new commissioner QIPP schemes will be added to the contracts via a contract variation once the Trust is satisfied that the schemes are achievable in the timeframes set out. GP referrals were 2.7% behind plan in November. Many of our outpatient services are now listing at 13 weeks and beyond, but continued focus on reducing 52 week waiters is producing positive results.

The Trust has agreed an April and May closedown position with East Kent CCGs and both parties had committed to a financial reconciliation and closedown of Q1 by the 1st October 2018. However, EK CCGs have subsequently challenged the Q1 outturn and it has not yet been possible to enact the closedown. Negotiations are ongoing. The Trust does not foresee any risk to our reported position.

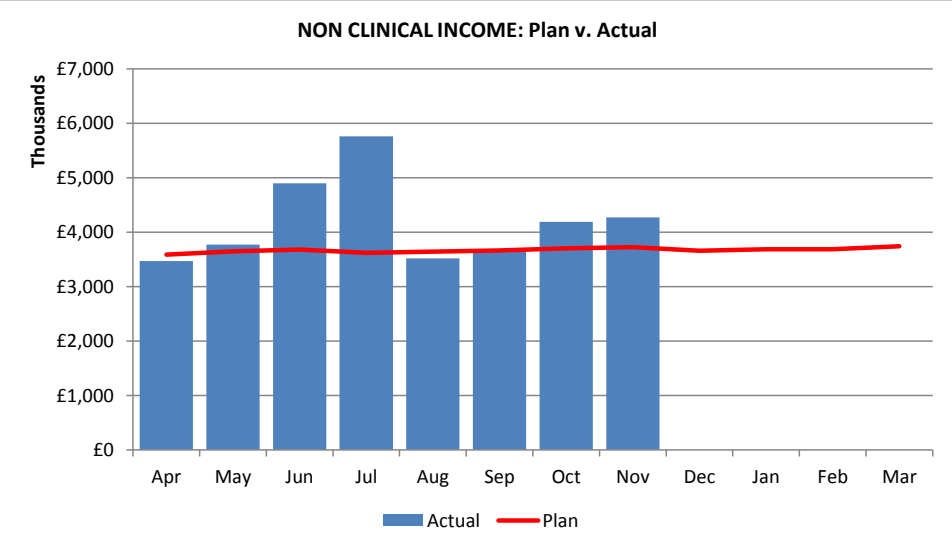
Key Highlights

Month 08 (November) 2018/19

NON CLINICAL INCOME

Non clinical income is favourable to plan by £0.5m in November and by £4.2m ytd.

The variance in month relates to unplanned income for goods and services provided to 2gether Support Solutions of £0.3m and income relating to the sale of equipment to 2gether Support Solutions of £0.5m, offset by an adverse performance against plan on pathology lab testing for other organisations of £0.2m.

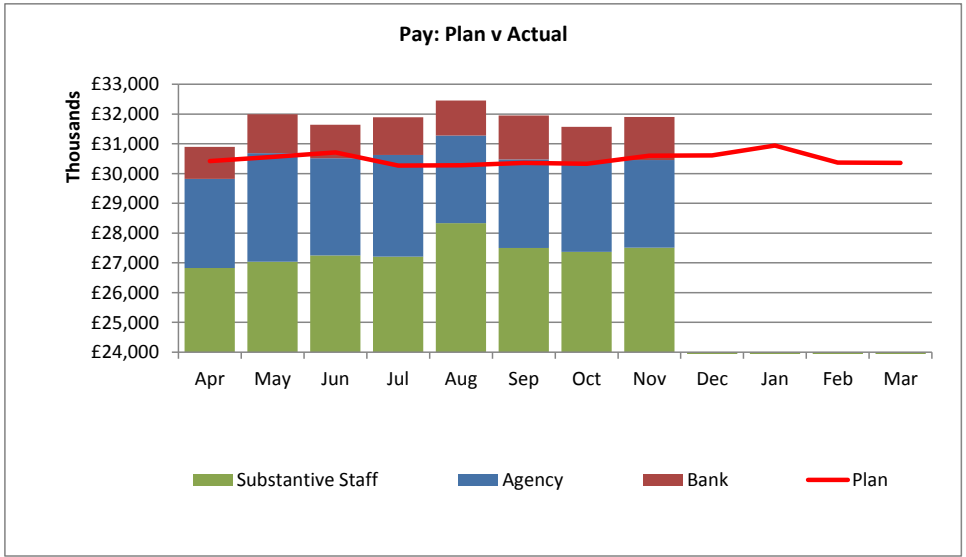


PAY

Pay performance is adverse to plan in November by £1.3m and by £10.8m ytd (4.4%). Pay CIPs are adverse to plan in month by £0.7m and by £3.1m ytd. The estimated AfC pay award excess impact not included in the base plan (funded in-year by the DOH in Clinical Income) is c£0.4m in month and £3.3m ytd.

Total expenditure on pay in November was £31.9m, £0.3m higher than in October. Expenditure on substantive and temporary staffing, including bank, agency and directly engaged medical staff, increased by £0.2m each.

The main driver for the pay overspend in month continues to relate to above plan usage of agency staff, partially offset by directly engaged medical locums, totalling £1.1m in month and £12.7m ytd. All Care Groups contribute to the overspend and CIP schemes are behind plan by £0.3m in November and by £2.2m ytd.



Key Highlights

Month 08 (November) 2018/19

NON-PAY

Non Pay expenditure is adverse to plan in November by £0.5m and by £4.8m (3.2%) ytd.

The main driver for the overspend in November are supplies and services general which is £0.8m adverse to plan due to phase two staffing transfers to the subsidiary and associated pay costs being recharged to the Trust via the Operated Healthcare Facility. This is offset by an underspend in month of £0.2m on clinical supplies. Overspends on Drugs and referrals to the independent sector totalling £0.3m are offset by an underspend on CNST contributions following a further rebate from the Maternity Incentive Scheme.

Non pay actual expenditure in November fell by £1.9m when compared to October with reductions in all non pay headings except drugs which increased marginally. Main headlines are: reduced establishment and premises costs of £0.4m, reduced spend on supplies and services £0.4m, a further rebate from the CNST maternity incentive scheme resulting in a reduced cost of £0.3m, reduced spend in E&T (mainly SIFT funding) £0.3m and reduced consultancy fees of £0.2m.

DEBT

Total invoiced debtors have decreased from the opening position of £28.5m by £10.9m to £17.6m (excluding the 2gether invoices totalling £115.7m of which £99.3m will be converted to long term debt/equity). Excluding 2gether, the largest debtors at 30th November were East Kent CCGs £5.2m and East Kent Medical Services £2.0m.

CAPITAL

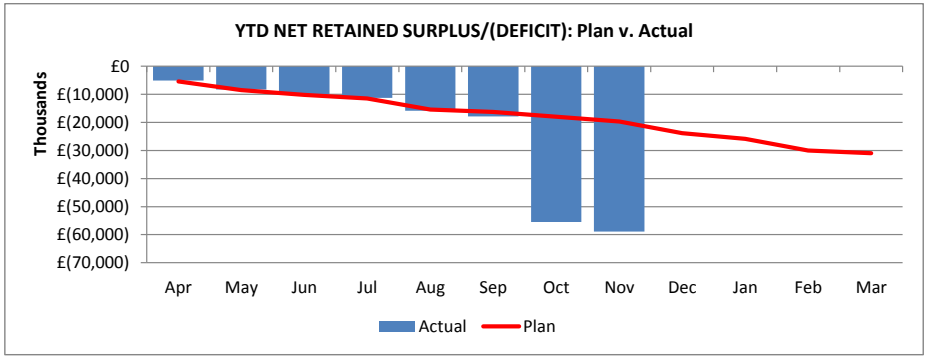
Total YTD expenditure for Mth 8 2018/19 is £5.6m below plan mainly driven by NHSI approval for funding the observation bays.

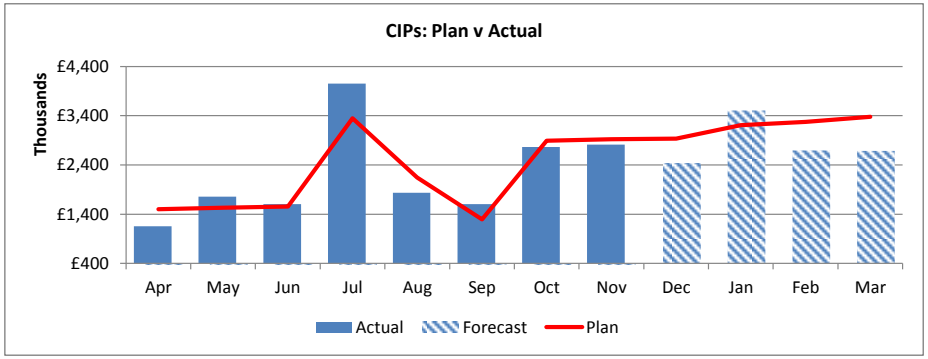
EBITDA

The Trust is reporting a year to date deficit EBITDA of £6.4m

CASH

The closing cash balance for the Trust as at 30th November was £3.4m





FINANCING

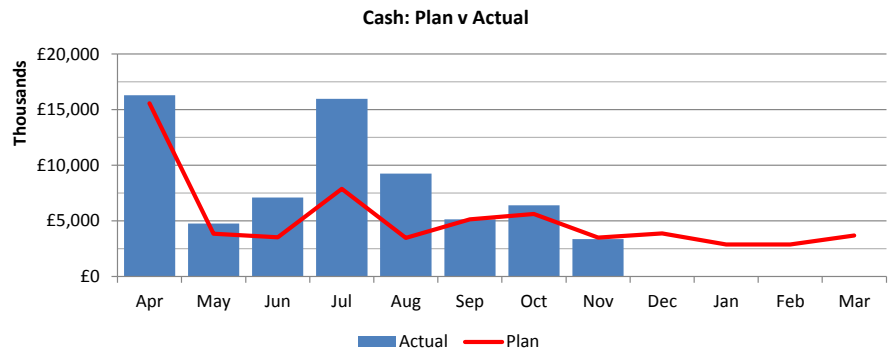
£1.8m of interest was incurred in respect of the drawings against working capital facilities to 30th November 2018

CIPS

The target for the year is £30m. The Trust is maintaining confirm and challenge meetings. As at the time of reporting, c.94% of schemes were 'green' rated . The major focus is on delivering 18/19 schemes and progressing 'red' and 'amber' schemes to 'green'. Care Groups, supported by the PMO, are being asked to work up schemes for 2019/20.

Cash Flow

Month 08 (November) 2018/19



Unconsolidated Cash balance was £3.4m at the end of November 2018, £0.1m below plan.

Total receipts in November 2018 were £2.7m above plan

- Receipts from East Kent CCGs were £2.0m below plan for Main Contract but £1.0m above plan for overperformance
- Receipt of £3.1m from 2gether for stocks
- Other receipts are £0.6m over plan

Total Payments in November 2018 were £4.7m over plan

- Monthly payroll was £0.2m below plan
- Creditor payments inc Capital were £2.3m below plan
- Payments to 2gether(prev Serco) were £6.1m over plan

YTD cash receipts are £16.7m above plan

- East Kent CCGs are net £6.5m below plan. Payments against contract are £8.8m below plan due to the reduction of their contract value. Payments for overperformance are £2.3m above plan
- Other NHS receipts are £4.7m above plan, which includes £3.3m AfC funding from DoH
- HMRC VAT returns are £3.1m above plan
- STF receipt was £1.4m above plan
- Loans from DHSC £7.5m above plan
- Receipts from 2gether £3.1m above plan
- Other receipts are £3.4m above plan; which includes £2.5m received from Serco

YTD cash payments are £16.8m above plan

- Payroll is £3.9m below plan
- Creditor Payments including Capital are £20.7m above plan

2018/19 Forecast

- The forecast includes restrictions on creditor payment runs throughout the year to ensure that a positive cash balance is maintained
- The impact of 2gether Support Solutions operating fully has been reflected in the Payroll and Creditors payments forecast. Additional changes to the forecast may still be made once the full effects are known.

Provider Sustainability Funding (Formerly Sustainability and Transformation Funding)

The Trust received £5.6m incentive Provider and Sustainability Funding (PSF) relating to 2017/18 in July 2018.
As a result of the Trust not agreeing to a control total, the Trust is not eligible for any PSF funding in 2018/19.

Working Capital Facility

Loan Schedule	Loan Value £'000	Facility Type	Repayment date	Interest rate	Total Interest if full term £'000
2016/17 Received	22,736	ISRWF	17/05/2021	3.50%	3,688
2017/18 Received	23,492	ISUCL	2020/21	3.50%	2,485
Apr' 2018 (Received)	2,234	ISUCL	2021/22	3.50%	323
July 2018 (Received)	3,410	ISUCL	2021/22	3.50%	359
Aug' 2018 (Received)	3,708	ISUCL	2021/22	3.50%	391
Sept' 2018 (Received)	5,103	ISUCL	2021/22	3.50%	538
Nov' 2018 (Received)	4,869	ISUCL	2021/22	3.50%	515
Dec' 2018 (Forecast)	5,207	ISUCL	TBA	TBA	TBA
Jan' 2018 (Forecast)	2,037	ISUCL	TBA	TBA	TBA
Feb' 2018 (Forecast)	2,192	ISUCL	TBA	TBA	TBA
March 2018 (Forecast)	6,661	ISUCL	TBA	TBA	TBA

Planned 18/19 Loan was £27.4m in line with the plan pre technical deficit but on current forecast this will be exceeded.
Future Loans have been rephased due to changes in the forecast

Creditor Management

- Creditor management continued to be applied throughout October 18. The Trust is close to the limit in restricting creditor payments and still being able to receive essential goods and services. At the end of October 2018 the Trust was recording 69 creditor days (Calculated as invoiced creditors at 30th November/ Forecast non pay expenditure x 365)
- The Trust has been flagged in the national press as one of the slowest paying Trusts in the country.

Facility Type Key

- ISRWF Single Currency Interim Revolving Working Capital Support Facility
- ISUCL Uncommitted Single Currency Interim Revenue Support - this facility replaces the ISRWF as the Trust is in Financial special measures and has a variable interest rate

Income and Expenditure Forecast

Month 08 (November) 2018/19

Unconsolidated

£000	Annual Plan	Forecast	Var.
Income			
Clinical Income	539,558	555,895	16,337
Non Clinical Income	44,059	46,637	2,578
Total Income	**583,617**	**602,532**	**18,915**
Expenditure			
Pay	(365,552)	(385,396)	(19,844)
Non Pay	(222,404)	(232,316)	(9,912)
Total Expenditure	**(587,956)**	**(617,712)**	**(29,756)**
Non-Operating Expenses	(26,648)	(57,765)	(31,117)
Income and Expenditure Surplus/(Deficit)	**(30,987)**	**(72,945)**	**(41,958)**
Add back all I&E impairments/(reversals)	500	34,317	33,817
Remove capital donations/grants I&E impact	525	637	112
Surplus/(Deficit) after technical adjustments	**(29,962)**	**(37,991)**	**(8,029)**

Consolidated

£000	Annual Plan	Forecast	Var.
Income			
Clinical Income	547,857	564,194	16,337
Non Clinical Income	42,682	47,560	4,878
Total Income	**590,539**	**611,754**	**21,215**
Expenditure			
Pay	(370,054)	(390,133)	(20,079)
Non Pay	(224,416)	(235,371)	(10,955)
Total Expenditure	**(594,470)**	**(625,504)**	**(31,034)**
Non-Operating Expenses	(26,924)	(58,507)	(31,583)
Income and Expenditure Surplus/(Deficit)	**(30,855)**	**(72,257)**	**(41,402)**
Add back all I&E impairments/(reversals)	500	34,317	33,817
Remove capital donations/grants I&E impact	525	637	112
Surplus/(Deficit) after technical adjustments	**(29,830)**	**(37,303)**	**(7,473)**

The Trust's consolidated year end forecast remains at an actual technically adjusted deficit of £29.9m , which has been reported to NHSi in September under a 'best case' scenario. When compared against a deficit control total equivalent (no PSF assumed) of £29.8m, this is £0.1m adverse to plan.

The data table on this page sets out the impact of the 'likely' scenario, which would outturn a comparable deficit of £37.3m and £7.5m adverse to deficit control total. The 'worst case' scenario currently stands at £52.7m and £22.3m adverse. The main variable between these scenarios are the ability of the Trust to deliver increased activity and income.

CIPS of £30.5m have been assumed in all scenarios to support the delivery of the 18-19 forecast.

The unconsolidated forecast for non-operating expenses worsens considerably because of a revised estimate of impairments triggered by the transfer of assets to 2SS from £25.0m to £34.3m.This assessment is subject to review however, as this forms part of NHSi technical adjustments, the impact is removed and reflected in the adjusted deficit forecast.

The Trust's income forecast is based on Month 5 actuals, adjusted for a number of assumptions including Elective and Day Case activity meeting planned levels by year end, two additional wards opening in emergency care over the winter at WHH and QEQM, the bridging solution for Elective orthopaedics coming on line and 2 additional ITU beds. Over performance in other NHS Clinical Income includes £5m unplanned funding for pay awards, £3m over performance for ITU and better than planned CQUIN achievement . Q1 achieved at 100%.

Expenditure includes an estimated additional £7m of cost for business cases approved to support the Winter plan

Work will continue to evaluate the forecast in 'best', 'likely' and 'worst' case scenarios considering current trends, progress against approved investments and identified risks

Risks and Opportunities

Month 08 (November) 2018/19

Risk/Opp	Area	Description	Narrative	Full Year (Risk)/Opp £000	Probability	Impact £,000
Risk	Clinical Income	Failure to deliver Planned activity	Organisation is running well behind planned activity levels which are required to meet the financial targets	(10,000)	40%	(4,000)
Risk	CIP Delivery	Red and Amber Schemes to be fully developed	Schemes which do not yet have a fully finalised plans have a higher risk of non delivery	(2,800)	25%	(700)
Risk	Pay and Non Pay	Costs of Additional Activity	The costs of additional activity may exceed the marginal costs for this activity and additional spend may be required to cover winter activity and address elective backlogs.	(5,857)	43%	(2,519)
			Total Risk			(7,219)
			Total Opportunity			
			NET (RISK)/OPPORTUNITY			(7,219)

Some risks have been realised and are now included in the Forecast, only remaining risks are shown in the table.

Clinical Income

Month 08 (November) 2018/19

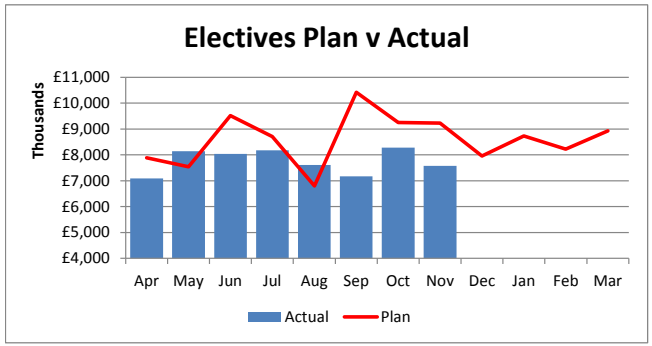
£000	This Month Plan	This Month Actual	This Month Variance		Year to Date Plan	Year to Date Actual	Year to Date Variance		Annual Plan
Electives	9,227	7,571	(1,656)	(17.9%)	69,361	62,085	(7,276)	(10.5%)	103,209
Non-Electives	13,246	13,921	675	5.1%	108,154	112,311	4,157	3.8%	161,862
Accident and Emergency	2,106	2,345	239	11.4%	17,586	19,468	1,882	10.7%	26,226
Outpatients	7,157	6,612	(544)	(7.6%)	54,538	51,641	(2,897)	(5.3%)	81,011
High Cost Drugs	4,575	4,708	133	2.9%	37,208	36,397	(811)	(2.2%)	55,662
Private Patients	21	21		0.5%	168	210	42	25.2%	248
Other NHS Clinical	9,674	10,090	417	4.3%	73,039	82,793	9,754	13.4%	109,496
Other Clinical	154	269	116	75.5%	1,228	1,308	80	6.5%	1,845
Prior Month Adjustment		(227)	(227)	0.0%				0.0%	
Total	**46,158**	**45,311**	**(847)**	(1.8%)	**361,282**	**366,213**	**4,931**	1.4%	**539,558**
				Adverse				Favourable	

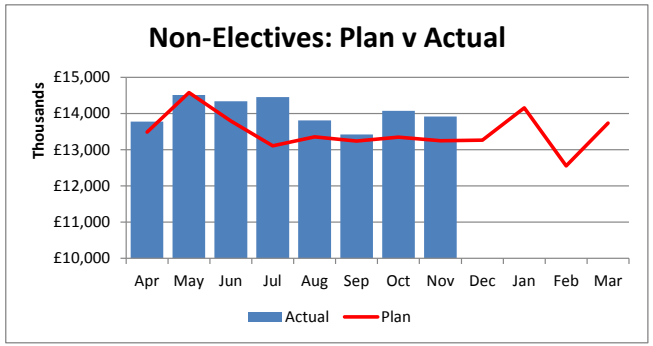
Income has performed under plan in November, due largely to underperformances within Elective and Outpatient activity. This is partially offset by £0.4m unplanned income to fund Agenda for Change pay awards, while Non-Electives, A&E, High Cost Drugs and Other NHS Areas also over performed in month.

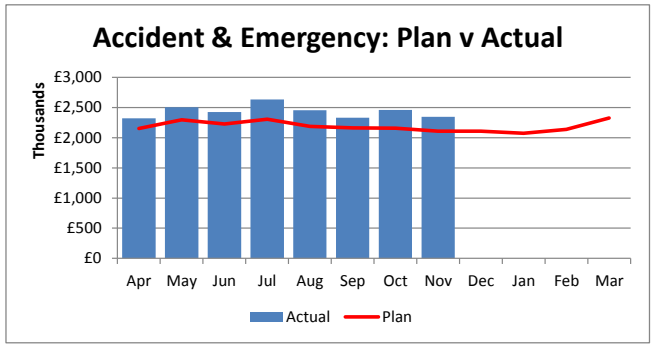
Elective inpatients and Day cases under performed in month by £1.7m as the Elective plan phasing was increased above run-rate incorporating the planned CIP schemes for the second half of the year. The main areas behind plan were T&O, General Surgery, Pain Management, General Medicine, Cardiology and Gynaecology. To mitigate the risk of non achievement, plans for using Independent Sector organisations for the rest of the year are as follows: 18 Week Support in Gastroenterology, Chaucer, One Ashford, SHS and Spencer wing for Trauma & Orthopaedics, DMC to continue to deliver Dermatology activity, Insourcing for Ear, Nose & Throat patients, HBS and Spencer Wing for Ophthalmology outpatient activity and Spencer Wing to help waiting times for Rheumatology Outpatient first attendances. The installation of the two Theatres Pods has been completed at Canterbury, and will be operational from December onwards. Non-Electives are over plan by £0.7m in November, largely due to Obstetrics, General Surgery, and General Medicine.

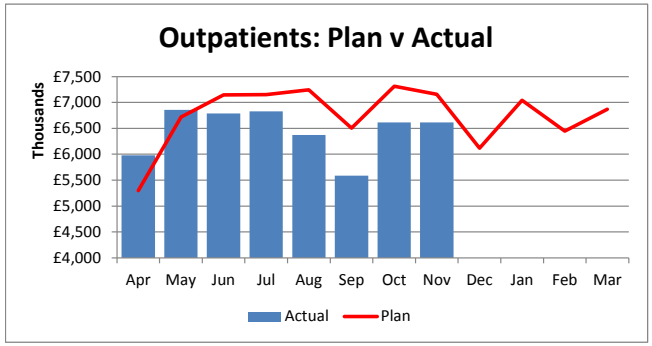
Other NHS Clinical activity is also ahead of plan due to an amount received to cover the increased pay award costs (£0.4m).

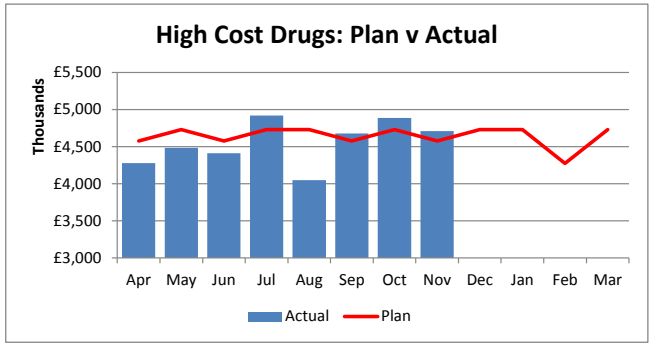
Rechargeable income is over plan in month with Drugs and Devices £58k above plan. This does not impact the bottom line as there is a corresponding increase in expenditure.

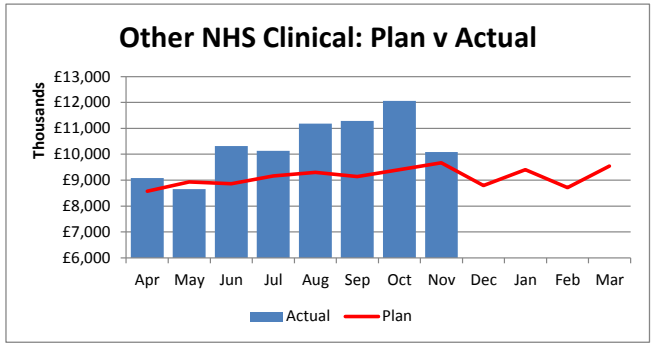












Clinical Activity

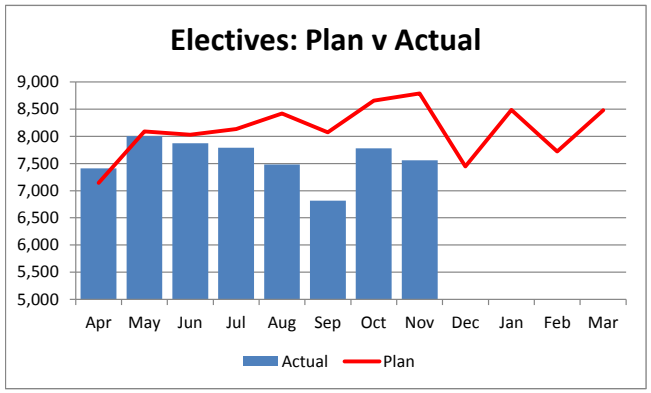
Month 08 (November) 2018/19

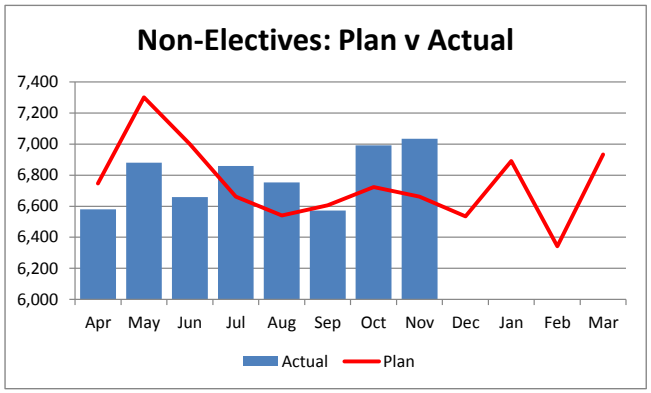
	This Month				Year to Date				Annual
Activity Units	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	8,791	7,560	(1,231)	(14.0%)	65,340	60,715	(4,625)	(7.1%)	97,477
Non-Electives	6,662	7,035	373	5.6%	54,243	54,331	88	0.2%	80,942
Accident & Emergency	16,929	18,008	1,079	6.4%	141,539	148,051	6,512	4.6%	211,076
Outpatients	72,351	62,225	(10,126)	(14.0%)	540,362	511,422	(28,940)	(5.4%)	802,917
Other NHS Clinical	472,832	494,965	22,133	4.7%	3,682,539	3,856,628	174,089	4.7%	5,397,116
Total	**104,733**	**94,828**	**(9,905)**	(9.5%)	**801,484**	**774,519**	**(26,965)**	(3.4%)	**1,192,412**
				Adverse				Adverse	

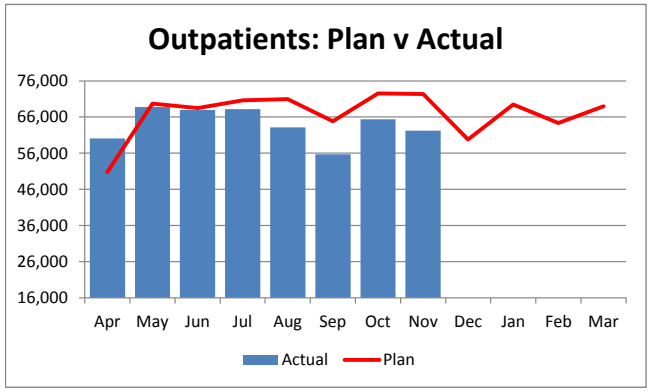
Within Elective activity (overall 14% under), Inpatient activity was 14% under plan largely due to Urology (by 42), T&O (by 77), General Medicine (by 92) and Gynaecology (by 32). Day case activity was 21% under plan (T&O 189, Neurology 91, Pain Management 182, Dermatology 145 and General Medicine 329). This is partially offset by continued activity over performance in Regular day attenders.

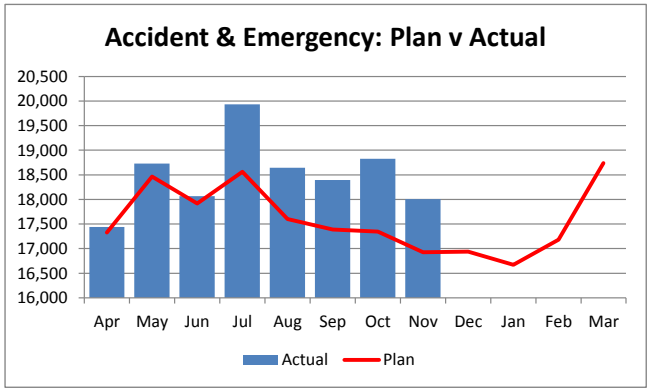
Outpatient activity under performed in month by 14% across new and follow up attendances, many areas were behind plan such as: Urology, General Surgery, T&O, ENT, Ophthalmology, Pain Management, General Medicine, Gastroenterology, Dermatology, Gynaecology, Respiratory Medicine, Diabetic Medicine, Rheumatology, Paediatrics, Clinical Oncology, Orthoptics, Orthotics and Physiotherapy, while the only notable over performing specialties were Cardiology and Oral Surgery.

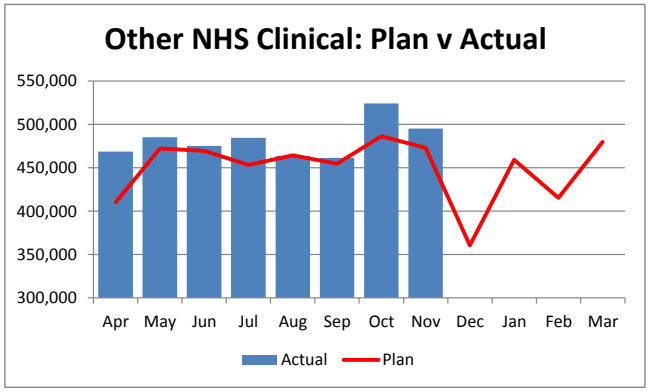
Most specialties reduced activity in September in order to ensure the smooth implementation of the new PAS system, however the October and November run rates are lower than the previous M1-5 run rate. This is being investigated by the Care groups.







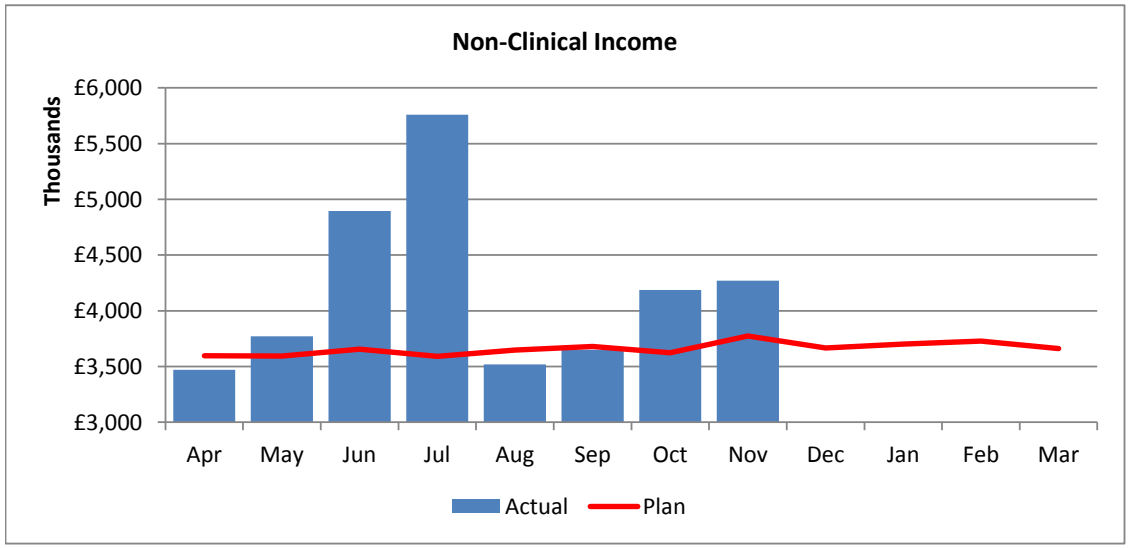




Non Clinical Income

Month 08 (November) 2018/19

Non-Clinical Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,429	1,535	106	11,435	12,631	1,196	17,150
Research and development	223	231	8	1,784	1,814	30	2,673
Education and Training	1,269	1,257	(12)	10,152	10,243	91	15,233
Car Parking income	425	428	3	3,124	3,281	157	4,766
Staff accommodation rental	235	219	(16)	1,623	1,535	(88)	2,494
Property rental (not lease income)	1	1	()	9	8	(1)	13
Cash donations / grants for the purchase of capital assets	42		(42)	336	160	(176)	500
Charitable and other contributions to expenditure	12	12	()	96	96	()	145
Other	91	586	496	724	3,756	3,031	1,085
Total	**3,727**	**4,270**	**543**	**29,283**	**33,524**	**4,241**	**44,059**
			14.58%			14.48%	
			Favourable			Favourable	



Non clinical income is favourable to plan by £0.5m in November and by £4.2m ytd. Income CIPs are favourable to plan by less than £0.1m in November and by £2.1m ytd.

The variance in month relates to unplanned income for goods and services provided to 2gether Support Solutions of £0.3m and income relating to the sale of equipment to 2gether Support Solutions of £0.5m, offset by an adverse performance against plan on pathology lab testing for other organisations of £0.2m due to an over estimate of income in October.

As previously reported, the majority of the over performance ytd relates to income received from Serco following early exit from the contract of £2.1m reflected as an income CIP and a favourable performance against plan on income relating to the PAS project totalling £0.6m. Unplanned income for goods, equipment and services provided to 2gether Support

Pay

Month 08 (November) 2018/19

Pay Expenditure	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,111	1,043	68	(8,084)	(8,458)	(374)	(65,055)	(64,506)	549	(97,531)
Nurses and Midwives	2,425	2,092	332	(7,646)	(7,699)	(53)	(61,531)	(60,758)	773	(92,248)
Scientific, Therapeutic and Technical	1,388	1,347	41	(4,506)	(4,322)	184	(36,264)	(34,682)	1,582	(54,367)
Admin and Clerical	1,439	1,263	175	(2,858)	(2,711)	147	(22,995)	(21,857)	1,137	(34,474)
Other Pay	1,442	1,322	120	(3,967)	(3,840)	127	(31,925)	(33,227)	(1,302)	(47,859)
Permanent Staff Total	**7,805**	**7,067**	**737**	**(27,061)**	**(27,030)**	**31**	**(217,769)**	**(215,031)**	**2,738**	**(326,479)**
Waiting List Payments										
Medical and Dental	0	0	0	(226)	(231)	(6)	(1,816)	(1,930)	(114)	(2,723)
Waiting List Payments Total	**0**	**0**	**0**	**(226)**	**(231)**	**(6)**	**(1,816)**	**(1,930)**	**(114)**	**(2,723)**
Medical Locums/Short Sessions										
Medical and Dental	1	0	1	(312)	(248)	64	(2,512)	(2,073)	439	(3,766)
Medical Locums/Short Sessions Total	**1**	**0**	**1**	**(312)**	**(248)**	**64**	**(2,512)**	**(2,073)**	**439**	**(3,766)**
Substantive	**7,805**	**7,067**	**738**	**(27,599)**	**(27,510)**	**89**	**(222,097)**	**(219,033)**	**3,064**	**(332,968)**
Bank										
Medical and Dental	0	25	(25)	(468)	(399)	70	(3,780)	(2,541)	1,239	(5,654)
Nurses and Midwives	0	89	(89)	(248)	(348)	(100)	(1,999)	(2,672)	(673)	(2,990)
Scientific, Therapeutic and Technical	1	3	(3)	(12)	(22)	(10)	(98)	(163)	(65)	(147)
Admin and Clerical	0	82	(82)	(94)	(227)	(133)	(758)	(1,337)	(579)	(1,133)
Other Pay	0	170	(170)	(289)	(447)	(158)	(2,331)	(3,362)	(1,031)	(3,487)
Bank Total	**1**	**369**	**(368)**	**(1,111)**	**(1,442)**	**(331)**	**(8,966)**	**(10,075)**	**(1,108)**	**(13,411)**
Agency										
Medical and Dental	38	150	(112)	(866)	(2,006)	(1,140)	(5,714)	(13,854)	(8,141)	(8,906)
Nurses and Midwives	0	136	(136)	(555)	(751)	(197)	(3,660)	(7,705)	(4,046)	(5,704)
Scientific, Therapeutic and Technical	0	32	(32)	(63)	(207)	(144)	(417)	(1,937)	(1,520)	(650)
Admin and Clerical	0	2	(2)	(7)	(13)	(6)	(47)	(151)	(104)	(73)
Other Pay	0	4	(4)	(53)	43	96	(353)	(955)	(602)	(550)
Agency Total	**38**	**323**	**(285)**	**(1,544)**	**(2,934)**	**(1,390)**	**(10,190)**	**(24,603)**	**(14,412)**	**(15,883)**
Direct Engagement - Agency										
Medical and Dental	0	(2)	2	(345)	(11)	334	(2,277)	(584)	1,693	(3,548)
Direct Engagement - Agency Total	**0**	**(2)**	**2**	**(345)**	**(11)**	**334**	**(2,277)**	**(584)**	**1,693**	**(3,548)**
Agency	**38**	**321**	**(283)**	**(1,889)**	**(2,945)**	**(1,056)**	**(12,467)**	**(25,187)**	**(12,720)**	**(19,431)**
Total	**7,844**	**7,757**	**86**	**(30,599)**	**(31,897)**	**(1,298)**	**(243,530)**	**(254,295)**	**(10,765)**	**(365,810)**
						-4.24%			-4.42%	
						Adverse			Adverse	

Pay performance is adverse to plan in November by £1.3m and by £10.8m ytd (4.42%). Pay CIPs are adverse to plan in month by £0.7m and by £3.1m ytd. The estimated AfC pay award excess impact not included in the base plan (funded in-year by the DOH in Clinical Income) is c£0.4m in month and £3.3m ytd. The net adjusted pay overspend is therefore £7.5m YTD.

Total expenditure on pay in November was £31.9m, £0.3m higher than in October. Expenditure on substantive and temporary staffing, including bank, agency and directly engaged medical staff, increased by £0.16m each.

Substantive staff expenditure is marginally favourable to plan in November and favourable to plan by £2.7m ytd. Expenditure on substantive medical and dental staff is overspent in month by £0.4m, continuing the adverse trend from October. All substantive staffing groups are underspent ytd except other staff which are £1.3m overspend ytd, predominantly relating to expenditure on HCAs which is overspent in month by £0.2m and by £1.3m ytd.

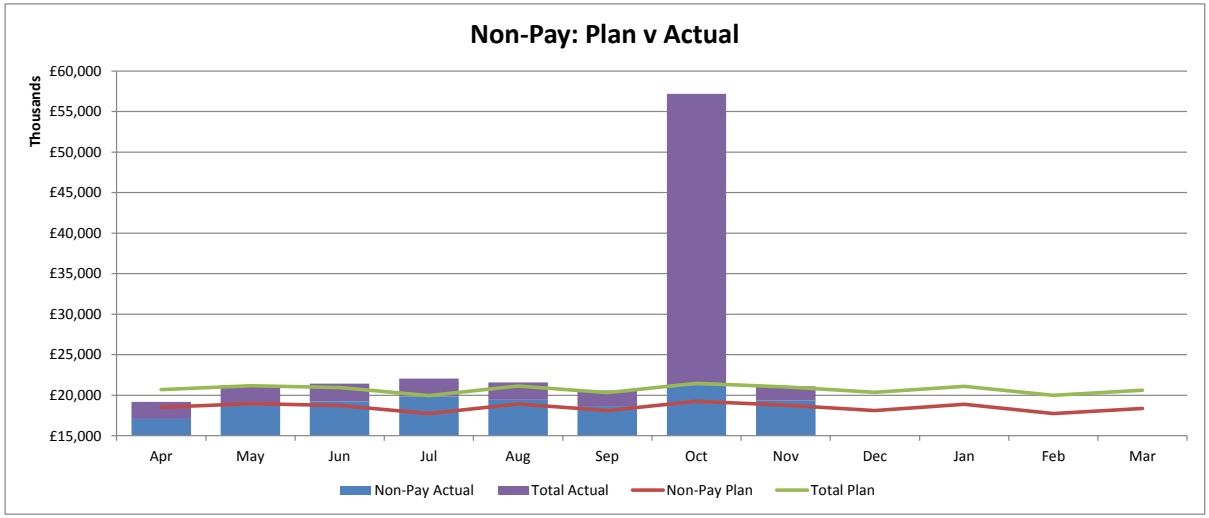
Expenditure on Bank staff is adverse to plan by £0.3m in month and by £1.1m ytd. All staffing groups are overspending against plan on bank staff in month and ytd except medical staffing which is favourable to plan by £0.1m in November and by £1.2m ytd. Actual expenditure on bank staff has increased by £0.2m in November, predominantly on medical staff and offset by a reduction in directly engaged agency staff.

Expenditure on agency staff is adverse to plan in November by £1.4m, offset by a favourable performance on directly engaged agency medical staff. Ytd the overall agency variance stands at £12.7m adverse to plan with overspends in all staffing groups, although the trend on HCA spend has improved following cessation of the usage of premium rate agency HCAs via TFS in September. All Care Groups contribute to the overspend and CIP schemes are behind plan by £0.3m in November and by £2.2m ytd in this category. Expenditure on agency staff fell by less that £0.1m overall in November with a reduction in directly engaged agency staff being offset by growth in expenditure on medical bank staff.

Non-Pay

Month 08 (November) 2018/19

£000	This Month Plan	This Month Actual	This Month Var.	Year to Date Plan	Year to Date Actual	Year to Date Var.	Annual Plan
Drugs	(5,565)	(5,736)	(171)	(45,371)	(43,395)	1,976	(67,802)
Clinical Supplies and Services - Clinical	(5,676)	(2,832)	2,844	(45,195)	(40,549)	4,646	(66,208)
Supplies and Services - Non-Clinical	(2,169)	(6,424)	(4,255)	(13,955)	(25,057)	(11,102)	(22,245)
Purchase of Healthcare	(761)	(929)	(168)	(6,094)	(7,016)	(922)	(9,138)
Education & Training	(246)	120	366	(1,968)	(1,183)	785	(2,951)
Consultancy	(72)	(43)	29	(576)	(640)	(64)	(861)
Premises	(1,718)	(1,276)	442	(13,824)	(14,313)	(489)	(20,552)
Clinical Negligence	(1,697)	(1,436)	261	(14,548)	(13,837)	711	(21,336)
Transport	(323)	(203)	120	(2,584)	(2,412)	172	(3,877)
Establishment	(274)	(183)	91	(2,206)	(2,453)	(247)	(3,296)
Other	(290)	(380)	(90)	(2,719)	(2,997)	(278)	(3,880)
Total Non-Pay Expenditure	**(18,791)**	**(19,321)**	**(530)**	**(149,040)**	**(153,853)**	**(4,813)**	**(222,146)**
Depreciation & Amortisation-Owned Assets	(1,517)	(1,163)	353	(12,134)	(11,603)	531	(18,201)
Impairment Losses	(42)	185	226	(333)	(34,132)	(33,799)	(500)
Profit/Loss on Asset Disposals	(10)		10	(80)	1	81	(120)
PDC Dividend	(501)	(557)	(56)	(4,009)	(3,432)	576	(6,013)
Interest Receivable	9	214	204	73	542	469	110
Interest Payable	(161)	(452)	(291)	(1,193)	(1,837)	(644)	(1,917)
Other Non-Operating Expenses	(1)		1	(5)		5	(7)
Total Non-Operating Expenditure	**(2,222)**	**(1,774)**	**448**	**(17,680)**	**(50,461)**	**(32,781)**	**(26,648)**
Total Expenditure	**(21,013)**	**(21,095)**	**(82)**	**(166,720)**	**(204,314)**	**(37,594)**	**(248,794)**



Non Pay expenditure is adverse to plan in November by £0.5m and by £4.8m (3.2%) ytd. Non Pay CIP schemes are adverse to plan in total by £0.1m in month and by £5.6m ytd.

Drug expenditure is adverse to plan by £0.2m in month and favourable to plan by £2.0m ytd. Passthrough drugs are adverse to plan in month by £0.1m and favourable to plan by £0.9m ytd, offset by an adverse position on clinical income. All other drugs are adverse to plan in month by £0.1m and favourable to plan by £1.1m ytd. CIP schemes remain at £0.2m favourable to plan ytd.

Clinical supplies are favourable to plan in month by £2.8m and by £4.6m ytd. However this favourable variance is offset by an overspend in Supplies and Services - General relating to passthrough expenditure on consumable items purchased via the Operated Healthcare Facility (OHF). Including the £2.7m in month and £5.5m ytd of OHF passthrough expenditure relating to clinical supplies, purchases are again favourable to the Trust's original plan by £0.2m in month and adverse to plan by £0.9m ytd. Slippage on CIP schemes accounts for all of the overspend ytd.

Expenditure on supplies and services general is adverse to plan in November by £4.3m and by £11.1m ytd. £3.4m of the total overspend in month (£6.8m ytd) relates to all passthrough costs (mainly clinical supplies and premises costs), now procured via the OHF provided by 2gether Support Solutions Ltd. Removing the effect of all passthrough costs, expenditure on non clinical supplies is adverse to plan by £0.8m in month and by £4.3m ytd. In month, the implementation of phase two staffing transfer to the subsidiary and an adverse performance against CIP targets accounts for £1.0m of the variance, offset by an estimated recharge for set up costs (eg uniforms) to the subsidiary of £0.3m. Ytd, underperformance on CIPs accounts for the majority of the variance, including £2.1m from Serco planned as non clinical supplies but realised as non clinical income.

The underspend shown here on Premises costs is offset by passthrough costs of £0.5m leaving a marginal deficit in month.

Non pay actual expenditure in November fell by £1.9m when compared to October with reductions in all non pay headings except drugs which increased marginally. Main headlines are: reduced establishment and premises costs of £0.4m, reduced spend on supplies and services £0.4m, a further rebate from the CNST maternity incentive scheme resulting in reduced cost of £0.3m, reduced spend in E&T (mainly SIFT funding) £0.3m and reduced consultancy fees of £0.2m.

Non Operating Expenditure YTD is £32.8m above plan. The Trust has incurred £1.8m interest charges in respect of the £65.6m cumulative facility utilised to date. Impairment losses of £34.3m in respect of the 5 year cyclical valuation have been recognised.

Cost Improvement Summary

Month 08 (November) 2018/19

Delivery Summary

	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Patient Flow/LOS	167	-	(167)	333	-	(333)	-	(1,000)
Agency	456	295	(161)	3,309	2,365	(944)	3,566	(1,851)
Workforce *	20	46	27	91	282	192	416	246
Procurement	207	123	(84)	1,153	555	(598)	1,058	(925)
Medicines Value	79	167	88	461	1,053	592	1,542	671
Division Schemes **	1,761	1,896	135	9,195	10,764	1,569	18,196	1,612
Sub-total	**2,689**	**2,528**	**(162)**	**14,543**	**15,019**	**476**	**24,778**	**(1,247)**
Central	235	284	48	2,660	2,566	(93)	4,510	535
Grand Total	**2,925**	**2,811**	**(113)**	**17,202**	**17,585**	**383**	**29,288**	**(712)**

*** Smaller divisional schemes not allocated to a work stream*

Delivered £000

Month	Target	Actual
April	1,504	1,155
May	1,534	1,758
June	1,553	1,604
July	3,349	4,054
August	2,148	1,835
September	1,295	1,603
October	2,894	2,766
November	2,925	2,811
December	2,937	
January	3,205	
February	3,276	
March	3,975	
	30,000	**17,585**
		58.6%

CIPs

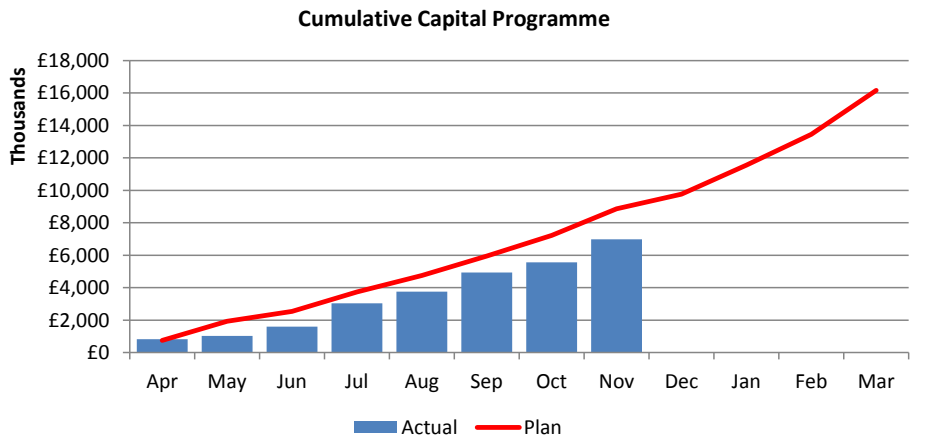
The CIPs Plan of £30.0m is net of the cost of delivery. CIPs achieved in M08 were £2.8m against a plan of £2.9m. Medicines Value and workforce over performed in month and YTD supported by Care Groups (including an additional £0.4m CNST rebate) and Central schemes YTD. Agency, Procurement and Patient Flow are adverse in month and YTD. CIPs in November amounted to £2.5m recurrent and £0.3m on a non-recurrent basis. The YTD position is recurrent £11.4m and non-recurrent £6.2m.

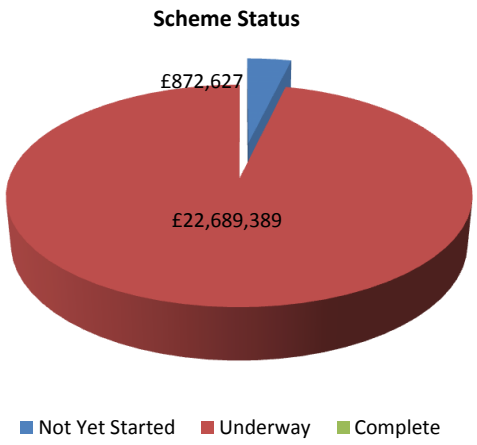
Capital Expenditure

Month 08 (November) 2018/19

Capital Programme	Annual	To Date		
£000	Plan	Plan	Actual	Variance
Dementia Village	974	159	49	110
A&E Observation Area	6,400	3,996	1,058	2,938
Clinical Strategy Plans	200	166	131	35
Orthopaedic Modular Theatres	2,066	1,054	685	369
CT/CT SPECT Replacement	212	31	39	(8)
Invest To Save Schemes	39			
Medical Devices Group	3,082	1,550	1,417	133
Patent Environment Investment Committ	2,788	1,799	1,219	580
Information Development Group	2,000	1,660	1,637	23
Other Equipment Schemes	402	90		90
Other Building Schemes	70			
Other IT Schemes	2,593	2,054	1,478	575
All Other Schemes	2,573	90	(311)	401
VAT Reclaim			(419)	419
Total	23,399	12,649	6,984	5,666

- Total expenditure at Mth 8 2018/19 is 45% below plan. However the main reason for the shortfall is the late approval of Observation Bay expenditure by NHSi meaning the programme was delayed. work is expected to complete in early January
- The capital forecast outturn position for 2018/19 is still to meet plan. The capital plan has been re-prioritised to recognise forecast slippage on the CT SPECT replacement scheme and to accommodate internal funding for the transfer of Elective Orthopaedics activity to K&C as part of the Trust's winter plan.
- Other than the Observation bays the capital underspend YTD is predominantly driven by slippage on the PEIC schemes and an unexpected VAT reclaim . This position is expected to recover by the end of the financial year.





Statement of Financial Position

Month 08 (November) 2018/19

£000	Opening	To Date	Movement	
Non-Current Assets	**270,767**	**326,658**	**55,891**	▲
Current Assets				
Inventories	8,949	3,817	(5,132)	▼
Trade and Other Receivables	39,034	48,316	9,283	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	7,157	3,368	(3,789)	▼
Total Current Assets	**55,139**	**55,502**	**362**	▲
Current Liabilities				
Payables	(39,536)	(43,814)	(4,278)	▲
Accruals and Deferred Income	(26,013)	(30,296)	(4,282)	▲
Provisions	(884)	(882)	1	▼
Net Current Assets	**(11,294)**	**(19,490)**	**(8,197)**	▼
Non Current Liabilities				
Provisions	(3,203)	(3,094)	109	▼
Long Term Debt	(46,228)	(158,495)	(112,267)	▲
Total Assets Employed	**210,042**	**145,578**	**(64,464)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	191,687	191,687	-	
Retained Earnings	(41,167)	(99,375)	(58,208)	▼
Revaluation Reserve	59,523	53,267	(6,256)	▼
Total Taxpayers' Equity	**210,042**	**145,578**	**(64,464)**	▼

Non Current asset values reflect in year additions of £7.1m (including donated assets) less depreciation charges of £11.6m a revaluation that resulted in our asset values being reduced by £41m. Non Current assets also includes the loan and equity that finances 2gether Support Solutions c.£99.3m

Trust closing cash balances for November was £0.1m below revised plan at £3.4m. See cash report for further details.

Trade and other receivables have increased from the 2018/19 opening position by £9.3m. Invoiced debtors have increased from the opening position of £28.5m by £5.5m to £34m at the end of November, (excluding £99.3 sale of Fixed asset invoice to 2gether that will be converted to long term debt / equity). The 2gether debtor in respect of VAT & other debt repayable in the short term is £16.4m of the invoiced debtor balance.

Accruals and Deferred Income have increased by 4.3m since the opening position. Of the £30.3m balance, £19.9m relates to Accruals and £10.4m is Deferred Income of which £2.9m relates to a notional profit on sale of assets to 2gether that has been eliminated on consolidation.

The long term debt entry reflects drawings against working capital facilities. Total drawing to date £65.6m see cash report for details. The balance of £46.7 relates to the long term finance lease debtor with 2gether.

Retained earnings reflects the year to date deficit which includes impairments of £34.3m.

Working Capital

Month 08 (November) 2018/19

Creditors

Invoiced creditors have decreased by £1.9m from the opening position to £31.7m. 45% relates to current invoices with 14% or £4.3m over 90 days.

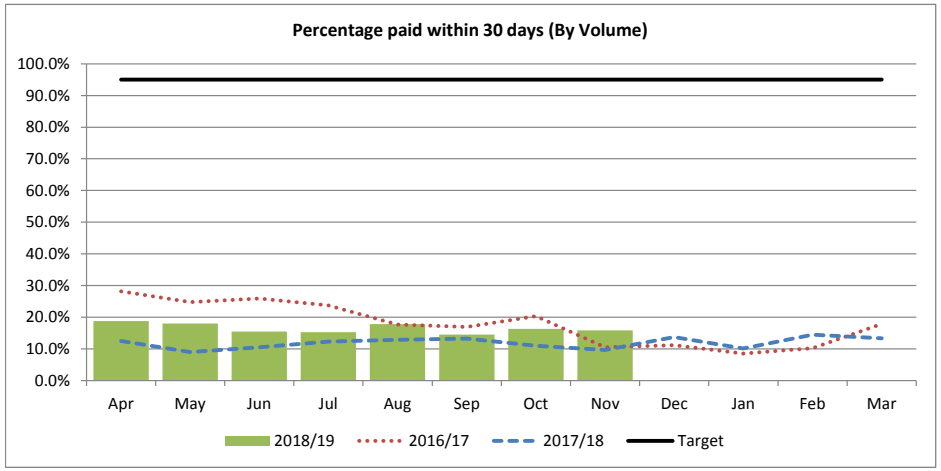
Over 90 days NHS creditors have increased by £325k in Month.

- Maidstone & Tunbridge Wells NHS Trust (RWF) - £176k
- Medway NHS Foundation Trust (RPA) - £139k

YTD the Trust has paid 68.2% of NHS and 48.5% of non NHS invoices by value to 30 days. The average payment terms are 47 days.

Better Payment Practice Code

	Year to Date		This Month	
	Non NHS Creditor Invoices	NHS Creditor Invoices	Non NHS Creditor Invoices	NHS Creditor Invoices
By Value £000				
0 - 30 days	(122,809)	(19,100)	(17,365)	(2,622)
30+ days	(130,486)	(8,891)	(17,705)	(794)
By Volume				
0 - 30 days	11,526	199	1,366	36
30+ days	57,325	1,739	7,260	210
% by Value £	48.5%	68.2%	49.5%	76.8%
% by Volume	16.7%	10.3%	15.8%	14.6%
Target	95.0%	95.0%	95.0%	95.0%



Debtors

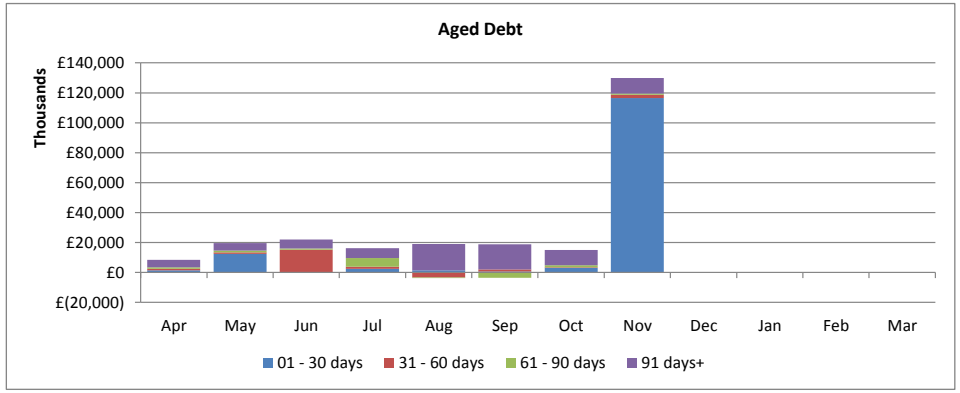
Total invoiced debtors have increased from the opening position of £28.5m by £104.8m to £133.3m.
At 30th November there were 6 debtors owing over £1m.

- 2gether Support Solutions have an outstanding balance on a long term loan of £115.7m, representing the sale of Trust Assets and Stocks.
- East Kent CCGs owing: South Kent Coast CCG £1.1m, Canterbury & Coastal CCG £1.6m, Ashford CCG £1.1m and Thanet CCG £1.4m. (outstanding invoices for 1718 and 1819 overperformance)
- East Kent Medical Services £2.0m

The debtors team are focussing on collection of all other debt to support the Trust cash position.

Aged Debt

£000	Current	01 - 30 days	31 - 60 days	61 - 90 days	91 days+	Total
Apr	12,651	1,397	1,073	974	4,911	8,354
May	925	12,478	1,013	1,216	5,018	19,725
Jun	527	39	15,136	845	5,989	22,009
Jul	2,660	2,515	1,255	5,771	6,687	16,228
Aug	1,382	1,455	(3,278)	(530)	17,545	15,192
Sep	4,338	556	1,550	(3,524)	16,703	15,285
Oct	120,626	3,059	337	1,492	10,244	15,131
Nov	3,356	116,458	2,283	765	10,466	129,972
Dec	0	0	0	0	0	0
Jan	0	0	0	0	0	0
Feb	0	0	0	0	0	0
Mar	0	0	0	0	0	0
		90%	2%	1%	8%	



Care Group Performance

Month 08 (November) 2018/19

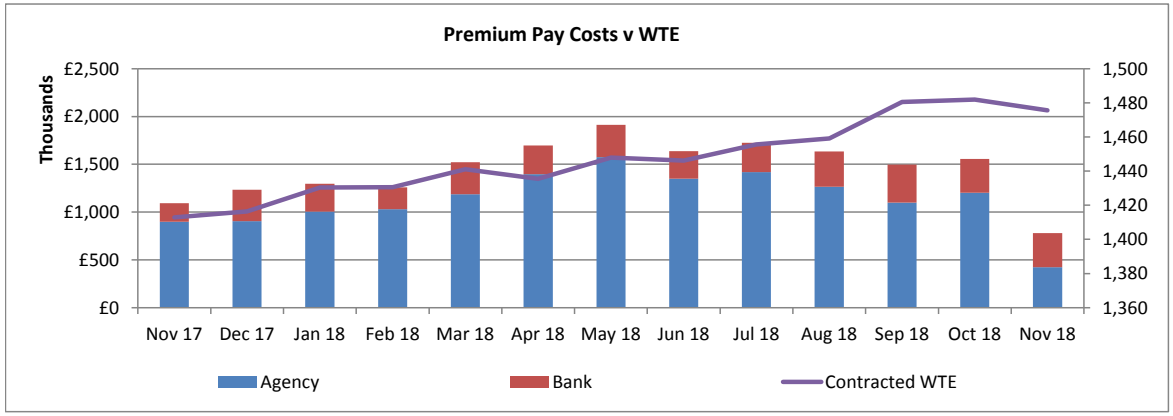
Year to Date Actual £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
General and Specialist Medicine	14,601	60,611	0	15,711	6,223	63	15,620	544	(56,690)	(21,036)	35,648
Urgent and Emergency Care	54	3,788	19,468	0	59	0	1,000	14	(24,602)	(2,956)	(3,177)
Surgery and Anaesthetics	29,895	25,752	0	10,053	200	59	9,573	1,231	(57,149)	(20,691)	(1,078)
Surgery - Head and neck, Breast Surgery and Dermatology	10,158	1,242	0	13,939	4,302	35	1,377	89	(10,059)	(7,264)	13,818
Clinical Support	428	19	0	2,853	10,838	49	22,771	4,020	(41,597)	(31,688)	(32,307)
Cancer Services	3,007	103	0	3,961	14,321		5,706	583	(5,054)	(16,860)	5,768
Women's and Children's Services	3,943	20,725	0	5,124	222	2	19,754	706	(32,762)	(3,015)	14,699
Clinical Total	**62,085**	**112,241**	**19,468**	**51,641**	**36,165**	**208**	**75,800**	**7,187**	**(227,912)**	**(103,511)**	**33,371**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	8,107	(7,864)	(29,982)	(29,738)
Corporate	0	0	0	0	0	0	0	11,854	(16,611)	(20,417)	(25,174)
Care Group Total	**62,085**	**112,241**	**19,468**	**51,641**	**36,165**	**208**	**75,800**	**27,148**	**(252,387)**	**(153,910)**	**(21,541)**
Central		70	0	0	232	2	8,301	6,376	(1,908)	57	13,130
							EBITDA				**(8,411)**
							Capital Charges and Interest			(50,461)	(50,461)
							Income and Expenditure Surplus/(Defic				(58,872)

Year to Date Variance to Plan £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
General and Specialist Medicine	(1,088)	2,990	0	(1,050)	(230)	5	(704)	109	(613)	(860)	(1,442)
Urgent and Emergency Care	52	39	1,841	()	40	0	153	(25)	(3,938)	(294)	(2,133)
Surgery and Anaesthetics	(5,070)	1,335	0	(1,192)	(78)	50	1,960	(61)	(4,344)	(414)	(7,814)
Surgery - Head and neck, Breast Surgery and Dermatology	(2,048)	205	0	(216)	(595)	(2)	562	()	(58)	39	(2,113)
Clinical Support	(4)	10	0	(36)	517	(12)	252	285	(1,388)	(1,992)	(2,366)
Cancer Services	518	(168)	0	148	(337)		44	(72)	(41)	283	375
Women's and Children's Services	(587)	(367)	0	(469)	(43)		(1,207)	(10)	(1,703)	387	(3,998)
Clinical Total	**(8,227)**	**4,043**	**1,841**	**(2,815)**	**(725)**	**42**	**1,061**	**225**	**(12,085)**	**(2,851)**	**(19,491)**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	737	218	(1,010)	(55)
Corporate	0	0	0	0	0	0	0	(27)	315	(132)	156
Care Group Total	**(8,227)**	**4,043**	**1,841**	**(2,815)**	**(725)**	**42**	**1,061**	**936**	**(11,552)**	**(3,993)**	**(19,389)**
Central	951	114	41	(82)	(86)		8,773	3,305	787	(820)	12,983
							EBITDA				**(6,406)**
							Capital Charges and Interest			(32,781)	(32,781)
							Income and Expenditure Surplus/(Defic				(39,187)

General and Specialist Medicine

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	2,267	1,711	(556)	15,689	14,601	(1,088)
Non-Electives	7,099	7,254	155	57,621	60,611	2,990
Accident & Emergency	0	0	0	0	0	0
Outpatients	2,205	2,102	(103)	16,761	15,711	(1,050)
High Cost Drugs	807	752	(55)	6,453	6,223	(230)
Private Patients	7	3	(4)	58	63	5
Other NHS Clinical	2,213	1,924	(289)	16,164	15,495	(669)
Other Clinical	20	20		161	125	(36)
Prior Month Adjustment	0	(127)	(127)	0		
Total Clinical Income	**14,618**	**13,639**	**(979)**	**112,907**	**112,829**	**(77)**
Non Clinical Income	53	100	47	436	544	109
Total Income	**14,671**	**13,739**	**(931)**	**113,342**	**113,374**	**31**
Expenditure						
Substantive Staff	(4,720)	(4,750)	(30)	(46,327)	(44,248)	2,079
Bank	(327)	(356)	(29)	(2,599)	(2,706)	(107)
Agency	(917)	(423)	494	(7,150)	(9,736)	(2,585)
Total Pay	**(5,965)**	**(5,529)**	**435**	**(56,076)**	**(56,690)**	**(613)**
Non Pay	(2,280)	(2,582)	(301)	(20,177)	(21,036)	(860)
Total Expenditure	**(8,245)**	**(8,111)**	**134**	**(76,253)**	**(77,726)**	**(1,473)**
Contribution	**6,426**	**5,628**	**(797)**	**37,089**	**35,648**	**(1,442)**



The Care Group is £0.8m adverse in November and £1.4m adverse YTD.

Income was £0.9m adverse to plan in November which returns the position to a break even YTD. Electives were significantly behind plan whilst the impact of activity recording for the new PAS is still under investigation in this area. Outpatients behind plan on Respiratory and Rheumatology. Other NHS Clinical adverse by £0.2m, the majority of which is not realising the additional income from Bowel Cancer Business Case this month. There was a one-off Prior Month Adjustment for £127k which should not appear next month.

This month saw the Acute Consultants moved out of the Care Group, which removed £1.8m YTD spend. Pay spending was favourable by £0.4m in November (£0.6m adverse ytd). Agency spend has dropped to £0.4m as a result of the YTD Acute Consultant costs being moved, but this will only occur for one month. Bank usage stayed the same at 30K adverse. Agency usage in the month dropped £100k from £1.2m to £1.1m. Consultant and Nursing Agency dropped by around £50k, with Non-Consultant Medical Agency increasing due to a large increase in usage at WHH.

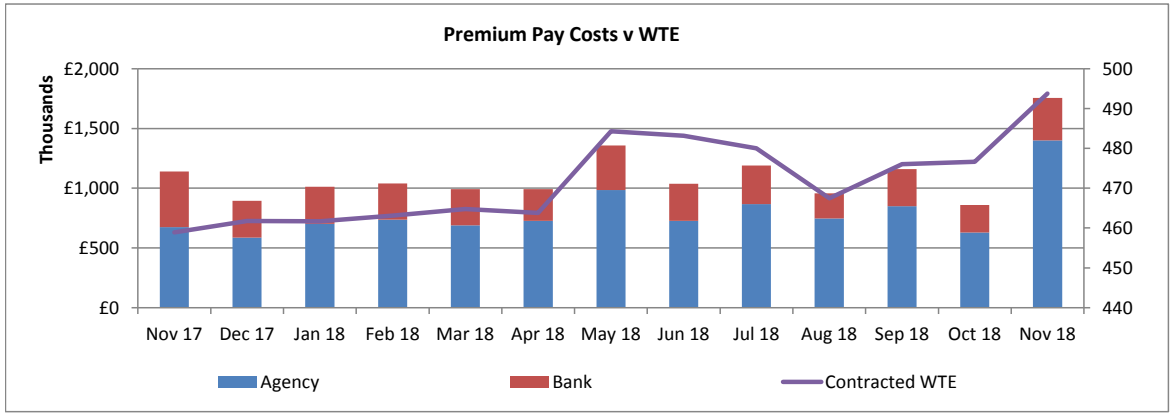
The non-pay run rate increased by less than 0.1m compared to October, but this is due to stock take issues on Cardiology which should be corrected next month.

CIPs fell short of the monthly target due to non-delivery of 18 Weeks, Bowel Cancer Business Case and Patient Flow 3 schemes.

Urgent and Emergency Care

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1	21	20	2	54	52
Non-Electives	471	545	74	3,749	3,788	39
Accident & Emergency	2,111	2,345	234	17,627	19,468	1,841
Outpatients	2	0	(2)		0	()
High Cost Drugs	2	4	1	19	59	40
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	106	229	123	847	1,000	153
Prior Month Adjustment	0	59	59	0	0	0
Total Clinical Income	**2,694**	**3,202**	**508**	**22,243**	**24,368**	**2,124**
Non Clinical Income	5	0	(5)	40	14	(25)
Total Income	**2,699**	**3,202**	**503**	**22,283**	**24,382**	**2,099**
Expenditure						
Substantive Staff	(3,073)	(2,795)	277	(17,435)	(15,294)	2,141
Bank	(285)	(355)	(70)	(2,226)	(2,381)	(155)
Agency	(142)	(1,401)	(1,259)	(1,003)	(6,927)	(5,924)
Total Pay	**(3,499)**	**(4,552)**	**(1,052)**	**(20,664)**	**(24,602)**	**(3,938)**
Non Pay	(321)	(364)	(44)	(2,662)	(2,956)	(294)
Total Expenditure	**(3,820)**	**(4,916)**	**(1,096)**	**(23,326)**	**(27,559)**	**(4,233)**
Contribution	**(1,121)**	**(1,714)**	**(593)**	**(1,043)**	**(3,177)**	**(2,133)**



Income was significantly above plan, reflecting the higher than planned attendances which have been in evidence throughout the year. Non elective income is also significantly above plan in month. Other Clinical Income is over performing due to additional CRU (Compensation Recovery Unit) receipts. The CRU works with insurance companies to recover costs incurred by NHS hospitals treating injuries from road traffic accidents and personal injury claims.

Pay was overspent by £1.1m in month, £900k of the variance is due to months 1-7 acute consultant budget and cost being transferred from the General and Specialist Medicine (GSM) Care Group. Agency increased by £800k from September to October, again this is related to the transfer of retrospective costs from GSM. Nursing agency was stable at £400k in the month, an improvement of £100k on the average for the year to date, but is still significantly higher than expenditure last year.

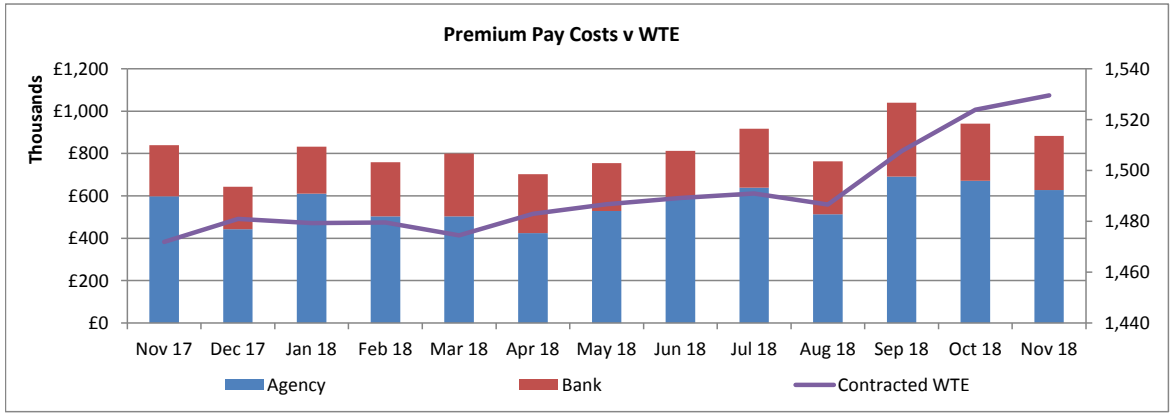
Non-pay was overspent by £44k. This was due to a mixture of small overspends on bariatric bed rentals, security services, computer equipment and drugs. The majority of these issues reflect the higher number of attendances going through A&E.

The annual CIP target for the Care Group is £2.5m and is mainly focused on agency reduction plans. Currently performance is £0.4m adverse to plan and is forecast to be £1.2m adverse at year end. The Care Group is investigating what measures can be taken non-recurrently to help address the gap. Overtime/temporary staffing controls are also being reviewed.

Surgery and Anaesthetics

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	5,007	3,585	(1,422)	34,965	29,895	(5,070)
Non-Electives	2,804	3,103	299	24,417	25,752	1,335
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,473	1,299	(174)	11,245	10,053	(1,192)
High Cost Drugs	35	31	(4)	278	200	(78)
Private Patients	1	9	8	9	59	50
Other NHS Clinical	1,020	1,157	136	7,547	9,485	1,938
Other Clinical	8	11	2	66	88	22
Prior Month Adjustment	0	(214)	(214)	0		
Total Clinical Income	**10,349**	**8,981**	**(1,368)**	**78,527**	**75,532**	**(2,995)**
Non Clinical Income	171	142	(29)	1,292	1,231	(61)
Total Income	**10,520**	**9,123**	**(1,397)**	**79,819**	**76,762**	**(3,056)**
Expenditure						
Substantive Staff	(6,056)	(6,363)	(307)	(48,032)	(50,334)	(2,302)
Bank	(212)	(257)	(44)	(1,672)	(2,130)	(458)
Agency	(393)	(627)	(234)	(3,101)	(4,685)	(1,583)
Total Pay	**(6,662)**	**(7,247)**	**(585)**	**(52,806)**	**(57,149)**	**(4,344)**
Non Pay	(2,691)	(2,345)	347	(20,277)	(20,691)	(414)
Total Expenditure	**(9,353)**	**(9,592)**	**(238)**	**(73,083)**	**(77,840)**	**(4,758)**
Contribution	**1,167**	**(468)**	**(1,635)**	**6,736**	**(1,078)**	**(7,814)**



The Care Group is £1.6m adverse to plan in month and £7.8m adverse YTD.

Below plan elective income (£5.1m) is mostly due to underperformance in Orthopaedics (£2.1m), and unachieved CIPs (£2.0m). Orthopaedic activity has been significantly impacted by reduced capacity issues, i.e. beds and Independent sector. However with the set up of the new Elective Orthopaedic Centre in November, the production plan forecasts that the Orthopaedic elective plan will now over achieve each month. Although Elective CIP plans were not achieved, this was offset from savings realised by ITU and Non Elective overperformances.

Non-Elective income is above plan (£1.3m) with high levels of General Surgery activity.

Outpatient performance is adverse (£1.2m), with Orthopaedics (£0.5m) the largest YTD which is mostly due to the greater than anticipated impact of the Virtual Fracture Clinics. Urology (£0.2m) and General Surgery (£0.2m) are also under performing.

Other NHS Clinical Income is favourable mostly due to ITU (£2.0m).

Pay is adverse with the continuation of high medical agency costs for middle grade vacancies in General Surgery, Urology, Vascular and also additional support for the ED's. Interviews and appointments have been made, and the delays on VISAs for foreign nationals is slowly unblocking. Nursing agency is still high at WHH for ITU and bedding of patients overnight in the Day Surgery Unit. These have contributed to an unmet CIP Pay target (£1.0m), which has instead been met through Income. ITU nursing recruitment from the approved business case is progressing well, whilst the SEAU and Hospital at Home services cases are awaiting review and approval of funding.

Non Pay is adverse (£414k) YTD with underspend on Independent Sector usage (£260k) for Orthopaedic services more than offset by Clinical Supplies overspend (£580k) and CIP underachievement (£633k).

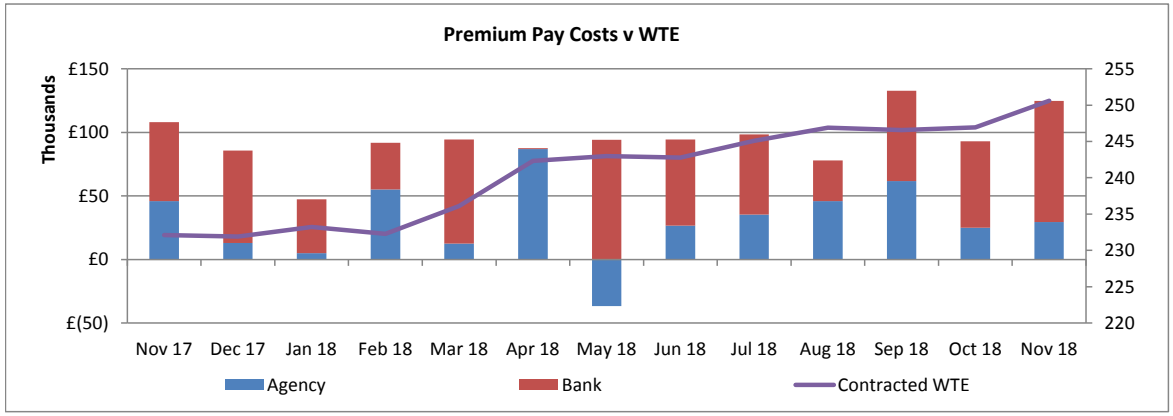
Included in the above expenditure is approximately £730k for medical patient outliers in the first six months, with no additional income. This has equated to the loss on average of 24 Surgical beds per day. Also incurred is £795k supporting the Winter/ED plan.

CIPs YTD target of £3.3m is underachieved by £495k .

Surgery - Head and neck, Breast Surgery and Dermatology

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,554	1,324	(230)	12,206	10,158	(2,048)
Non-Electives	120	154	34	1,037	1,242	205
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,802	1,737	(65)	14,155	13,939	(216)
High Cost Drugs	612	594	(18)	4,897	4,302	(595)
Private Patients	5	3	(1)	36	35	(2)
Other NHS Clinical	122	211	89	782	1,369	587
Other Clinical	4	2	(2)	32	8	(25)
Prior Month Adjustment	0	74	74	0	0	0
Total Clinical Income	**4,219**	**4,100**	**(119)**	**33,147**	**31,053**	**(2,094)**
Non Clinical Income	11	11		89	89	()
Total Income	**4,230**	**4,112**	**(119)**	**33,235**	**31,141**	**(2,094)**
Expenditure						
Substantive Staff	(1,191)	(1,258)	(66)	(9,300)	(9,293)	8
Bank	(56)	(95)	(40)	(442)	(492)	(50)
Agency	(28)	(29)	(1)	(258)	(274)	(16)
Total Pay	**(1,275)**	**(1,383)**	**(108)**	**(10,000)**	**(10,059)**	**(58)**
Non Pay	(847)	(947)	(100)	(7,304)	(7,264)	39
Total Expenditure	**(2,122)**	**(2,330)**	**(208)**	**(17,304)**	**(17,323)**	**(19)**
Contribution	**2,108**	**1,782**	**(326)**	**15,931**	**13,818**	**(2,113)**



The Care Group is £0.3m adverse to plan in month and £2.1m adverse YTD.

Below plan elective income (£2.0m) is mostly due to underperformances in Dermatology (£0.6m), Ophthalmology (£0.5m) & ENT (£0.3m), together with unachieved CIPs (£0.4m). Dermatology activity is offset by over performance in outpatients and the release of a risk provision (related to the outcome of the expert determination negotiation). Elective CIP underachievement is partially offset by savings realised by Non Elective overperformances.

Non-Elective income is above plan (£0.2m) with high levels of Maxillo Facial activity.

Outpatient performance is adverse (£216k), with underperformances in ENT (£190k) & Ophthalmology (£140k) partly offset with an overperformance in Dermatology (£131k). Forecast production plans for all specialties, apart from ENT, indicate monthly overperformances which will deliver the year end plan.

High Cost Drugs under performance (£595k) is solely in relation to Ophthalmology AMD patients, and is offset with an underspend in expenditure.

Other NHS Clinical Income is favourable mostly due to the Dermatology risk provision.

Pay is slightly adverse YTD (£58k). Medical agency costs have reduced significantly with ENT remaining the sole specialty requiring agency cover. However the prior months high usage of Medical agency has contributed to an unmet CIP Pay target (£113k).

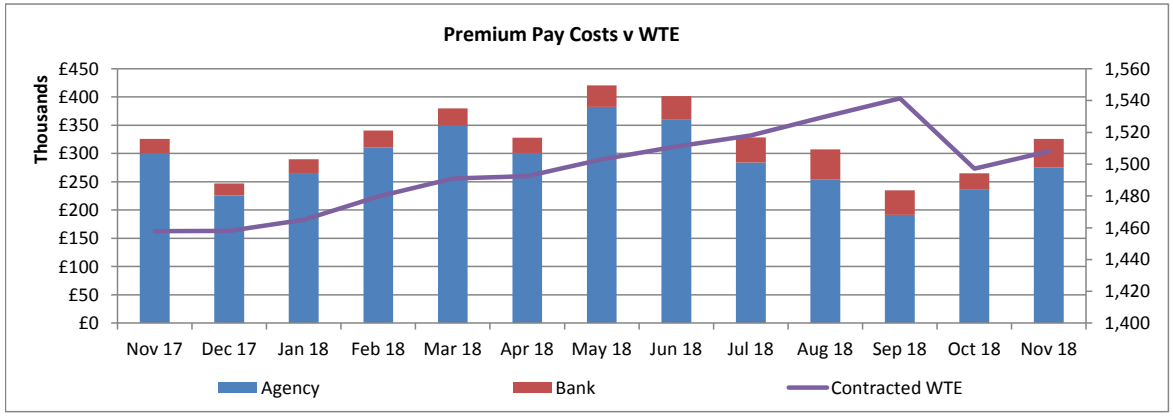
Non Pay is favourable (£39k) YTD, however the underspend on Drugs (£598k) is offset by the above planned usage (£603k) of Ophthalmology insourcing services. This was originally only planned to be utilised for the first five months, but is now required until the end of the financial year.

CIPs YTD target of £725k is underachieved by £285k.

Clinical Support

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	45	52	8	432	428	(4)
Non-Electives	()	0		9	19	10
Accident & Emergency	0	0	0	0	0	0
Outpatients	411	311	(100)	2,889	2,853	(36)
High Cost Drugs	1,290	1,531	241	10,320	10,838	517
Private Patients	8	5	(3)	60	49	(12)
Other NHS Clinical	2,966	2,905	(61)	22,518	22,770	252
Other Clinical	0	0	0	0		
Prior Month Adjustment	0	(945)	(945)	0	0	0
Total Clinical Income	**4,720**	**3,860**	**(860)**	**36,229**	**36,957**	**729**
Non Clinical Income	479	344	(135)	3,735	4,020	285
Total Income	**5,199**	**4,204**	**(994)**	**39,964**	**40,978**	**1,014**
Expenditure						
Substantive Staff	(4,892)	(4,955)	(63)	(38,612)	(38,985)	(373)
Bank	(23)	(50)	(27)	(191)	(326)	(134)
Agency	(9)	(276)	(266)	(1,406)	(2,286)	(880)
Total Pay	**(4,925)**	**(5,281)**	**(356)**	**(40,209)**	**(41,597)**	**(1,388)**
Non Pay	(3,736)	(4,289)	(553)	(29,696)	(31,688)	(1,992)
Total Expenditure	**(8,660)**	**(9,569)**	**(909)**	**(69,905)**	**(73,285)**	**(3,380)**
Contribution	**(3,461)**	**(5,365)**	**(1,904)**	**(29,941)**	**(32,307)**	**(2,366)**



The Care Group position worsened significantly this month reflecting the commissioning challenge which was upheld against the Trusts MRI counting methodology (£1m). Across the Care Group, the actual income for the activity delivered in the month reduced when compared with October (£0.16m).

Homecare drugs were above plan (£0.24m) as was Direct Access and GUM pathology and also Interventional Radiology.

Therapies income trend continued below plan with a drop in activity in Physiotherapy and Occupational Therapy, this has been driven by the implementation of Allscripts which has caused issues with the booking templates. A third party has been engaged to rectify this issue but it is forecast that activity will continue to be below plan in December too.

Pay increased in November in Pathology medical staff for backdated private hospital work and agency spend; in Therapies and Outpatients, neither Therapies nor Outpatients are above their overall budgeted establishment but they have lower vacancy rates than last financial year making the workforce more expensive. Medical staff agency costs increased in Radiology and Pathology. Recruitment has been successful in both area recently however agency risk continues with imminent leavers and retirements.

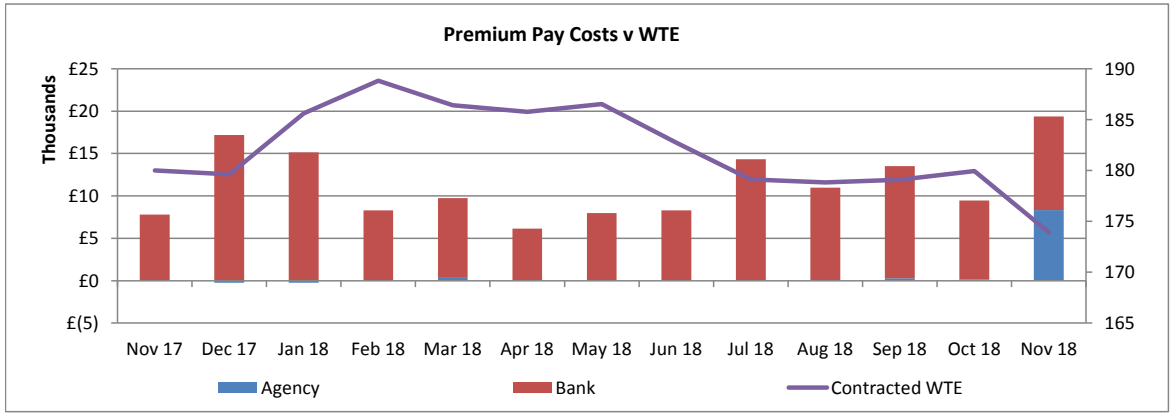
Non-pay overspends continue in the Care Group. Homecare drugs represent £0.26m of the overspend in month 8 which is recovered in the income position. Within Radiology outsourcing costs are £0.1m over budget reflecting the increase in demand in MRI and CT. The department has workforce schemes in place to reduce the reliance on 3rd party providers of Radiology reporting especially as the price in due to increase as a result of the latest tender. Winter pressures also pose a risk to achieving this reduction. Pathology costs are also overspent in November, although not cumulatively year to date. The main cost pressure in pathology is diagnostic tests referred to other organisations e.g. Viapath.

The Care Group is meeting its CIP target, (£3.26m achieved) and is forecast to achieve £5.2m in total this year.

Cancer Services

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	357	383	27	2,489	3,007	518
Non-Electives	46	7	(39)	272	103	(168)
Accident & Emergency	0	0	0	0	0	0
Outpatients	524	501	(24)	3,812	3,961	148
High Cost Drugs	1,832	1,733	(99)	14,658	14,321	(337)
Private Patients		0	()			
Other NHS Clinical	754	685	(68)	5,662	5,705	43
Other Clinical		0	()		1	1
Prior Month Adjustment	0	(116)	(116)	0	0	0
Total Clinical Income	**3,513**	**3,193**	**(320)**	**26,893**	**27,098**	**206**
Non Clinical Income	86	72	(14)	655	583	(72)
Total Income	**3,598**	**3,265**	**(333)**	**27,547**	**27,681**	**134**
Expenditure						
Substantive Staff	(621)	(617)	4	(4,917)	(4,963)	(47)
Bank	(12)	(11)	1	(96)	(81)	14
Agency	0	(8)	(8)	0	(9)	(9)
Total Pay	**(633)**	**(636)**	**(3)**	**(5,012)**	**(5,054)**	**(41)**
Non Pay	(2,089)	(2,049)	40	(17,143)	(16,860)	283
Total Expenditure	**(2,722)**	**(2,685)**	**37**	**(22,155)**	**(21,913)**	**242**
Contribution	**877**	**580**	**(297)**	**5,392**	**5,768**	**375**



The income plan in November was set high in comparison with previous months by £0.2m based on the activity profile last November. This expectation was not quite met in most areas across the Care Group. However the main drivers of under performance of income in November was a reversal of a prior month adjustments (£0.1m) and also a continuation of High cost drugs usage which were below plan (£0.1m) this is offset in the non-pay position.

Chemotherapy, Outpatients and Non-Electives were all below plan in November, however it is only Non-electives and High cost drugs which are below plan year to date. Other income is below plan in month reflecting a reduction in Macmillan funding.

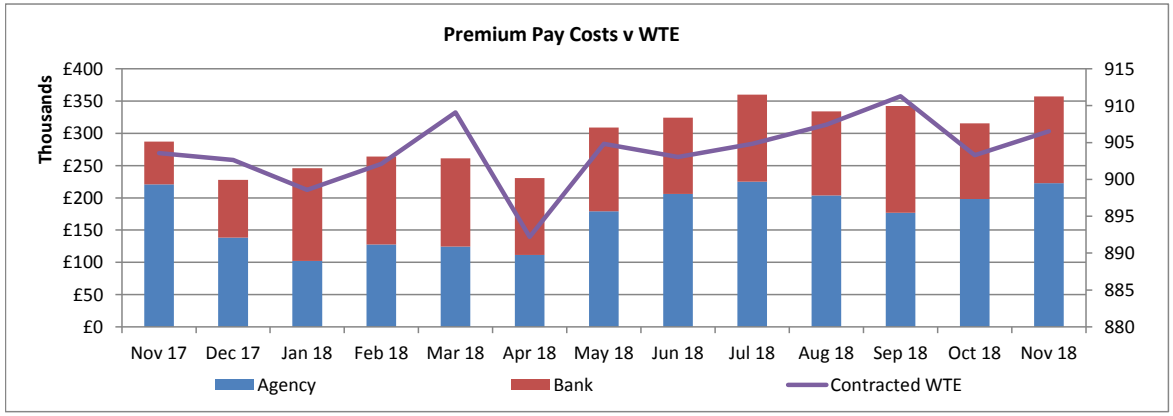
Pay is very slightly over budget due to the increase in recruitment and retention in comparison to 17-18 as well as some back dated pay due in Chemotherapy.

Non-pay is underspent overall. The CIP target for the CCHH care group is exceeded by £0.24m, mainly due to the success of Saturday working at Kent & Canterbury Hospital which the department hope to roll out to the other sites and is working on the business case in collaboration with Pharmacy colleagues to extend the scope to a Saturday Chemotherapy service.

Women's and Children's Services

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	564	493	(71)	4,530	3,943	(587)
Non-Electives	2,711	2,788	77	21,092	20,725	(367)
Accident & Emergency	0	0	0	0	0	0
Outpatients	728	662	(66)	5,594	5,124	(469)
High Cost Drugs	33	34	1	265	222	(43)
Private Patients				2	2	
Other NHS Clinical	2,695	2,404	(291)	20,815	19,702	(1,113)
Other Clinical	18	7	(11)	145	52	(93)
Prior Month Adjustment	0	63	63	0	0	0
Total Clinical Income	**6,749**	**6,453**	**(297)**	**52,442**	**49,770**	**(2,673)**
Non Clinical Income	92	87	(5)	716	706	(10)
Total Income	**6,841**	**6,540**	**(301)**	**53,158**	**50,476**	**(2,683)**
Expenditure						
Substantive Staff	(3,699)	(3,822)	(123)	(29,522)	(30,189)	(666)
Bank	(103)	(134)	(31)	(825)	(1,049)	(225)
Agency	(28)	(223)	(194)	(712)	(1,524)	(812)
Total Pay	**(3,831)**	**(4,179)**	**(348)**	**(31,059)**	**(32,762)**	**(1,703)**
Non Pay	(416)	(63)	353	(3,402)	(3,015)	387
Total Expenditure	**(4,246)**	**(4,242)**	**5**	**(34,461)**	**(35,777)**	**(1,315)**
Contribution	**2,595**	**2,298**	**(297)**	**18,697**	**14,699**	**(3,998)**



Elective income is significantly adverse to plan in month and cumulatively. This reflects continued gynaecology underperformance. Work is focused on addressing efficiency and capacity problems. There has been significant success in reducing waiting time breaches and improving productivity, but despite an increase in the run rate, overall activity continues to fall below the plan.

Non-elective performance improved markedly in November, predominantly within Paediatrics. Investigations are underway to identify the reason for the change to trend- Year to date performance is adverse by £0.4m across the Care Group.

Overall outpatient income was significantly below plan in month. This continues to be driven by underperformance in both gynaecology and paediatrics. Some gynaecology capacity has been switched in order to focus on elective activity/breach avoidance. An increase in the Gynaecology income run rate is offset by a decline in Paediatrics so performance continues to fall behind the overall plan. Paediatrics are investigating the viability of employing NHS locum resource to help recover the position.

The adverse performance in the 'Other NHS Clinical' category is driven by lower than planned activity in NICU/SCBU and the maternity pathway. Both areas have struggled to reach planned levels over the year to date. NICU/SCBU was closed to births below 36 week gestation until 30th October, due to precautionary infection control measures being taken. Consequently, this had a knock on effect into early November.

Overall pay was significantly overspent in November and year to date. Savings shortfalls (£100k in month) are a key driver. Temporary pay costs are also, on average, £90k a month higher than last year with junior/middle grade vacancies/sickness/maternity leave being particular issues. Recruitment into O&G middle/junior grade roles and into midwifery has led to improvements from September to October, but these have been offset by additional medical cover required for the Paediatric rota and nursing cover for the Paediatric ward at WHH. Interim operational manager costs have also pushed up agency costs this month.

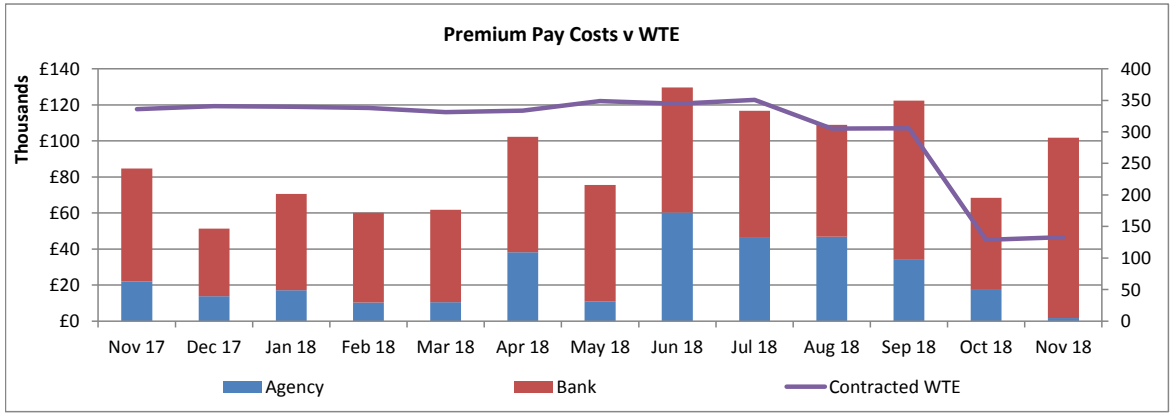
Non-pay is significantly underspent due to the receipt of a £500k CNST incentive bonus- £340k was back dated for April to November.

Overall CIP performance is above plan year to date, however a deficit of £200k is forecast due to the phasing of schemes in the second half of the year. The recurrent shortfall is £1.1m. The Care Group is investigating what further measures can be taken to improve recurrent performance.

Strategic Development and Capital Planning

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	0	0	0	0	0	0
Non-Electives	0	0	0	0	0	0
Accident & Emergency	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0
High Cost Drugs	0	0	0	0	0	0
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	0	0	0	0	0	0
Prior Month Adjustment	0	0	0	0	0	0
Total Clinical Income	**0**	**0**	**0**	**0**	**0**	**0**
Non Clinical Income	913	1,101	188	7,370	8,107	737
Total Income	**913**	**1,101**	**188**	**7,370**	**8,107**	**737**
Expenditure						
Substantive Staff	(478)	(482)	(4)	(7,504)	(7,038)	465
Bank	(64)	(100)	(36)	(406)	(569)	(163)
Agency	(1)	(2)	(1)	(173)	(257)	(84)
Total Pay	**(543)**	**(584)**	**(41)**	**(8,082)**	**(7,864)**	**218**
Non Pay	(4,369)	(4,420)	(50)	(28,971)	(29,982)	(1,010)
Total Expenditure	**(4,913)**	**(5,004)**	**(91)**	**(37,054)**	**(37,846)**	**(792)**
Contribution	**(4,000)**	**(3,903)**	**97**	**(29,684)**	**(29,738)**	**(55)**



The position as at month 8 is £(55)k adverse. Income is £737k favourable YTD, pay £218k favourable YTD and non-pay £(1.01)m adverse YTD. The variance s between Income & Expenditure is due to invoices raised to 2gether following transfer.

Income is £188k favourable in month and £737k favourable.

The position in month is mostly due to £254k of expenditure that has been invoiced to 2gether; £24k of income is for 2gether NHSP bank/agency staff, £28k is for ring-fenced expenditure, £17k September staff costs.
The rest is for various Facilities/Estates contracts that relate to October onwards; these are offset by expenditure.
The position YTD is mostly attributable to car parking £256k favourable YTD, laundry, external utility recharges and income for 2gether recharges - as indicated above.

Pay is favourable £218k YTD and adverse £(41)k in month; £(2)k in month and £(16)k YTD is due to PAS OT worked; the PAS OT is being offset by income.
£(24)k of the adverse position in month is due to 2gether NHSP agency/bank expenditure, which is offset by income. The rest of the adverse variance is due to minimal overspend in IT and Strategic Development management report
The YTD position is due to vacancies earlier in the year, most of which have transferred to 2gether in October. The vacancy rate is just over 2% compared to 10% in previous months, the reduction in contracted WTE can be seen on the graph below.

Non Pay is adverse £(50)k in month and £(1.010)m YTD
The position is offset by income from 2gether equating to £206k in month and £464k YTD. Therefore, the actual position in month is £156k favourable in month and adverse £(546)k YTD.
The position in month is due to IT and car parking reactive work underspends.
The position YTD is as follows:

- Laundry is £(103)k (partly offset by the income from 2gether)
- Estates day to day budgets £(338)k (partly offset by the income from 2gether)
- Waste adverse £(87)k YTD (prior year costs and sharps bins)
- Utilities is adverse £(204)k YTD; increased rates for water, wastewater and gas overspend at QEQM due to boiler issues in previous months.
- Procurement £(41)k adverse YTD (this is offset by income from 2gether)
- In addition to this, £(165)k adverse variance YTD shows subjectively under non pay on the CIP report, this is offset by non recurrent pay savings , CIP report overall is £(39)k adverse YTD.

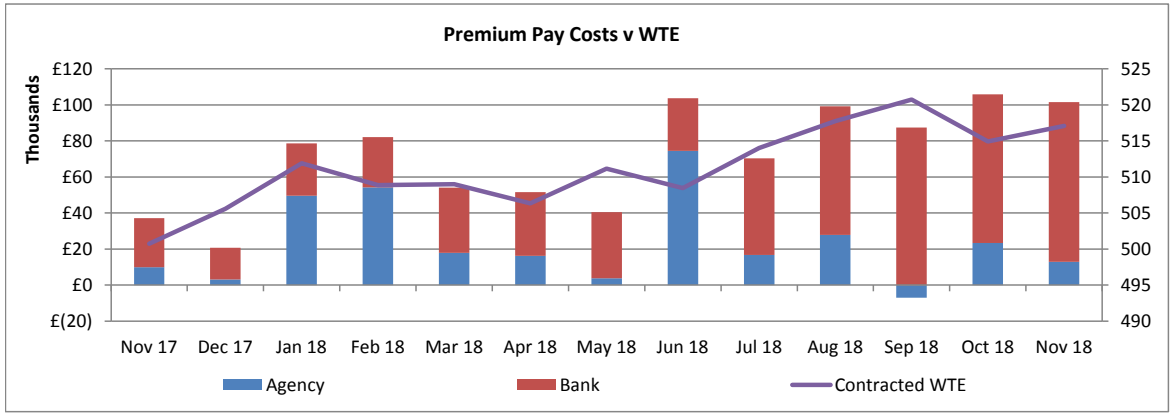
The above overspends are partly offset by IT, carbon tax and Rent/Hire Premises underspends.

Savings are £(39)k adverse YTD against plan. Those o/s are the procurement work plan schemes details awaited from procurement All of the schemes are continually being monitored. Forecast savings to be achieved in full.

Corporate

Month 08 (November) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	0	0	0	0	0	0
Non-Electives	0	0	0	0	0	0
Accident & Emergency	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0
High Cost Drugs	0	0	0	0	0	0
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	0	0	0	0	0	0
Prior Month Adjustment	0	0	0	0	0	0
Total Clinical Income	**0**	**0**	**0**	**0**	**0**	**0**
Non Clinical Income	1,472	1,451	(21)	11,881	11,854	(27)
Total Income	**1,472**	**1,451**	**(21)**	**11,881**	**11,854**	**(27)**
Expenditure						
Substantive Staff	(2,172)	(2,086)	87	(16,902)	(15,958)	944
Bank	(6)	(89)	(82)	(23)	(485)	(462)
Agency	0	(13)	(13)	0	(168)	(168)
Total Pay	**(2,179)**	**(2,187)**	**(9)**	**(16,925)**	**(16,611)**	**315**
Non Pay	(2,196)	(2,270)	(74)	(20,285)	(20,417)	(132)
Total Expenditure	**(4,375)**	**(4,457)**	**(82)**	**(37,211)**	**(37,028)**	**183**
Contribution	**(2,903)**	**(3,007)**	**(104)**	**(25,330)**	**(25,174)**	**156**



The position is £156k favourable as at month 8; of which £175k is PGME/Library.

Income is adverse £(21k) in month and £(27)k YTD. Finance and Performance adverse £(25)k, £(17)k is due to a provision being dropped for reference costing support. £(10)k is adverse in Comms due to advertising income not achieving. These are partly offset by Chaplaincy and Health Education England income.

Pay is adverse £(9)k in month and favourable £315k YTD. The current vacancy rate is just over 50 WTE.
The largest adverse variance in month is within the CQ&PS directorate, which due to additional cost centres being situated here and in addition to this higher costs being incurred following the implementation of the Care Group structure .
The percentage vacancy rates, budgeted against contracted, are on average 10% in each directorate. Validation ongoing.

Each directorate has incurred agency and bank staff costs, these are the material areas: Finance (temporary PMO staff, clinical coders and Information Team), CQ&PS (Ops Management and Patient Experience), HR (HR Systems & HR Management) and Trust Board. The majority of the cost for the use of temporary / bank staff is being funded by the existing vacancies within each dept, the PMO posts have now recruited into substantial posts.

Non pay is adverse £(74)k in month and £(132)k YTD.
The position in month is due to reprofiling of training budget within CQ&PS resulting in an adverse variance of £(40)k, HR border agency permits adverse £(23)k and £(10)k of settlement discount ceasing .
The position YTD is mainly due to overspend on Trust Management, which consists of: recruitment fees for exec posts, management consultancy, transcription services for committee minutes and refurbishment costs of £(39)k. Additionally, HR border agency permits adverse £(76)k YTD, this cost pressure was raised last financial year due to the costs trebling. Finance Senior Mgt report is adverse YTD due to asset valuation fees (Cushman and Wakefield Debenham Tie Leung Ltd and QE Facilities Ltd) and settlement discount ceased from Month 5 £(44)k adverse YTD, again this is to be raised as a cost pressure for 19/20

Year on Year Analysis

Month 08 (November) 2018/19

	Year to Date	Prior Year to Date	Year on Year	
	Actual	Actual	Variance	Variance %
Income				
Electives	62,085	60,590	1,495	2.5%
Non-Electives	112,311	105,452	6,859	6.5%
Accident and Emergency	19,468	17,444	2,023	11.6%
Outpatients	51,641	52,407	(767)	(1.5%)
High Cost Drugs	36,397	36,059	338	0.9%
Private Patients	210	169	41	24.1%
Other NHS Clinical Income	82,792	76,863	5,928	7.7%
Other Clinical Income	1,308	1,292	16	1.3%
Total Clinical Income	**366,211**	**350,278**	15,933	4.5%
Non Clinical Income	33,524	35,540	(2,016)	(5.7%)
Total Income	**399,735**	**385,818**	13,917	3.6%
Expenditure				
Substantive Staff	(211,284)	(199,825)	(11,459)	(5.7%)
Overtime	(3,774)	(3,319)	(455)	(13.7%)
Waiting List Payments	(1,930)	(1,397)	(532)	(38.1%)
Medical Locums/Short Sessions	(2,073)	(2,453)	380	15.5%
Bank	(10,047)	(8,877)	(1,170)	(13.2%)
Agency	(24,603)	(12,314)	(12,289)	(99.8%)
Direct Engagement - Agency	(584)	(2,860)	2,276	79.6%
Total Pay	**(254,295)**	**(231,046)**	(23,249)	(10.1%)
Non-Pay				
Drugs	(43,395)	(44,278)	883	2.0%
Clinical Supplies and Services - Clinical	(40,549)	(45,765)	5,215	11.4%
Supplies and Services - Non-Clinical	(25,057)	(13,971)	(11,087)	(79.4%)
Purchase of Healthcare	(7,016)	(5,106)	(1,910)	(37.4%)
Education & Training	(1,183)	(1,687)	504	29.9%
Consultancy	(640)	(452)	(188)	(41.6%)
Premises	(14,313)	(12,636)	(1,676)	(13.3%)
Clinical Negligence	(13,837)	(14,297)	459	3.2%
Transport	(2,412)	(2,434)	22	0.9%
Establishment	(2,453)	(2,405)	(49)	(2.0%)
Other	(2,997)	(3,790)	793	20.9%
Total Non-Pay	**(153,853)**	**(146,821)**	(7,033)	(4.8%)
Total Expenditure	**(408,148)**	**(377,866)**	(30,282)	(8.0%)
EBITDA	**(8,412)**	**7,952**	(16,364)	(205.8%)
Non-Operating Expenses	(50,461)	(16,949)	(33,512)	(197.7%)
Income and Expenditure Surplus/(Deficit)	**(58,874)**	**(8,997)**	(49,876)	(554.4%)

Clinical Income

- Non Elective income and A&E Activity is higher
- Other NHS Clinical Activity in the current year includes the 2018/19 pay award.

Non Clinical Income

- No PSF income 18-19 but £3.2m in 17-18
- PAS Project income 18-19
- Serco contract early exit fee £2.1m 18-19
- Recharges to 2gether Support Solutions as part of OHF set up arrangements £0.5m 18-19

Pay

- Pay inflation, incl AfC and Medical Pay Award
- Consultant Job Plan and Junior Doctors roll out.
- No RMO usage in this period 17-18.
- No A&E Improvement costs in this period 17-18.
- Divisional run rate increases to support activity and operational requirements including use of TFS Nurse Agency.
- Subjective impact of staff transferring to Operated Healthcare Facility

Non Pay

- Drugs - lower expenditure on rechargeable between years.
- Clinical Supplies - inflation and activity related cost of delivery.
- Purchase of Healthcare - increased use of insourcing companies
- Premises - PAS project costs 18-19 and Estates non pay profile prior to transfer to Operated Healthcare Facility
- Subjective impact of Operated Healthcare Facility from pay to non pay and across categories within non pay.

Cash Flow

Month 08 (November) 2018/19

Year to Date		This Month			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual		Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast
7,157	**Opening Bank Balance**	5,618	6,406	789	7,157	16,287	4,760	7,090	15,985	9,247	5,129	6,406	3,464	5,613	3,013	2,174
49,887	Ashford CCG	5,919	5,773	(146)	7,445	5,494	7,891	5,771	5,775	5,770	5,968	5,773	5,770	5,770	5,770	5,770
80,342	C4G	9,844	9,669	(176)	10,918	9,344	11,531	9,619	9,622	9,621	10,019	9,669	9,619	9,619	9,619	9,619
91,660	South Kent Coast CCG	11,105	9,740	(1,366)	12,809	10,529	12,943	11,220	10,846	10,829	12,745	9,740	10,438	10,827	10,827	10,827
63,052	Thanet CCG	8,048	8,110	62	8,180	7,824	8,233	7,195	7,835	7,835	7,839	8,110	7,835	7,835	7,835	7,835
576	Additional Income		576	576								576				
392	Dartford, Gravesham & Swanley CCG	38	39	1	38	38	38	63	92	45	38	39	97	38	38	38
1,502	Medway CCG	164	174	10	263	165	190	174	173	180	182	174	165	164	164	164
1,839	Swale CCG	306	301	(5)	306	306	299	323	304			301	332	306	306	306
3,422	West Kent CCG	449	427	(22)	377	377	531	427	428	427	428	427	451	449	449	449
64,994	NHS England	8,059	8,013	(45)	8,082	7,728	8,453	7,346	9,707	7,657	8,006	8,013	8,547	8,059	8,059	8,059
27,150	All Other NHS Organisations	960	2,560	1,600	5,317	1,119	801	5,645	2,866	2,447	6,396	2,560	1,555	5,335	1,223	1,423
0	Capital Receipts															
25,095	All Other Receipts	1,783	4,976	3,193	2,664	2,277	2,274	3,976	2,866	1,672	4,389	4,976	5,507	3,183	3,109	3,546
5,603	Provider Sustainability Fund							5,603								
19,324	Working Capital Facility	5,855	4,869	(986)	2,234			3,410	3,708	5,103		4,869	5,207	2,037	2,192	6,661
	Working Capital Facility Repaid															
	Permanent Loan															
434,835	**Total Receipts**	**52,531**	**55,226**	**2,696**	**58,633**	**45,202**	**53,184**	**60,772**	**54,222**	**51,585**	**56,010**	**55,226**	**55,522**	**53,621**	**49,591**	**54,696**
	Payments															
(218,079)	Monthly Payroll inc NI & Super	(27,708)	(27,453)	255	(26,383)	(26,617)	(26,681)	(27,120)	(28,165)	(28,308)	(27,351)	(27,453)	(27,103)	(27,222)	(27,268)	(27,118)
(208,416)	Creditor Payment Run	(25,682)	(30,054)	(4,372)	(21,600)	(27,605)	(23,054)	(24,445)	(31,892)	(23,180)	(26,586)	(30,054)	(24,211)	(27,366)	(20,118)	(21,237)
(8,612)	Capital Payments	(1,265)	(767)	498	(1,503)	(2,508)	(1,085)	(312)	(848)	(861)	(729)	(767)	(1,866)	(1,762)	(1,994)	(1,828)
(2,634)	PDC Dividend Payment									(2,634)						(3,007)
(884)	Interest Payments				(18)		(34)		(55)	(719)	(57)		(30)	(61)	(210)	(704)
(438,624)	**Total Payments**	**(54,655)**	**(58,274)**	**(3,619)**	**(49,503)**	**(56,730)**	**(50,854)**	**(51,877)**	**(60,960)**	**(55,703)**	**(54,723)**	**(58,274)**	**(53,210)**	**(56,411)**	**(49,590)**	**(53,894)**
(3,789)	**Total Movement In Bank Balance**	**(2,125)**	**(3,048)**	**(923)**	**9,130**	**(11,527)**	**2,330**	**8,895**	**(6,738)**	**(4,118)**	**1,287**	**(3,048)**	**2,312**	**(2,790)**		**803**
3,368	**Closing Bank Balance**	**3,493**	**3,368**	**(125)**	**16,287**	**4,760**	**7,090**	**15,985**	**9,247**	**5,129**	**6,416**	**3,368**	**5,680**	**2,890**	**2,891**	**3,693**
	Plan				15,584	3,861	3,529	7,882	3,470	5,153	5,618	3,493	3,879	2,890	2,890	3,693
	Variance				704	899	3,561	8,102	5,777	(25)	798	(125)	1,801	()		

Clinical Income - by Commissioner

Month 08 (November) 2018/19

	This Month £000			Year to Date £000			Annual £000
Commissioner	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**
NHS Ashford CCG	6,047	6,179	132	46,437	49,212	2,775	69,236
NHS Canterbury & Coastal CCG	10,185	10,109	(75)	77,311	79,712	2,401	115,422
NHS South Kent Coast CCG	11,011	11,022	11	87,192	89,297	2,105	129,925
NHS Thanet CCG	7,932	7,811	(121)	62,906	64,099	1,192	94,021
East Kent CCGs	35,175	35,121	(53)	273,847	282,320	8,473	408,603
NCA - England	282	415	133	3,282	3,533	251	4,686
NHS England - Armed Forces	14	9	(6)	113	127	13	159
NHS England - Specialised Services	6,707	6,668	(38)	53,171	53,589	418	79,165
NHS England - Health In Justice	10	7	(2)	78	58	(19)	116
NHS England - Secondary Dentistry	544	573	29	4,325	4,358	33	6,429
NHS England - Public Health	684	556	(128)	5,076	4,471	(604)	7,811
Kings	22	22		176	173	(3)	264
NCA - Wales	12	9	(3)	95	82	(13)	142
NCA - Northern Ireland		1		3	7	4	5
NCA - Scotland	2	2		15	13	(2)	22
Other Trusts	149	202	52	1,196	1,600	404	1,793
East Kent Overseas	(6)	27	33	6	452	446	
NHS Dartford, Gravesham & Swanley CCG	31	34	3	347	292	(55)	455
NHS Medway CCG	179	190	11	1,430	1,432	3	2,075
NHS Swale CCG	270	373	103	2,535	2,344	(191)	3,643
NHS West Kent CCG	419	603	184	3,519	3,921	402	5,122
Other Organisations	1,413	555	(858)	10,064	2,568	(7,496)	16,059
Cancer Drugs Fund	251	171	(79)	2,005	2,052	47	3,007
Adjust Prior Month Reported Position		(227)	(227)				
Prior year Income		(1)	(1)		2,819	2,819	
Total	46,158	45,311	(847)	361,282	366,211	4,930	539,558

East Kent Commissioner contracts are all over performing YTD, however the in month position is under Contract. NHSE Specialised Services is also ahead of Contract YTD but has a small under performance in month. The Cancer Drugs Fund and West Kent CCG is ahead of Contract YTD, while the North Kent CCGs are collectively behind Contract despite an improving position this month. Other Organisations include provisions for risks along with the planned CIP schemes and £3.3m YTD unplanned income to fund AfC pay awards.

EK CCGs continue to materially challenge Trust data on a monthly basis, however through joint discussions they are reducing. In July £2m of patient level data queries were received, of which only a handful of challenges were accepted with minimal financial impact. The monthly challenges have since reduced to more reasonable levels.

The Expert Determination items from 17-18 that roll into 18-19 are being actively progressed. The unbundled radiology challenge has now been resolved with a credit to commissioners for 17-18 of £1.5m. The Unbundled Radiology and Dermatology activity reporting have now been amended to comply with the rulings. There are no material contracting issues with any of our other Commissioners.

KPIs

Month 08 (November) 2018/19

		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Clinical Income	**Plan**	42,848	45,649	46,985	46,015	44,480	46,915	47,069	46,849	43,841	47,000	43,204	47,002
Consolidated	**Actual**	42,369	47,016	47,467	47,702	46,857	47,609	47,860	46,273				
	Variance	-479	1,367	482	1,687	2,377	694	791	-576				
	Quarterly rolling average spend	43,089	44,782	45,617	47,395	47,342	47,389	47,442	47,247				
Other Income	**Plan**	3,475	3,534	3,566	3,508	3,529	3,552	3,587	3,613	3,546	3,574	3,570	3,628
Consolidated	**Actual**	3,329	3,588	4,824	5,604	3,633	3,691	4,173	3,455				
	Variance	-146	54	1,258	2,096	104	139	586	-158				
	Quarterly rolling average spend	5,875	6,087	3,914	4,672	4,687	4,309	3,832	3,773				
Pay	**Plan**	-30,772	-30,911	-31,066	-30,623	-30,634	-30,717	-30,686	-30,953	-30,960	-31,294	-30,721	-30,717
Consolidated	**Actual**	-31,253	-32,237	-32,156	-32,254	-34,168	-33,635	-33,878	-34,293				
	Variance	-481	-1,326	-1,090	-1,631	-3,534	-2,918	-3,192	-3,340				
	Quarterly rolling average spend	-31,203	-31,818	-31,882	-32,216	-32,859	-33,352	-33,894	-33,935				
Non Pay Operating Expenses	**Plan**	-18,693	-19,143	-18,927	-17,936	-19,125	-18,308	-19,439	-18,979	-18,303	-19,074	-17,944	-18,545
Consolidated	**Actual**	-17,358	-19,394	-19,634	-20,118	-18,502	-17,558	-19,430	-17,211				
	Variance	1,335	-251	-707	-2,182	623	750	9	1,768				
	Quarterly rolling average spend	-19,920	-20,168	-18,795	-19,715	-19,418	-18,726	-18,497	-18,066				
Non Operating	**Plan**	-2,228	-2,228	-2,228	-2,229	-2,235	-2,238	-2,236	-2,246	-2,259	-2,257	-2,260	-2,280
Consolidated	**Actual**	-2,118	-2,214	-2,179	-2,213	-2,176	-1,949	-35,884	-1,725				
	Variance	110	14	49	16	59	289	-33,648	521				
	Quarterly rolling average spend	-1,942	-1,971	-2,170	-2,202	-2,189	-2,113	-13,336	-13,186				
Agency	**Plan**	-1,849	-1,702	-1,617	-1,552	-1,460	-1,450	-1,432	-1,292	-1,289	-1,278	-1,279	-1,258
Unconsolidated	**Actual**	-3,186	-3,921	-3,264	-3,411	-2,949	-2,983	-2,996	-2,945				
	Variance	-1,337	-2,219	-1,647	-1,859	-1,489	-1,533	-1,564	-1,653				
	Quarterly rolling average spend	-3,237	-3,484	-3,457	-3,532	-3,208	-3,114	-2,976	-2,975				
CIPS	**Plan**	1,502	1,534	1,553	3,357	2,156	1,295	2,895	2,925	2,937	3,205	3,276	3,975
Unconsolidated	**Actual**	1,155	1,758	1,629	4,081	1,777	1,598	2,763	2,811				
	Variance	-348	224	75	723	-378	303	-132	-113				
Cash	**Plan**	15,584	3,861	3,529	7,882	3,470	5,153	5,618	3,493	3,879	2,890	2,890	3,693
Unconsolidated	**Actual**	16,287	4,762	7,090	15,985	9,247	5,129	6,406	3,368				
	Variance	704	901	3,561	8,102	5,777	-25	789	-125				

Cost Improvement Summary

Month 08 (November) 2018/19

Planned Summary	2018 - 2019			Target Variance	
Programme Care Groups £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Clinical Support	4,159	3,637	3,629	(522)	(530)
General & Specialist Medicine	4,321	3,687	3,687	(633)	(633)
Urgent & Emergency Care	2,477	1,229	1,229	(1,249)	(1,249)
Surgery & Anaesthetics	6,075	4,630	4,355	(1,445)	(1,720)
Upper Surgery	1,137	803	785	(334)	(352)
Women's & Children's	2,913	2,702	2,702	(211)	(211)
Cancer	567	869	869	302	302
Corporate	71	379	379	308	308
SD&CP	1,300	1,279	1,224	(21)	(76)
Procurement	2,693	1,562	1,537	(1,131)	(1,156)
Medicines Value	871	1,542	1,541	671	670
Sub-total	**26,584**	**22,319**	**21,938**	**(4,265)**	**(4,646)**
Central	3,416	6,969	6,969	3,553	3,553
Grand Total	**30,000**	**29,288**	**28,907**	**(712)**	**(1,093)**

Planned Summary	2018 - 2019			Target Variance	
Programme Themes £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Patient Flow/LOS	1,000	-	-	(1,000)	(1,000)
Agency	5,417	3,566	3,565	(1,851)	(1,851)
Workforce *	170	416	416	246	246
Procurement	1,982	1,058	1,033	(925)	(950)
Medicines Value	871	1,542	1,541	671	670
Care Group Schemes **	16,584	18,196	17,841	1,612	1,257
Sub-total	**26,025**	**24,778**	**24,397**	**(1,247)**	**(1,628)**
Central	3,975	4,510	4,510	535	535
Grand Total	**30,000**	**29,288**	**28,907**	**(712)**	**(1,093)**

Cost Improvement Phasing

Month 08 (November) 2018/19

Work stream Gross £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	-	-	-	-	167	167	167	167	167	167	1,000
Agency	368	382	378	422	414	467	420	456	450	530	567	560	5,417
Workforce	2	2	2	4	20	20	20	20	20	20	20	20	170
Procurement	50	69	87	129	199	206	207	207	207	207	208	208	1,982
Medicines Value	30	45	50	55	66	68	70	79	88	98	108	116	871
Clinical Support Services	184	165	166	251	248	251	250	246	243	271	269	270	2,817
General & Specialist Medicine	59	59	58	134	127	(42)	260	259	258	261	261	261	1,956
Urgent & Emergency Care	1	1	1	1	1	1	1	1	1	1	1	1	8
Surgery & Anaesthetics	322	290	305	394	394	394	611	611	611	698	723	723	6,075
Upper Surgery	65	98	83	90	89	56	91	90	90	86	86	86	1,012
Women's & Children's	173	175	173	221	219	(434)	382	379	375	372	372	372	2,778
Cancer Services	52	51	54	61	56	(68)	62	61	60	60	60	60	567
Corporate - Other	6	6	6	6	6	6	6	6	6	6	6	6	71
SD&CP	108	109	108	108	108	108	108	108	108	108	108	107	1,300
Sub-total	**1,420**	**1,451**	**1,470**	**1,878**	**1,947**	**1,033**	**2,654**	**2,689**	**2,684**	**2,885**	**2,956**	**2,957**	**26,025**
Central	83	83	83	1,471	200	262	240	235	252	320	320	422	3,975
Grand Total	**1,504**	**1,534**	**1,553**	**3,349**	**2,148**	**1,295**	**2,894**	**2,925**	**2,937**	**3,205**	**3,276**	**3,379**	**30,000**

Workstream RAG adj £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	-	-	-	-	-	-	-	-	-	-	-
Agency	434	275	352	308	236	206	260	295	289	299	311	302	3,565
Workforce	22	53	2	25	44	44	44	46	33	33	33	33	416
Procurement	35	44	59	106	54	52	82	123	99	127	127	125	1,033
Medicines Value	42	57	109	222	194	161	102	167	108	117	127	136	1,541
Clinical Support	157	184	234	330	357	144	161	276	243	289	288	289	2,953
General & Specialist Medicine	1	67	87	100	255	207	171	126	217	229	222	222	1,905
Urgent & Emergency Care	-	-	-	80	20	20	20	20	20	20	20	20	240
Surgery & Anaesthetics	132	583	366	445	302	260	369	367	381	383	383	383	4,355
Upper Surgery	9	94	64	82	41	11	54	86	77	82	93	93	785
Women's & Children's	89	82	131	184	164	482	174	469	236	190	228	258	2,687
Cancer Services	113	110	84	51	89	3	71	50	72	78	73	73	869
Corporate - Other	-	11	7	7	7	7	754	407	406	406	406	406	2,823
SD&CP	20	198	108	113	172	105	120	95	92	92	92	15	1,224
Sub-total	**1,055**	**1,758**	**1,604**	**2,054**	**1,935**	**1,703**	**2,383**	**2,528**	**2,274**	**2,345**	**2,405**	**2,355**	**24,397**
Central	100	-	-	2,000	(100)	(100)	383	284	163	1,160	291	329	4,510
Grand Total	**1,155**	**1,758**	**1,604**	**4,054**	**1,835**	**1,603**	**2,766**	**2,811**	**2,437**	**3,506**	**2,695**	**2,684**	**28,907**

Debtor Balances

Month 08 (November) 2018/19

Debtor	Top ten debtor balances outstanding as at 30/11/2018						Creditor balance as at 30/11/2018	Notes
	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total		
76480-2GETHER SUPPORT SOLUTIONS LTD	1,059,496	114,561,077	53,413	0	0	115,673,986		£112m sale of assets, £5.7m sale of stocks
51136-EAST KENT MEDICAL SERVICES	183,488	5,120	275,031	165,656	1,397,121	2,026,416	1,047,789	Reciprocal payment arrangement in place
61865-NHS CANTERBURY AND COASTAL CCG	130,936	133,385	280,834	4,702	1,085,150	1,635,007	74,762	£1.0m 1718 overperformance, £0.3m 1819 overperformance
62033-NHS THANET CCG	10,350	133,859	399,869	7,511	883,257	1,434,846	80,522	£0.9m 1718 overperformance, £0.4m 1819 overperformance
61818-NHS ASHFORD CCG	5,957	6,291	441,478	3,704	687,058	1,144,488	57,352	£0.6m 1718 overperformance, £0.4m 1819 overperformance
62003-NHS SOUTH KENT COAST CCG	13,793	348,441	14,108	2,894	736,009	1,115,245	99,968	£1.0m 1718 overperformance
50010-MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	165,183	100,112	33,230	35,244	599,670	933,438	1,618,494	Trust creditor balance with MTW is larger than the debtor balance. Difference being reduced as invoices are authorised
62048-NHS WEST KENT CCG	12,161	18,346	8,564	15,584	766,852	821,507		16/17 overperformance in dispute
51708-MEDWAY NHS FOUNDATION TRUST	6,020	51,174	6,854	49,251	649,631	762,930	1,201,668	Reciprocal payments to keep outstanding balances in line
62138-NHS ENGLAND SOUTH EAST COMMISSIONING HUB (14G)	73,900	0	147,800	0	517,301	739,002		Unpaid Hep C Drugs invoices
Other Govn.	1,187,314	890,878	444,271	393,845	2,451,964	5,368,272		
Other Non Govn.	507,452	209,530	177,221	86,452	692,006	1,672,661		
	3,356,051	116,458,213	2,282,672	764,843	10,466,019	133,327,797	4,180,555	

Creditor Balances

Month 08 (November) 2018/19

Unpaid at last Payment Run

Supplier Name	Total
Other Creditors	1,876
NHS Professionals Ltd	2,932
NHS Business Services Authority Prescription Pricing D	455
NHS Blood & Transplant T1460	419
Bayer PLC	237
Novartis Pharmaceuticals UK Ltd	220
Alcura UK Ltd	175
Kent Community Health NHS Foundation Trust (RYY)	138
NHS Supply Chain 8HD71 - Stock	133
B Braun Avitum (UK) Ltd	133
Roche Products Ltd	133
Total	**6,852**

At the last payment run of the period we had a total of £10.3m of invoices authorised and ready for payment.

Of the £10.3m, £3.4m was released leaving £6.9m unpaid due to low liquidity.

Aged Creditors now stands at £31.7m.

The Accounts Payable team prioritises key suppliers and those threatening to restrict supplies.

Top Ten Aged Creditor

Supplier Name	Current	1-30	31-60	60-90	90 +	Total
Other Creditors	7,966	4,865	1,185	1,016	2,130	17,162
NHS Professionals Ltd	2,426	3,326	2		22	5,775
Maidstone & Tunbridge Wells NHS Trust (RWF)	414	220	195	193	597	1,618
2gether Support Solutions Ltd	892	154	149	11		1,207
Medway NHS Foundation Trust (RPA)	147	203	127	161	564	1,202
East Kent Medical Services Ltd T/a The Spencer Wing				173	875	1,048
Healthcare At Home Ltd	852	18			0	870
NES Holdings (UK) Ltd	321	334	164		16	835
NHS Blood & Transplant T1460	223	204	226		81	734
Novartis Pharmaceuticals UK Ltd	410	220				630
AAH Pharmaceuticals LTD	569	29	0	0	0	598
Total	**14,219**	**9,572**	**2,047**	**1,554**	**4,287**	**31,679**

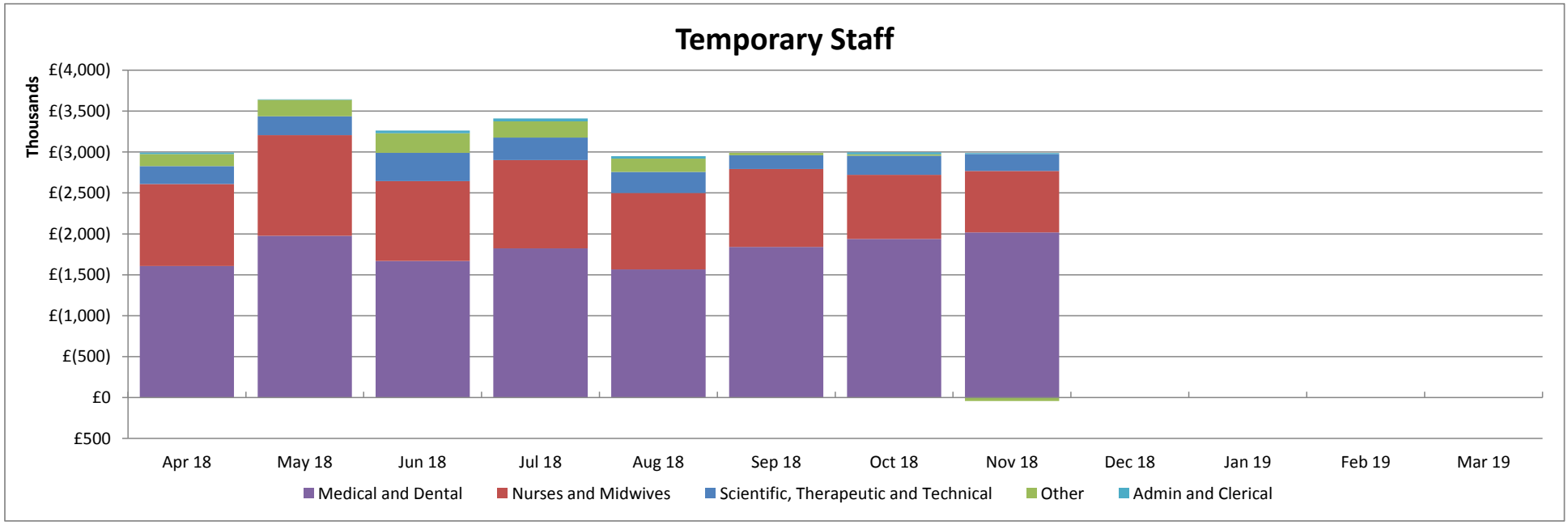
Aged Creditor By Reason

Reason Description	Current	1-30	31-60	60-90	90 +	Total
Current	14,219					14,219
Cash Flow		6,405	446		0	6,852
Waiting on a GRN		1,272	941	368	1,054	3,635
Waiting on Authorisation		680	184	831	486	2,182
Not Recorded		1,072	187	60	313	1,632
Disputed		74	85	32	1,377	1,568
Creditor Debit Balance				173	831	1,004
Purchase Order Value Exceeded		11	156	18	77	261
Price Query		34	31	30	102	197
Order Raised after Invoice Received		24	17	42	43	127
Other			1	0	2	3
Total	**14,219**	**9,572**	**2,047**	**1,554**	**4,287**	**31,679**

Pay Analysis - Temporary Staff

Month 08 (November) 2018/19

In Month £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medical and Dental	**(1,608)**	**(1,976)**	**(1,670)**	**(1,822)**	**(1,567)**	**(1,841)**	**(1,938)**	**(2,017)**				
Agency	(1,476)	(2,079)	(1,571)	(1,702)	(1,515)	(1,741)	(1,765)	(2,006)				
Direct Engagement	(132)	103	(99)	(121)	(51)	(100)	(173)	(11)				
Scientific, Therapeutic and Technical	**(217)**	**(231)**	**(348)**	**(275)**	**(257)**	**(168)**	**(234)**	**(207)**				
Agency	(217)	(231)	(348)	(275)	(257)	(168)	(234)	(207)				
Nurses and Midwives	**(1,002)**	**(1,230)**	**(974)**	**(1,080)**	**(933)**	**(951)**	**(784)**	**(751)**				
Agency	(1,002)	(1,230)	(974)	(1,080)	(933)	(951)	(784)	(751)				
Admin and Clerical	**(18)**	**(6)**	**(33)**	**(36)**	**(28)**	**7**	**(23)**	**(13)**				
Agency	(18)	(6)	(33)	(36)	(28)	7	(23)	(13)				
Other	**(150)**	**(201)**	**(239)**	**(198)**	**(164)**	**(29)**	**(17)**	**43**				
Agency	(150)	(201)	(239)	(198)	(164)	(29)	(17)	43				
Total	**(2,995)**	**(3,637)**	**(3,231)**	**(3,375)**	**(2,921)**	**(2,990)**	**(2,973)**	**(2,933)**				



Pay Analysis - Temporary Staff

Month 08 (November) 2018/19

Temporary Staff Actual £m	M & D	N & M	PAMS	A&C Other	Total	Variance v 2018/19	Variance v 2017/18
General and Specialist Medicine	0.19	0.21	0.03		0.42	(0.79)	(0.41)
Urgent and Emergency Care	1.00	0.40			1.40	0.54	0.88
Surgery and Anaesthetics	0.48	0.12	0.03		0.63	0.04	0.19
Surgery - Head and neck, Breast Surgery and Dermatol	0.03				0.03	(0.01)	0.01
Clinical Support Services	0.12		0.15		0.28	(0.01)	0.04
Cancer Services				0.01	0.01	0.01	0.01
Women's and Children's Services	0.17	0.03		0.03	0.22	0.03	0.09
Strategic Development and Capital Planning						(0.03)	(0.01)
Corporate				0.01	0.01	(0.01)	(0.01)
Central	0.02			(0.08)	(0.06)	0.03	(0.01)
Total	**2.01**	**0.76**	**0.21**	**(0.03)**	**2.95**	**(0.20)**	**0.78**
Variance v 2018/19 average	0.21	(0.21)	(0.04)	(0.17)	(0.20)		
Variance v 2017/18 average	0.67	0.15	0.06	(0.09)	0.78		

Temporary Staff Year to Date £m	M & D	N & M	PAMS	A&C Other	Total	Average per Month
General and Specialist Medicine	6.54	2.43	0.21	0.57	9.74	1.22
Urgent and Emergency Care	2.92	3.87		0.14	6.93	0.87
Surgery and Anaesthetics	3.34	1.08	0.26		4.69	0.59
Surgery - Head and neck, Breast Surgery and Dermatol	0.26	0.01			0.27	0.03
Clinical Support Services	0.79		1.49	0.01	2.29	0.29
Cancer Services				0.01	0.01	
Women's and Children's Services	1.22	0.27		0.03	1.52	0.19
Strategic Development and Capital Planning				0.26	0.26	0.03
Corporate		0.01		0.16	0.17	0.02
Central	(0.62)	0.03	(0.02)	(0.06)	(0.68)	(0.09)
Total	**14.45**	**7.70**	**1.94**	**1.12**	**25.21**	**3.15**
Average per month	1.81	0.96	0.24	0.14	3.15	

REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE 18/118

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE (SWC)**
BOARD SPONSOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

This report presented reflects Committee activity for the December 2018 meeting.

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

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

MEETING HELD ON 11 DECEMBER 2018

1. Strategic Workforce Committee

The Committee going forward will focus more on the strategic elements regarding workforce, it will continue to monitor performance at an operational level.

2. Workforce Modelling

2.1 The Committee is looking at workforce modelling to inform the development of the workforce strategy, which includes:

2.1.1 HR Business Partners working to determine the type of staff and the numbers necessary for each professional group to deliver services to align with the development of the Trust's clinical strategy and the new models of care being developed.

2.1.2 Activity to date has involved working with clinicians to identify specific staffing needs according to emerging clinical service developments. A significant aspect of this is the development of 7 day services and the associated staffing needs to meet this enhanced demand in delivery.

2.1.3 While the clinical strategy is being developed, the Trust is seeking to consider smarter ways of working, around recruiting and developing a workforce that is fit for purpose, skilled, cost effective and available.

2.1.4 Traditional ways of delivering care using existing staffing structures and professional groups is being challenged within the Trust and a greater emphasis is now being placed on encouraging staff to work to the top of their licence. The Trust is introducing new roles that are more effective both in terms of training requirements, accessibility and undertaking further activity to develop apprenticeships and similar roles.

REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE 18/118

2.1.5 The use of current recruitment and turnover data to inform the Trust's generic recruitment requirements for the immediate future. New models of care and a broader range of roles will be developed will enable EKHUFT to project with greater accuracy the specific profile needed to meet future needs. Alongside the recruitment to new roles the Trust will also be reviewing the emerging learning and development needs of current staff to ensure that they are equipped with the appropriate skills as EKHUFT moves towards different models and adjusting its workforce profile accordingly.

3. Integrated Performance Report (IPR) – HR Performance Metrics for October 2018

3.1 The Committee discussed and noted the following headlines:

3.1.1 There has been good progress in relation to recruitment.

3.1.2 Turnover fell during October but the overall 12 month average has marginally increased.

3.1.3 The rise in vacancy rates over the rolling 12 months, but in month vacancy rates have continued to reduce for the second month.

3.1.4 Sickness absence reduced during the reporting period to 3.74%, although the rolling 12 month average shows an increase to 4%. New data capture mechanisms are being developed to enable real time data to be captured.

3.1.5 Statutory training compliance is above the Key Performance Indicator (KPI) target and has increased to 90%, an increase on the same period the previous year.

3.1.6 Appraisal rates have continued to increase but have not yet reached the target and is lower on a rolling 12 month average than this time the previous year. Appraisal rates are being monitored and raised at the new Executive Performance Review (EPR) process by the Chief Operating Officer on a monthly basis, and the Director of HR quarterly.

3.1.7 A new agency cascade has been agreed as well as revised rates across the Sustainability and Transformation Partnership (STP). The use of agency is being monitored on a post by post basis through agency reduction plans within the Care Groups.

3.1.8 Collaborative bank options within the STP are also being pursued to support the required reduction in agency staff.

4. Quality and Culture Improvement

4.1 The Committee received and discussed a paper in relation to a key priority of the Trust around having in place the right culture for quality improvement to deliver success. The Trust aspires to be a vibrant place for staff to work, enable staff to develop by becoming involved in new initiatives and building careers allowing them to be fulfilled at work. A key element is the further development of EKHUFT to be a true learning organisation to ensure new ideas are captured and the Trust becomes a more progressive and dynamic organisation.

5. Quality Improvement Strategy

The Committee noted that the quality strategy would be rebranded as 'Quality Improvement Strategy' and an update would be presented to the April 2019 Committee meeting.

6. Leadership Academy

The Committee will sponsor the EKHUFT Leadership Academy and an update on the Leadership Framework will be presented to the Committee at its meeting in April 2019.

REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE **18/118**

7. Other Reports

7.1 The Committee received and discussed the following reports:
- 7.1.1 Board Assurance Framework (BAF) and Annual Priorities 2018/19: Quarter 2.
- 7.1.2 HR, Workforce and Organisational Development Risks Review.
- 7.1.3 Updates on the Doctors in Training (DiT) Action Plan and the Specialty and Associate Specialist (SAS) Doctor Action Plan.
- 7.1.4 Guardian of Safe Working Quarterly Report for the period 1 August 2018 to 31 October 2018.

7.2 The Committee received and noted reports and confirmed minutes from the following:
- 7.2.1 Integrated Education, Training and Leadership Development Board (IETLDB).
- 7.2.2 Joint Chairs of Staff Committee.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and accept the report from the Strategic Workforce Committee for approval.

CHARITABLE FUNDS COMMITTEE CHAIR REPORT **18/119**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**CHARITABLE FUNDS COMMITTEE (CFC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF CHARITABLE FUNDS COMMITTEE**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Charitable Funds Committee remit is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy.

Chair's summary of the key issues highlighted at the Charitable Funds Committee meeting held on 13 December 2018.

1. <u>Finance Report</u>

1.1 The Committee discussed and noted a report on the current financial position and income and expenditure of the East Kent Hospitals Charity, this included the following key elements:
- 1.1.1 The Charity fund balances of £2.9m.
- 1.1.2 Income of £0.2m.
- 1.1.3 Expenditure of £0.4m, of which grants to the Trust amounted to £0.3m.
- 1.1.4 Cash position of £0.7m.
- 1.1.5 Investments of £2.3m.

2. <u>Appeal and Fundraising Update</u>

2.1 The Committee received and noted an update report on the current fundraising activities of the Charity, which included:
- 2.1.1 The dementia appeal fundraising total of £133,000k.
  - 2.1.1.1 The Dementia Team was awarded the "Fundraiser of the Year" Trust Award for their dedication to this appeal.
  - 2.1.1.2 The wider aim of the appeal regarding expanding awareness of dementia, and to date over 300 'Dementia Friends' have been created within the Trust, as part of the Alzheimer's Society's initiative.
  - 2.1.1.3 The 'Memory Lane Newsletter' that is published four times a year by the Charity working with the Dementia Team, this is a very useful publication to promote the appeal and associated events internally and with key fundraisers.
  - 2.1.1.4 Work continues focussing on developing projects for the appeal and meetings have taken place to progress proposed projects that include:
    - 2.1.1.4.1 Kent & Canterbury Hospital (K&CH) – Day Room on Harbledown Ward and Invicta Ward.
    - 2.1.1.4.2 William Harvey Hospital (WHH) – Day Room on the Cambridge Floor.
    - 2.1.1.4.3 Queen Elizabeth the Queen Mother Hospital (QEQMH) - Sensory Garden to the side of the St Augustine's Ward.

CHARITABLE FUNDS COMMITTEE CHAIR REPORT **18/119**

2.1.2 Various services/appeals/sub-brands picked by the local community with regards to Charity of the Year profile and status, these included:
- 2.1.2.1 Kentish Express – Dementia Appeal.
- 2.1.2.2 Ashford Borough Council – Padua Children's Ward.
- 2.1.2.3 Broadstairs Vale Holiday Park – Rainbow Children's Ward.
- 2.1.2.4 Marks & Spencer Food, Ashford – Tiny Toes Neonatal Intensive Care Unit (NICU).
- 2.1.2.5 Autoquip Garage Equipment – Tiny Toes NICU.
- 2.1.2.6 The Kent Go-Kart Company – Tiny Toes NICU.
- 2.1.2.7 Mum2Mum Market – Tiny Toes NICU.
- 2.1.2.8 Marks & Spencer, Westwood Cross – Tiny Toes Special Care Baby Unit (SCBU).
- 2.1.2.9 Thanet Earth – Tiny Toes SCBU.
- 2.1.2.10 Hamstreet & District Sports & Leisure Association – Tiny Toes.

2.1.3 The Charity will be participating in the following public events in 2019:
- 2.1.3.1 Brighton Marathon (Sunday 19 April), 6 places are offered of which 3 have already been claimed, £50 is requested to secure a place with a minimum fundraising target of £400.
- 2.1.3.2 Prudential RideLondon 100 bike event (Sunday 4 August), 7 places are offered and 1 has been claimed so far, £100 is requested to secure a place with a minimum fundraising target of £500.

2.1.4 The Committee noted the Critical Care Garden Project proposal for a sensory garden for the sole use of Intensive Therapy Unit (ITU) patients at WHH. A quote and design has been agreed for this project that is a joint collaboration with the Friends of the WHH, who have agreed to pay for the addition of a ramp and extension to the doorway to accommodate beds.

2.1.5 In relation to the Twinkling Stars Project the Bereavement Suite on Maternity at WHH, quotes for the refurbishment of the Counselling Room have been agreed and work is to commence soon on this project.

2.1.6 Current projects being progressed regarding the Precious Memories appeal, the Bereavement Suite on Maternity at the QEQMH include:
- 2.1.6.1 A private garden to the side of Ocean Suite.
- 2.1.6.2 Refurbishment of the Counselling Room.

2.1.7 The Tiny Toes fundraising campaign for NICU and SCBU has now topped £41,700.

2.1.8 The donation of £6,000 from The Alexa Trust to be used solely for the NICU Expressing Room project.

2.1.9 The addition of a patient toilet in SCBU as currently families have to use the public toilet facilities when their baby is on SCBU. The Ward Manager is working with the Estates Team to obtain quotes for the reconfiguration of this environment to create a new reception desk and parent toilet.

2.1.10 The UK's highest bungee jump was accomplished by two brave fundraisers and this raised £4,255 for Tiny Toes NICU.

2.1.11 A fundraiser and his friends walked for 24 hours from Hillingdon Hospital in London where he was born, to the WHH where his daughter was born (73 miles). This Tiny Toes Trek raised over £6,000 for Tiny Toes NICU.

2.1.12 The Charity is promoting its brand and brought some festive cheer over the Christmas period to each of the patient facing wards and departments, by repeating its 'Festive Fund' project. This enabled wards to claim £50 for decorations in line with some strict criteria.

2.1.13 Following the success of Tiny Toes the Charity has been working with the Maternity and Child Health teams to launch similar brands for their services. It is hoped that these will develop into successful fundraising campaigns:
- 2.1.13.1 Maternity – "Heart in Hands, part of East Kent Hospitals

CHARITABLE FUNDS COMMITTEE CHAIR REPORT **18/119**

Charity".

2.1.13.2 Child Health – "Child Health, part of East Kent Hospitals Charity".

2.1.14 A joint Charity forum with the Leagues of Friends (LoF) took place on 29 October 2018. It was agreed that the forum will meet again on 3 May 2019. Key issues covered included:

2.1.14.1 An update on the Trust, key charity initiatives, the Commissioning for Quality and Innovations (CQUINs) targets, space and support for the shops, 2gther Support Solutions and support to Charity projects.

2.1.14.2 An update on the Foundation Trust (FT) membership and the Trust volunteer programme.

3. <u>Community Fundraising Manager</u>

3.1 Vicky Adley, the full time Community Fundraising Manager, took up a promotional role at Demelza (the Kent Children's' Hospice) in December 2018. Vicky had been with the Charity for a little over 2 years and during that time made a huge impact particularly from her direct work with supporters of the Charity and staff alike. She developed initiatives promoting the Charity around the use of social media and a range of marketing materials. The Charity and Committee expressed their thanks and appreciation for all her hard work and support in the successful fundraising events, extending their best wishes for her new role. She will be greatly missed by the Charity and the Trust.

3.2 A replacement for the Community Fundraising Manager post is being progressed. A review of the fundraising function will be undertaken to further enhance this function, around supporting alternative methods to generate income for the Charity and the development of the services and innovation. It was noted that for the size of the Charity (turnover and assets) it is evidenced that this fundraising function is a relatively small.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Charity has to remain financially stable and cannot over commit to projects that could lead to an overreach of funding capacity. The Committee oversees the financial position and activities to ensure the Charity achieves its strategies and objectives.
LINKS TO STRATEGIC OBJECTIVES:	The broad objectives of the Charity link to all the strategic objectives of the Trust. **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	No
RESOURCE IMPLICATIONS:	Not applicable
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

CHARITABLE FUNDS COMMITTEE CHAIR REPORT **18/119**

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss, note and accept the report for approval from the Charitable Funds Committee.

INTEGRATED PERFORMANCE REPORT **18/120.1**

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**INTEGRATED PERFORMANCE REPORT (IPR)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: INTEGRATED PERFORMANCE REPORT – DECEMBER DATA**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Performance Report (IPR) 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 IPR 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 December 2018 report. The report has been discussed in detail by the Board's Quality Committee, Finance and Performance Committee and Strategic Workforce Committee. A summary of discussions at these meetings are included in Chair Reports to the Board of Directors.

A&E 4 Hour Compliance

December performance for the organisation against the 4 hour target was 79.36%; against the NHS Improvement (NHSI) trajectory of 88.6%. This represents a decrease in performance compared to the previous month. There were no 12 Hour Trolley Waits in December.

The number of patients who left the department without being seen remained compliant at 3.03%.

The unplanned re-attendance position remains high at 9.46%. Time to treatment reduced below 50% to 48.7% in December; from 52.7% the previous month.

18 Weeks Referral to Treatment (RTT) Standard

December performance improved to 72.42% against an improvement trajectory of 81.40%. There is a focus on improving clinic utilisation and reducing the number of 'Did Not Attends' (DNA's) and cancellations. The number of patients waiting over 52 weeks for first treatment has continued to over perform and improve with the number decreasing further to 74. This is within the trajectory of 150 submitted to NHSI and is a reduction of over 50% since April 2018 when there were 222 patients waiting.

An update on performance against our improvement plan can be found within the detail of the IPR.

Cancer 62 day GP Referral to Treatment Standard

December 62 day performance is currently 82.21% against the improvement trajectory of 83.12%, validation continues until the beginning of February in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,589 and there were 4 patients waiting 104 days or more for treatment or potential

diagnosis.

An update on performance against our improvement plan can be found within the detail of the IPR.

6 Week Referral to Diagnostic Standard

The standard has been met for December 2018 with a compliance of 99.56%. The number of patients waiting has decreased by 1094. As at the end of the month there were 54 patients who had waited over 6 weeks for their diagnostic procedure.

An update on performance against our improvement plan can be found within the detail of the IPR.

Patient Experience and Patient Safety

In terms of patient safety, the following positive improvements were reported:

- The Friends and Family test inpatient satisfaction rate remains positive at 97% and the overall patient experience continues to report as green.
- The ratio of compliments to complaints is registering as 'green' with 47 compliments for every complaint.
- Complaints performance has improved this month with 3 day acknowledgement registering 97% and complaint response times registering 95% for responding within timescales agreed with the client.
- A number of patients feeding back to us that they are up and dressed has increased. The Trust's 'Get Up, Get Dressed, Get Moving' campaign enables patients to feel more like themselves and aids recovery.
- The Trust reported a decrease in *E.coli* baceraemia rates, related to the prevalence of catheter associated urinary tract infection (UTI) and new UTIs with harm. Rates continue to report below the national average for acute hospitals.
- Harm free care for new harms reported positively at 99% and favourably against the Trust's peers.
- The prevalence of new venous thromboembolism (VTEs) (0.58%) remains lower than the national average for acute hospitals (0.59%). However, the VTE assessment recording for the last 12 months reported a decrease (92.6%), a reflection of a drop in monthly performance in December to 90.1%.
- The prevalence of new pressure ulcers (0.10%) also remains lower than the national average for acute hospitals (0.78%).
- Clostridium difficile infections continue to report below the Department of Health trajectory.
- The Trust's influenza vaccination rate reported >76% for clinical staff and >70% for all staff, this being the Trust's highest rate ever recorded.

In December a total of 23 unjustified mixed sex occurrences were reported, similar to the number reported last month but remains half the number reported during the Summer months. The reason for the breaches continues to be related to maintaining safety and flow through the Emergency Departments.

Improvement work is in place across the paediatric pathway (from Emergency Department to ward / theatres). Processes are in place to receive daily assurances that safety checks are completed and that safe staffing levels are in place within these areas.

Unfortunately, the falls rate increased to 5.58 and falls with harm (0.68) reported higher than the national average for acute hospitals (0.36). The IPR provides more detail around a number of measures put in place to prevent falls.

The hand hygiene audit compliance reported a decline in performance at 94%. Work continues with clinical teams.

INTEGRATED PERFORMANCE REPORT **18/120.1**

Financial Performance

Performance is monitored in detail by the Finance and Performance Committee and reported to the Board of Directors. Below summarises the December 2018 position.

The Trust delivered a year to date deficit at Month 9 at £29.5m deficit, which is £6.5m worse than plan. The main drivers of the deficit in month are the continuing themes whereby operational pressures are leading to significant Agency spend on Medical and Nursing staff but Elective activity and income are increasingly falling behind plan which was based on increasing inpatient elective activity in Q3 and 4 as well as a slowing down of outpatient work following the PAS implementation.

Whilst non elective work is over performing it is insufficient to make up for the elective shortfall. Reserves now remaining are very small and the financial position relies on the delivery of increased elective and outpatient activity over the coming three months which, if not delivered, will lead to a failure to deliver the revised financial forecast.

Income and Expenditure Cost Improvement Schemes (CIPs) reported £17.6m at month 8 against a plan of £17.2m. Risks remain in relation to finalising full delivery of identified schemes.

The Trust's detailed finance position can be found on page 44 of the report. We continue to work with our regulators to monitor the Trust's Financial Recovery plan.

Human Resources

The Turnover rate in month decreased slightly to 12.0% (last month 12.1%), and the 12 month average has increased to 13.9% (last month 13.8%). 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 vacancy rate increased to 12.9% (last month 12.7%) for the average of the last 12 months, which is higher than last year. However, the monthly rate remained below 10% at 9.7%. More work is being undertaken to target hard to fill vacancies, particularly within nursing and some Medical specialties.

Our Human Resources Team is working hard with Care Groups to identify new ways and methods of recruitment in a more timely way and to explore different workforce models. Exit interviews are constantly reviewed and analysed and a detailed report is provided periodically to the Board's Strategic Workforce Committee and reported to Board through the Chair Report.

All HR metrics are reviewed and challenged at a Care Group level in our monthly Executive Performance Reviews.

A full report on the HR metrics can be found on pages 32 – 36 of the IPR.

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.

INTEGRATED PERFORMANCE REPORT **18/120.1**

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	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report.

NHS
East Kent
Hospitals University
NHS Foundation Trust

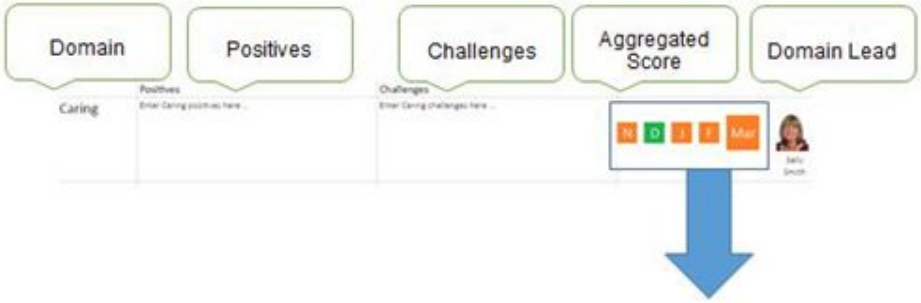
DECEMBER 2018

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

1 Headlines: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that the CQC organises its inspection into specific areas.

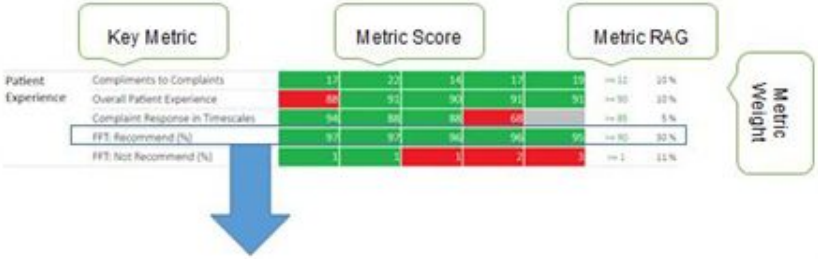


2 Domain Metrics: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall domain score. The second page illustrates key (but not all) metrics measured within that sub-domain.
This is important as it explains why the sum of each metric doesn't total 100%. A list of all metrics used in the calculation is summarised in the Glossary pages.

East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

3 Key Metrics: This section provides the actual data that builds up into the domain, the actual performance in percentage or volume terms for any given metric. These metrics are explored in more detail in the next section, Strategic Themes.



4 Strategic Themes: The Strategic Theme pages house key metrics with additional analysis, showing trend over the last 12 months. They show the latest month RAG together with the last 12 months position status (ie improved or worsened % from the previous 12 months plus average metric score). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.

All RAGs are banded as Green, Amber and Red. A grey cell indicates that data is not yet available. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Priorities

NHS
East Kent
Hospitals University
NHS Foundation Trust

Contents

Headlines	Organisation Overview	6
	Caring	9
	Effective	11
	Responsive	13
	Safe	15
	Well Led	17
Strategic Themes	Patient Safety	20
	Human Resources	32
	Key Performance Indicators	37
	Finance	43
	Health & Safety	44
	Use of Resources	46
	Improvement Journey	48
Glossary	Metric Descriptions	50

NHS
East Kent Hospitals University
NHS Foundation Trust

Headlines

	Positives	Challenges		
Caring	The Friends and Family test inpatient satisfaction rate remains positive at 97%. The compliments to complaints ratio is registering green this month with 47compliments for every complaint. Complaints performance has improved in December with 3 day acknowledgement registering 97% and complaint response times registering 95% for responding within timescales agreed with the client. We have seen an improvement this month is the number of patients feeding back to us that they are up and dressed. This allows them to feel more like themselves and aids recovery.	In December we reported 23 unjustified mixed sex occurrences. This is similar to last month but remains half the number we were reporting in the Summer. The reason for the breaches is to maintain safety and flow through the Emergency Departments. Improvement work is in place across the paediatric pathway (from ED to ward / theatres). We continue to receive daily assurance that safety checks are completed and that safe staffing levels are in place within these areas.	A S O N Dec	 Sally Smith
Effective	Beds During December there has been an increased focus on Matron review of all complex patients who have been in hospital over 7 and 21 days. There has also been continued focus on discharges before midday with 15% of patients achieving this and a greater number of patients being discharged through the Discharge Lounges. Clinical Outcomes 99% of patients have the WHO checklist completed in theatre. Demand and Capacity Out patient waiting lists are being validated to improve data quality post Allscripts (new PAS implementation). Theatres Increased focus on Day Case and Pre-Assessment activity to improve theatre productivity and patient experience.	The implementation of the new PAS has created challenges for staff across all the Constitutional and internal standards and although there have been sustained improvements in month there continues to be a requirement for further training and embedding of new processes. There is concern regarding the increasing number of DTOC patients across the sites. The number of out patient appointments that are DNA'd has increased in month.	A S O N Dec	 Lee Martin

Responsive

4 hour Emergency Access Standard
December performance for the 4 hour target is 79.36% excluding the community MIU and 82.25% including and against a NHS Improvement trajectory of 88.6%. There were no 12 Hour Trolley Waits. The number of patients who left the department without being seen continued to be compliant 3.03%. Time to treatment (60 minutes) has improved to the highest level since January 2018 and is compliant as 48.7%.

RTT
December performance improved to 72.42% against an improvement trajectory of 81.40%. There is a focus on improving clinic utilisation and reducing the number of DNA's and cancellations.

The number of patients waiting over 52 weeks for first treatment has continued to over perform and improve with the number decreasing further to 74. This is within the trajectory of 150 submitted to NHSI and is a reduction of over 50% since April 2018 when there were 222 patients waiting.

DM01
The standard is compliant for December 2018 with a compliance of 99.59% against a trajectory of 99.11% which is a significant improvement over the last six months.

Cancer
December performance for 62 day treatments is currently 82.21% against the improvement trajectory of 83.12%, validation continues until the beginning of February in line with the national timetable. The total number of patients on an active cancer pathway at the end of the month was 2,589 and there were 8 patients waiting 104 days or more for treatment or potential diagnosis.
2ww performance has been achieved at 93.29% against a performance standard of 93%.

All patients on a 2ww pathway and those who are over 73 days are reviewed daily and into patient level detail at the weekly cancer PTL meetings to ensure timely investigations and treatment for patients.

4 hour Emergency Access Standard
The A&E four hour standard remains a priority for the Trust. Patient flow delays due to timely bed availability continue to be a challenge due to the high number of patients with a length of stay over 7 and super stranded patients with a length of stay over 21 days.

RTT
Ensuring that all out patient outcome forms are completed in real time in the OPD environment. Ensuring out patient clinic activity is fully booked and utilised.

CANCER
Managing 2ww patient referrals to ensure that there is sufficient capacity to book all patients within 48 hours of receipt of a referral.

A S O N Dec

Lee Martin

Safe	Positives this month include a fall in E.coli bacteraemia rates, related to the prevalence of Catheter associated urinary tract infection (UTI) and New UTI's with Harm continuing below the national average for Acute Hospitals. Harm free care for new harms was 99.0%. As part of this the prevalence of New VTE's (0.58%) remains lower than the national average for Acute Hospitals (0.59%) and the prevalence of New Pressure Ulcers (0.10%) also remains lower than the national average for Acute Hospitals (0.78%). Clostridium difficile infections are now below the DH trajectory. Influenza vaccination rate is now >76% for clinical staff and >70% for all staff. Our highest rates ever.	The falls rate has increased this month to 5.58 and Falls with Harm (0.68) are higher than the national average for Acute Hospitals (0.36). Hand hygiene audit compliance has slipped backwards to 94%. VTE assessment recoding for the last 12 months has dipped to 92.6, a reflection of a drop in monthly performance in December to 90.1%	A S O N Dec	 Paul Stevens
Well Led	Vacancy (M8 - 12.6% , M7 - 13.2%) and Staff Turnover (M8 - 14.5%, M7 - 14.6%) rates have both improved in month. I&E CIPS of £17.6m are reported up to Month 8 against a plan of £17.2m. Risks remain in relation to finalising full delivery of some identified schemes (e.g. Patient Flow savings) in order that the full net £30m of savings can be delivered by the year end.	The Trust delivered a £3.6m deficit (after NHSi adjustments) in Month 8 which was £2m behind plan. This brings the YTD position to a deficit of £23.4M which is behind plan by £4.5m (consolidated position including Spencer Wing and 2geather Support Solutions and is after technical adjustments). Trust Pay is £1.3m over plan in month and £10.8m over plan YTD. The main overspend is in Agency costs (£12.7m over plan YTD) offset by an underspend on permanent staffing (£3m under plan YTD). The key driver for the overspend against plan are the continuing Medical and Nursing pressures in U&LTC and increased pressures in Medical pay in Surgery. Risks are increasing in relation to the impact on Income of lower than planned elective activity. Total Cash borrowed has risen to £65.5m Staff sickness (M8 - 5.5%, M5 4.7%) and Appraisal rates (M8 - 75.4% , M7 - 77.2%) rates have both worsened in month.	A S O N Dec	 Susan Acott

NHS
East Kent
Hospitals University
NHS Foundation Trust

Caring

	A	S	O	N	Dec	
OVERALL DOMAIN SCORE						Weight
Patient Experience						100 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Caring

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Patient Experience	Mixed Sex Breaches	73	19	0	22	23	>= 0 & <1	10 %
	AE Mental Health Referrals	115	81	116	113	93		5 %
	Compliments to Complaints (#/1)	23	17	32	51	47	>= 12	10 %
	Overall Patient Experience %	89.7	90.0	89.7	89.2	88.7	>= 90	10 %
	IP FFT: Recommend (%)	96	97	97	97	97	>= 90	30 %
	IP FFT: Not Recommend (%)	1.7	1.2	1.3	1.0	1.1	>= 0 & <1	10 %
	Complaint Response in Timescales %	90.2	75.7	72.1	81.6	94.6	>= 85	5 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Effective

	A	S	O	N	Dec	Weight
OVERALL DOMAIN SCORE						
Beds	A	S	O	N	Dec	33 %
Clinical Outcomes	A	S	O	N	Dec	33 %
Productivity	A	S	O	N	Dec	33 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Effective

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Beds	DToCs (Average per Day)	52	48	48	55	53	>= 0 & <35	30 %
	Bed Occupancy (%)	79	82	84	89	90	>= 0 & <92	60 %
	IP - Discharges Before Midday (%)	13	17	14	15	15	>= 35	10 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	4.4	3.9	3.7	3.5		>= 0 & <2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	15.6	15.7	15.4	15.4		>= 0 & <15	15 %
	Audit of WHO Checklist %	98	100	99	99	99	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	8.5	9.0	8.8	7.9	8.9	>= 0 & <7	
	DNA Rate: Fup %	7.3	8.3	9.3	7.6	9.0	>= 0 & <7	
	New:FUp Ratio (1:#)	1.9	1.8	1.9	1.9	1.8	>= 0 & <7	
Productivity	LoS: Elective (Days)	2.8	3.2	3.4	3.0	3.4		
	LoS: Non-Elective (Days)	6.1	6.1	6.3	5.9	6.3		
	Theatres: Session Utilisation (%)	81	79	81	80	78	>= 85	25 %
	Theatres: On Time Start (% 15min)	42	46	51	50	44	>= 90	10 %
	Non-Clinical Cancellations (%)	0.9	1.4	2.2	1.3	1.3	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	0	0	0	0	0	>= 0 & <5	10 %
	EME PPE Compliance %	78	79	79	77	76	>= 80	20 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Responsive

	A	S	O	N	Dec	Weight
OVERALL DOMAIN SCORE						
A&E						25 %
Cancer						25 %
Diagnostics						25 %
RTT						25 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Responsive

		Aug	Sep	Oct	Nov	Dec	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	83.52	81.02	83.88	84.50	82.25	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	80.04	77.15	80.89	81.74	79.36	>= 95	1 %
Cancer	Cancer: 2ww (All) %	93.64	90.96	83.54	93.29	96.76	>= 93	10 %
	Cancer: 2ww (Breast) %	86.32	94.39	68.70	84.17	95.00	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	94.57	96.81	97.49	96.95	96.02	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	95.65	96.00	93.22	100.00	96.97	>= 94	5 %
	Cancer: 31d (Drug) %	98.98	97.87	99.21	98.11	98.81	>= 98	5 %
	Cancer: 62d (GP Ref) %	66.13	71.30	77.05	71.73	82.21	>= 85	50 %
	Cancer: 62d (Screening Ref) %	94.37	81.48	87.50	83.78	86.67	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	94.87	76.00	82.14	84.85	75.00	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	98.03	98.53	99.31	99.66	99.56	>= 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 (%)	79.06	76.27	74.89	72.16	72.42	>= 92	100 %
	RTT: 52 Week Waits (Number)	125	129	120	102	74	>= 0	

NHS
East Kent
Hospitals University
NHS Foundation Trust

Safe

OVERALL DOMAIN SCORE	A	S	O	N	Dec	Weight
Incidents	A	S	O	N	Dec	20 %
Infection	A	S	O	N	Dec	20 %
Mortality	A	S	O	N	Dec	50 %
Observations	A	S	O	N	Dec	10 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Safe

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Incidents	Clinical Incidents: Total (#)	1,295	1,268	1,371	1,475	1,405		
	Serious Incidents (STEIS)	9	9	12	15	10		
	Harm Free Care: New Harms (%)	99.3	99.2	99.1	98.9	99.0	>= 98	20 %
	Falls (per 1,000 bed days)	4.94	5.30	5.64	5.22	5.64	>= 0 & <5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.16	0.13	0.14	0.19	0.19	>= 0 & <0.15	10 %
Infection	Cases of C.Diff (Cumulative)	22	25	26	26	32	<= Traj	40 %
	Cases of MRSA (per month)	0	1	0	2	0	>= 0 & <1	40 %
	Hand Hygiene Audit	94.0	96.8	92.1	96.2	94.0	>= 95	
Mortality	HSMR (Index)	96	96	96			>= 0 & <90	35 %
	Crude Mortality EL (per 1,000)	0.9	0.7	1.2	0.9	0.9	>= 0 & <0.33	10 %
	Crude Mortality NEL (per 1,000)	24.8	27.3	25.9	28.2	33.5	>= 0 & <27.1	10 %
	RAMI (Index)	89	89	89	90	90	>= 0 & <87.45	30 %
Observations	Cannula: Daily Check (%)	68.9	65.6	65.9	65.9	62.9	>= 50	10 %
	Catheter: Daily Check (%)	43.7	36.9	39.6	39.4	36.7	>= 50	10 %
	Central Line: Daily Check (%)	66.1	62.3	63.8	62.3	58.7	>= 50	10 %
	VTE: Risk Assessment %	93.0	90.3	90.3	91.8	90.1	>= 95	20 %
	Obs. On Time - 8pm-8am (%)	92.0	91.5	92.1	92.2	94.3	>= 90	25 %
	Obs. On Time - 8am-8pm (%)	89.6	89.4	89.7	89.3	92.2	>= 90	25 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Well Led

	A	S	O	N	Dec	Weight
OVERALL DOMAIN SCORE	A	S	O	N	Dec	
Data Quality & Assurance	A	S	O	N	Dec	15 %
Finance	A	S	O	N	Dec	25 %
Health & Safety	A	S	O	N	Dec	15 %
Staffing	A	S	O	N	Dec	25 %
Training	A	S	O	N	Dec	20 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

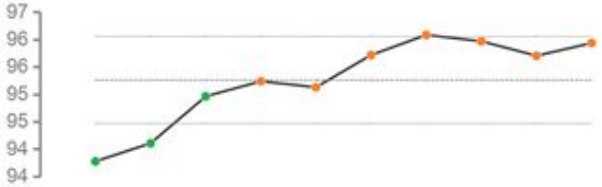
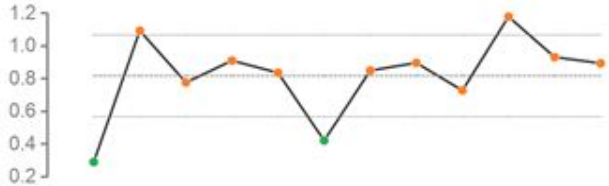
Well Led

		Aug	Sep	Oct	Nov	Dec	Green	Weight
Data Quality & Assurance	Not Cached Up Clinics %	0.6	0.7	0.6	0.5	1.2	>= 0 & <0.2	25 %
	Uncoded Spells %	0.5	0.7	0.4	0.4	1.2	>= 0 & <0.25	25 %
Finance	Forecast £m	-30.0	-29.9	-29.9	-29.9	-41.8	>= 0	10 %
	Total Cost £m (Trust Only)	-54.0	-52.5	-88.8	-53.0	-53.4	>= 0	20 %
	Cash Balance £m	9.2	5.1	6.4	3.4	8.7	>= 0	20 %
	I&E £m (Trust Only)	-4.4	-2.1	-37.6	-3.4	-6.7	>= 0	30 %
Health & Safety	Formal Notices	0	0	0	0	0	>= 0 & <1	15 %
	RIDDOR Reports (Number)	0	1	1	4	2	>= 0 & <3	20 %
Staffing	Sickness (%)	3.8	3.8	3.8	3.8	4.5	>= 0 & <3.3	10 %
	Agency %	7.5	7.4	7.6	8.0	7.3	>= 0 & <10	
	Bank Filled Hours vs Total Agency Hours	60	59	58	59	61		1 %
	Shifts Filled - Day (%)	93	93	97	98	95	>= 80	15 %
	Shifts Filled - Night (%)	104	102	105	106	104	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	12	11	11	11	12		
	Staff Turnover (%)	13.9	14.2	14.6	14.4	14.4	>= 0 & <10	15 %
	Vacancy (%)	14.2	13.8	13.2	12.6	12.7	>= 0 & <7	15 %
	Total Staff In Post (SiP)	7027	7076	6928	6998	6996		1 %
Training	Appraisal Rate (%)	75.9	76.3	77.2	75.4	79.6	>= 85	50 %
	Statutory Training (%)	98	98	97	97	96	>= 85	50 %

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Mortality

Dec	HSMR (Index)	95 (1.8%)		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)	89 (1.3%)		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)	0.8 (26.8%)		"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."

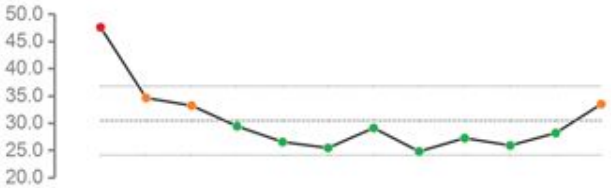
NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Dec

Crude Mortality NEL (per 1,000)

30.5
(4.4%)



"The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

Crude Mortality Rate: The 2 year trend shows the Trust to follow the peer trend but consistently at a higher crude rate. The peer distribution showed the Trust rate of 1.4% to be 0.2% higher than the peer rate for the 2 year period. For the last 12 month period (November 2017 to October 2018) the Trust rate was also 1.4%, 0.2% higher than peer rate for the 12 month period. This is all largely unchanged.
RAMI: The latest risk associated mortality index (RAMI) of 89.1 for this 12 month reporting period (November 2017 to October 2018) is on the peer 50th percentile nationally. The upper control limit of the SPC run chart for the actual month is breached, an expected result because of the seasonal variation in mortality (national results are the same).
HSMR: The hospital standardised mortality ratio (HSMR) for the latest period (November 2017 to October 2018) was 95.7 compared to a peer value of 97.6. This is in the 25th to 50th quartile of HES Acute Peers. HSMR also varies throughout the year and follows the same pattern as crude mortality. The diagnostic groups are chosen to cover over 80% of in hospital deaths and during this reporting period covered 86.8% of in hospital deaths. There is very little site variation between the 2 acute sites, but an understandably lower HSMR on the K&CH site.
SHMI: The latest date of the national summary hospital mortality index covers up to June 2018. SHMI is not shown on this report but is relevant to understanding overall Trust mortality data.The value of 1.05 is banded as expected. During this latest period 35.2% (1492/4242) were attributed to Out of Hospital Deaths, this is at variance with the England average of 29.1% and is a consistent finding. We also have a lower percentage of deaths with palliative care diagnosis coding compared with the England average (24.1 versus 32.9) and a lower depth of coding for both elective (3.4 versus 4.4) and non-elective admissions (3.8 versus 4.6).

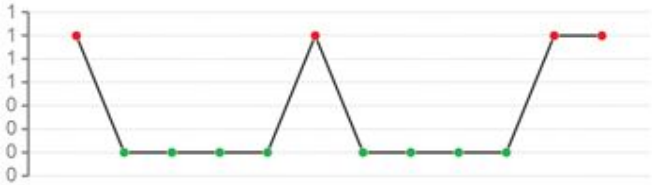
These differences in coding, if inaccurate, will result in a higher SHMI for the Trust and the depth of coding will also influence both HSMR and RAMI.

Actions
1. Exploration of coding to ensure that all relevant comorbidity for both elective and non-elective episodes is captured together with a review of accuracy of palliative coding.
2. Further analysis of those areas where observed mortality is significantly higher than expected notwithstanding the fact that the expected mortality may be lower as a consequence of the lower depth of coding.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Serious Incidents

Dec	Serious Incidents (STEIS)	110 (59.4%)		"Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."
Dec	Never Events (STEIS)	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."

Highlights and Actions:

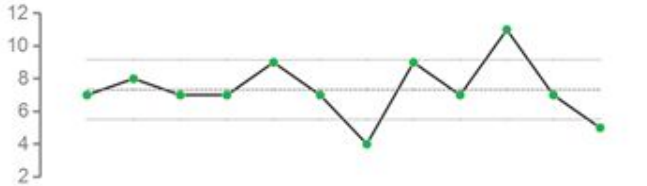
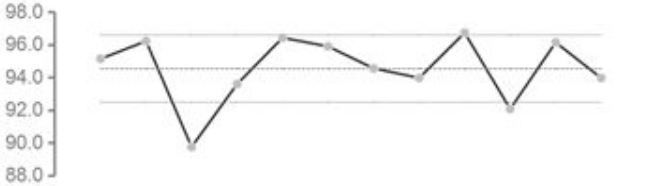
Total open SIs on StEIS in December 2018: 98 (including 12 new).
SIs under investigation: 49
Breaches: 7
Non-breaches: 42
Waiting EKHUFT non-closure response: 21
Waiting CCG response: 27

Supporting Narrative:
The number of breached cases is seven. Breaches are due to delays in report writing and gaps in and the rigour of the analysis. The Executive SI Meeting continues to support completion and the quality of the investigations. This is attended by the Medical Director, Chief Nurse and Chief Operating Officer. 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. The Chief Nurse and Medical Director now receive weekly updates on the breached cases.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Infection Control

Dec	Cases of MRSA (per month)	7 (-36.4%)		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)	32 (23.1%)		"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	88 (2.3%)		"The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Dec	MSSA	27 (-25.0%)		"The total number of MSSA bacteraemia recorded, post 48hrs.
Dec	Hand Hygiene Audit			"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Highlights and Actions:

C.difficile
C.difficile data is presented as the cumulative number of cases and resets to zero each April. In the new reporting period since April to date the number of cases as at the 8/1/2019 was 33 against a trajectory set for the year by the Department of Health of 37. There has been a period of increased incidence on Kings B ward in Ashford, no avoidable causes were found but ribotyping is not yet available.
New Actions:
1. A 'stocktake' of Infection Prevention and Control was undertaken by the newly appointed Director of Infection Prevention and Control (DIPC) for the Kent & Medway System together with the NHSI DIPC at both the WHH & QEQMH on the 19th & 20th December. Full report is awaited but in preliminary feedback there were no major issues.
2. Further work from the IPC nursing team will be undertaken with the wards in respect of appropriate use of the Diarrhoea Assessment Tool.

MRSA
From April 2018, all post 48 hour MRSA bacteraemias have been automatically assigned to the Trust and all pre 48 hour cases to the CCG. Year to date there have been 5 hospital onset MRSA bacteraemias (unchanged position from last month).

MSSA
The number of Trust apportioned MSSA bacteraemias year to date is 23 (as at 23/01/2019), MSSA is reported as an SPC run chart in this report and this month has dipped below the lower control limit. This is reflected in the monthly rate per 100,000 occupied bed days (6.97)which compares favourably with the England average (9.78)

Actions:
Staphylococcus aureus, whether MRSA or MSSA, is found on people's skin and in the respiratory tract and therefore easily colonises ulcers. Care of indwelling devices that breach natural defences is therefore an integral part of prevention of both MRSA and MSSA bacteraemias.
1. Continue to revisit the 5 moments of hand hygiene with all clinical teams (before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings).
2. Continue with implementation of the aseptic non-touch technique and audit of compliance with ANTT guidance for wound care and care of indwelling devices

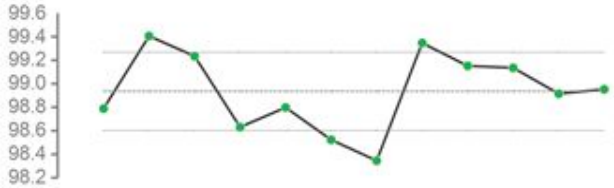
E.coli
The number of E.coli bacteraemias (hospital onset is also presented as an SPC run chart and this month has come back below the lower control limit, and encouraging reduction. Our Trust monthly rate per 100,000 occupied bed days is above the England average (25.46 versus 23.03) but below the Kent average (26.64). E.coli bacteraemia in hospital is almost exclusively associated with pathology in the urinary and digestive tracts and other than infection associated with indwelling urethral catheters is largely unpreventable. The underlying causes of community onset E.coli bacteraemia are similar and work to reduce E.coli bacteraemia centres around a collaborative aiming to reduce those bacteraemias associated with urinary tract infection through introduction of catheter bundles in both hospital and community.

Action
Audit of hospital onset E.coli bacteraemia to determine underlying associations and inform future preventative actions.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Harm Free Care

Dec	Harm Free Care: New Harms (%)	98.9 (0.4%)		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 (%)	91.1 (-1.5%)		"Percent of inpatients deemed free from harm as measured by the Safety Thermometer audit ie free from old and new harms: - Old and new pressure ulcers (categories 2 to 4) - Injurious falls - Old and new UTI - Old and new DVT, PE or Other VTE. Data source - Safety Thermometer (old and new harms)."

Highlights and Actions:

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 December-18 (91.87%) shows a slight improvement since last month (91.65%). A marked improvement is seen in Urgent and Emergency Care with a rise to 97.75% (92.05% November 18).

Actions include:
- The review of incidence of these harms during October 18 demonstrated that there were no particular themes.
- EKHUFT involvement with the 2nd phase of the NHS Improvement Falls Collaborative continues and ;
- Worldwide stop the pressure event held trust-wide. PROMPT cards given to all nursing staff
- Awaiting publication of national guidance to inform completion of Kent & Medway wide catheter guidelines and catheter passport and to roll out.

Harm Free Care experienced in our care (New Harms only) at 98.81% were similar to last month (98.87% November-18). The prevalence of New VTE's (0.58%) are lower than the national average for Acute Hospitals (0.59%) and New Pressure Ulcers (0.10%) are lower than the national average for Acute Hospitals (0.78%). Falls with Harm (0.68) are higher than the national average for Acute Hospitals (0.36). The prevalence of Catheters and New UTI's with Harm continues to remain below the national average for Acute Hospitals.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Pressure Damage

Dec	Pressure Ulcers Cat 2 (per 1,000)	0.17 (-34.5%)		"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)	0.00 (-74.8%)		"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."

Highlights and Actions:

December 2018

There were a total of 48 pressure ulcers reported, 4 less than last month. 36 of these were category 2 ulcers an increase of 9. At time of writing the report the trust equalled 0.19 avoidable incidence/1000 bed days this month. 5 were avoidable 3 less than last month. All of these reported at WHH. Four affected the sacrum; this was avoidable due to lack of evidenced repositioning and a prolonged period in the chair. One affected the neck on Kings D due to the Orthopaedic neck collar as the dressing underneath was not placed correctly causing pressure damage.

There were no confirmed category 3 or 4 pressure ulcers.

Twelve potential deep ulcers were reported. Two of these were avoidable a decrease of 3 from last month. All at WHH. Both affected the sacrum. One on Richard Stevens due to lack of repositioning evidence. The second was on Kings D female due to a prolonged length of time on the bedpan. The trust came under the set trajectory with a result of 0.060/1000 bed days.

Actions in December 2018:

- Patient centred wound care group continues wound care passport nearly complete and for launch trust-wide.
- Active mattress trials to be commenced with a day of evaluations held in Buckland
- Hybrid trial commenced at QEQM
- Review of ED checklist to ensure skin checks and risk assessments are completed in the ED
- Heelpro educator carried out ward based training on all sites

Recommendations:

- Commence active mattress trial in ITU at QEQM and K&C
- Pressure ulcer policy to be ratified
- Multi-disciplinary meeting to take place re leg ulcer care
- Continue to implement changes as per NHSI document
- Bespoke teaching to be held in areas of concern

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Falls

Dec	Falls (per 1,000 bed days)	5.22 (-32.6%)		"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."

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Highlights and Actions:

Falls incidents have increased in December.

There were a total of 181 patient falls, 47 at K&CH , 46 at QEQMH and 88 at WHH.

All patients who had more than one fall were assessed by the Falls Team and measures put in place to prevent falls.

Actions:

1. Following the recent Leadership Forum the Falls Risk Assessment and Care Plan audit will become a 'must do' audit, completed on 5 patients weekly on all adult wards. The Post Fall Audit will also be completed by investigators. This enables us to measure post fall care against the local post fall protocol and NICE standards.

2. The Trust has registered for the new National Falls Audit which will focus on patients who sustain a hip fracture while in hospital. This involves measurement of care against NICE standards and NRLS reporting.

2. Educational collaboration with the Manual Handling Team is being planned following a number of incidents where patients were moved incorrectly following a fall. This includes post fall protocol and hoverjack use.

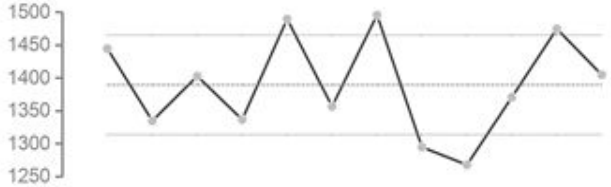
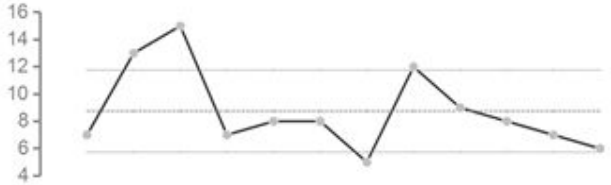
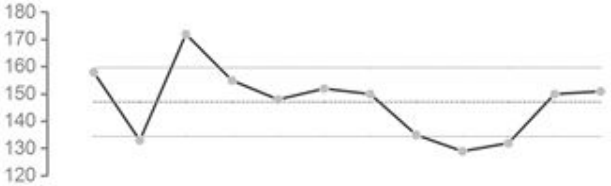
3. The Falls Team are continuing to work with agency staff on CJ (where there is a high number of agency nurses) to ensure appropriate awareness of falls policy and risk assessment tools.

4. Targeted ward based FallStop training at K&CH is being delivered, as staff are unable to leave ward areas to attend the 3 hour sessions.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Incidents

Dec	Clinical Incidents: Total (#)	16,677 (1.1%)		"Number of Total Clinical Incidents reported, recorded on Datix.
Dec	Blood Transfusion Incidents	105 (-29.1%)		"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."
Dec	Medicines Mgmt. Incidents	1,765 (11.0%)		"The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Highlights and Actions:

Clinical incidents overall summary
A total of 1408 clinical incidents have been logged as occurring in Dec-18 compared with 1480 recorded for Nov-18 and 1417 in Dec-17.

In Dec-18, 12 incidents have been reported on StEIS. 18 serious near miss incidents have been reported. Comparison of moderate harm incidents reported: 14 in Dec-18 and 17 in Nov-18, and 11 in Dec-17.

Over the last 12 months incident reporting is declining at K&C and QEQM, but increasing at WHH.

Blood transfusion (submitted by the Blood Transfusion Coordinator)

There were 7 Blood Transfusion related incidents November 2018 (8 in October 2018 and 15 in November 2017).

Of the 7 incidents 5 were graded as no harm and 2 as low harm.

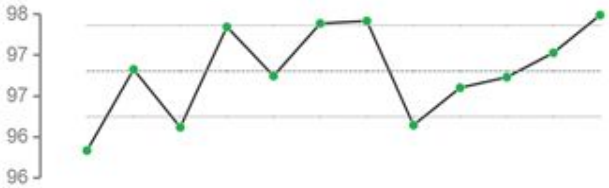
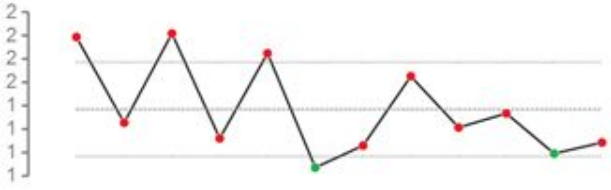
Medication incidents (submitted by the Medication Safety Officer)
As of 18/01/2018 the total number of medication related incidents reported in December 2018 was 156. These included 113 no harm, 40 low harm, 2 moderate harm and 1 death incident. The severity of medication related incidents reported in December 2018 shows that 72.4% of medication related incidents reported were no harm incidents. There was 1 medication related incident reported in December that required RCA investigation and 1 incidents sTEIS reported.

There were 43 incidents in December 2018 categorised as 'omitted medicine/ingredient', representing 27.6% of all medication related incidents reported in December. The data produced by the Medication Safety Thermometer in December 2018 was taken from 19 wards across the sites, and has shown that the percentage of patients with an omitted dose of medication was 19.4% and the percentage of patients with a missed critical medicine was 9.7% in December.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Friends & Family Test

Dec	IP FFT: Response Rate (%)	35 (-5.2%)		"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	IP FFT: Recommend (%)	97 (0.4%)		
Dec	IP FFT: Not Recommend (%)	1.3 (-23.8%)		"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."

Highlights and Actions:

A total of 8133 responses were received (57% eligible patients). Overall response rates improved for inpatients, EDs, Day Cases and fell in maternity. Response rate for the EDs was 41.6% (12.8% November-18), inpatients 37.6% (30.8% November-18), maternity; birth only 7.4% (40.6% November-18) and day cases 27.6 (20.3% November -18).

The Trust star rating in December is 4.58 (4.59 November-18). Recommendations by patients in December improved in outpatients, day cases and inpatients, however fell in EDs and maternity. The total number of inpatients, including paediatrics, who would recommend our services 97.5% (97% November-18), EDs 85.4% (85.6% November-18), maternity 97.7% (99% November-18), outpatients 91.9% (91.2% November-18) and day cases 96.2% (95.2% November-18).

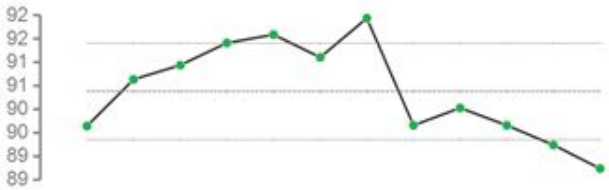
Care, Staff attitude and Implementation of care are the three top positive themes for December-18. The three top negative themes for the trust were Care, Staff Attitude and waiting times demonstrating the importance of good patient communication with a positive staff attitude and improving patient waiting times.

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 Care Group Governance teams.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 1

Dec	Overall Patient Experience %	90.6 (-0.3%)		Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Dec	Privacy for discussions with Nurses %	41 (2.8%)		Privacy for discussions Nurses
Dec	IP Survey: Are you aware of which nurse is in charge of your care each shift? (%)	79 (0.5%)		IP Survey: Are you aware of which nurse is in charge of your care each shift? (%)

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Dec

IP Survey: Encouraged to get up and wear own clothes (%)

63

Responses taken from the Inpatient Survey. Question: "Have you been encouraged to get up during your hospital stay and wear your own clothes?"

Highlights and Actions:

Overall patient experience, as a calculated average of the key questions within the local inpatient survey, which enables our patients to record their experience in real-time. This month we received 2196 completed inpatient surveys, an improvement from 1392 last month.

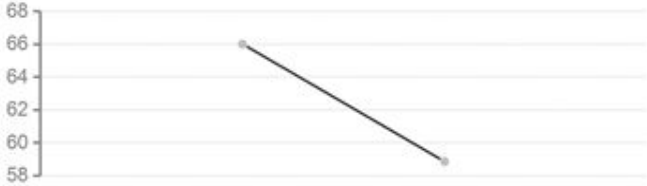
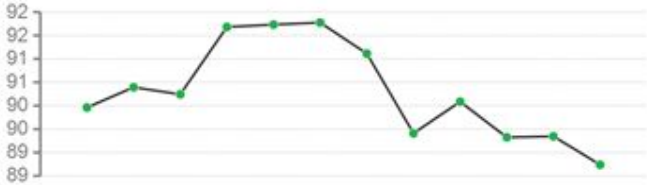
New questions were added into the survey on 1st November 18 to enable close monitoring of three key areas where our performance in the 2017 national inpatient survey (published in May-18) was below the national average. Baseline performance in ensuring patients are aware of which nurse is in charge of their care, ensuring patients have been encouraged to get up during their hospital stay and wear their own clothes and ensuring that patients received enough help from staff to eat their meals demonstrates significant opportunity for improvement.

This month a small increase for each of these important elements of patient experience, which is positive. This local survey will reflect improvement priorities, with progress monitored through the Patient Experience Group

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 2

Dec	IP Survey: Help from Staff to Eat Meals (%)	63		Responses taken from the Inpatient Survey. Question: "Did you get enough help from staff to eat your meals?"
Dec	Cleanliness %	90 (0.4%)		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.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Dec

Hospital Food? %

69
(-2.2%)

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.

Highlights and Actions:

Patient experience is additionally reported per ward within the heat map and focused work continues to promote this reporting. Most wards have reported their performance (against the patient experience metrics) through the inpatient survey in December-18 apart from 5 wards; 2 wards are still experiencing Wi-Fi issues and 3 ward have been non-compliant. However, compliance will continue to improve for the Trust.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Mixed Sex

Dec

Mixed Sex Breaches

692 (-25.4%)

"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."

Highlights and Actions:

There were 4 reportable mixed sex accommodation occurrences affecting 23 patients .

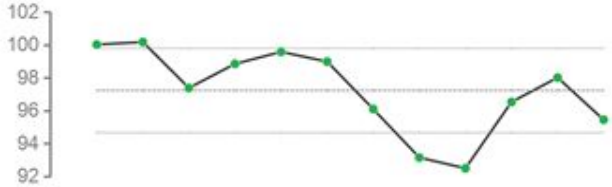
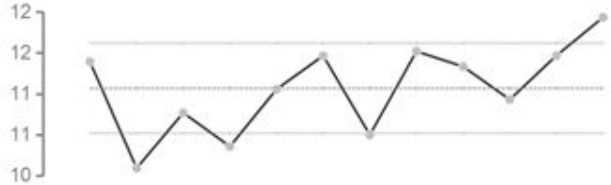
These were within the WHH AMU B linked to flow and capacity issues. The remaining incidents occurred in the WHH CCU (5), QEQM Fordwich (1) which were justifiable based on clinical need. This information has been reported to NHS England.

During December patients flow and same sex accommodation is achieved by moving beds, in order for the ward to reduce same sex accommodation occurrences. Rigorous work continues as the Trust is working closely with the CCGs and NHSI on the Mixed Sex Accommodation Improvement Collaborative. This will support the trust in achieving compliance with the national definition of mixed sex accommodation.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Safe Staffing

Dec	Shifts Filled - Day (%)	97 (-1.9%)		Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). 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	Shifts Filled - Night (%)	105 (-2.9%)		Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). 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	Care Hours Per Patient Day (CHPPD)	11 (-4.0%)		Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. 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.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Patient Safety

Highlights and Actions:

Percentage fill of planned (funded establishment) and actual (filled shifts) by hours is required to be reported monthly by registered nurse and care staff, by day and by night, in line with National Quality Board expectations. Reported data is derived from the Healthroster system. The average overall fill rate fell slightly to 98.5% from 101.0% in November.

Low fill rates were seen, in registered nurse day shifts, on several wards due to a combination of high sickness, maternity leave and vacancies (St Margarets, Harvey, Invicta, Cambridge L, Mount McMaster, Fordwich, Kingston, Harbeldown, St Augustines, Quex and WHH CDU).

Care Hours per patient day (CHPPD) relates actual staffing to patient numbers and includes registered staff and care staff hours against the cumulative total of patients on the ward at 23.59 hrs each day during the month. CHPPD is similar to November and within the control limits. The range is from around 5.5 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required. Comparative data within the Model Hospital Dashboard for October shows EKHUFT average CHPPD is in the mid to low 25% (Quartile 2) and in line with our recommended peer group and peer median based on spend and clinical output.

Actions;
• There is a Trust wide recruitment and retention improvement plan in place
• Incentives have been implemented such recruitment and retention premium for hard to recruit areas
• A financial reward for each person a staff member attracts to the Trust once that person starts in the organisation
• All vacant posts are being recruited to on NHS jobs as well as via open days and recruitment fairs
• The Trust has a proactive recruitment programme. We have recruited overseas staff through Skype interviews.
• Around 60 of our Healthcare Assistants who are overseas trained are undertaking a core programme to enable them to achieve the English language requirements and OSCE in preparation for UK registration.
• We have recruited two Matrons to focus solely on recruitment and retention

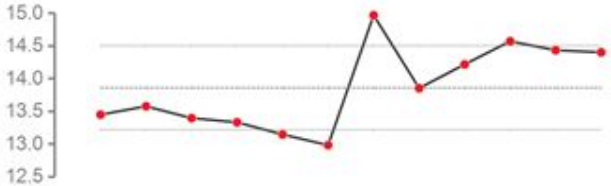
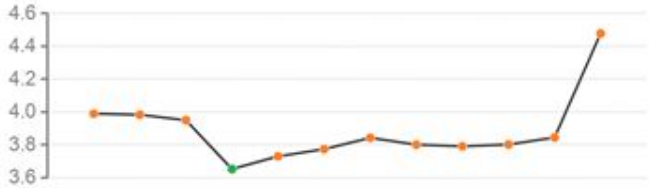
• • There is a daily focus via safety huddles of the paediatric staffing in the wards and ED. The actions and mitigations are reported by noon each day to the Chief Nurse, Medical Director and Chief Operating Officer
• The twice daily site reports make staffing risks and mitigations visible to managers, leaders and the Executive.

All of the above is being monitored weekly for assurance purposes.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Human Resources

Gaps & Overtime

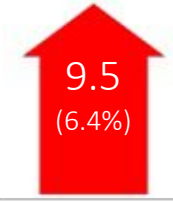
Dec	Vacancy (%)	12.9 (15.2%)		"% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Dec	Staff Turnover (%)	13.9 (7.0%)		"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Dec	Sickness (%)	3.9 (-0.3%)		% 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

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Human Resources

Dec

Overtime %



% of Employee's that claim overtime.

Highlights and Actions:

Gaps and Overtime

The vacancy rate increased to 12.9% (up from 12.7%) for the average of the last 12 months, which is higher than last year. However, the monthly rate remained below 10% at 9.70%. More work is being undertaken to target hard to fill vacancies, particularly within nursing and some Medical specialties. There are currently over 600 candidates in the recruitment pipeline - i.e. those who have been offered positions and are gaining pre-employment clearances - with more than 80 staff attending the first Welcome Day in January 2019. This includes approximately 400 Nursing and Midwifery staff (including ODPs) and 80 Medical and Dental staff.

The Turnover rate in month decreased slightly to 12.0% (last month 12.1%), but the 12 month average increased to 13.9% (13.8% last month). 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 Trust has introduced a Refer A Friend scheme, and also a recruitment and retention scheme for medical staff in hard to recruit areas and ED nursing staff.

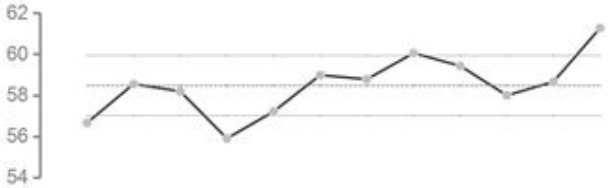
The in month sickness absence position for November was over 4.20% - which is an increase from 3.96% in October. The 12 month average is 3.9%, down from 4.1%. Care Groups have developed sickness absence reduction plans, with a focus on long term sickness absence and an integrated approach to proactively managing absence with Occupational Health through case conferencing and regular contact. This includes supporting stress, anxiety and compassion fatigue through Respect & Resilience workshops, Mindfulness Courses and Mental Health First Aid training. A deep dive into sickness absence is currently being carried out by the Corporate HR Business Partner, who is working with the Care Group Business Partners to create a Trust action plan.

Overtime as a % of wte decreased very slightly on last month. The average over the last 12 months increased to 9.5% from 9.4% last month. All metrics are reviewed and challenged at a Care Group level in the monthly Executive Performance Reviews.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Human Resources

Temporary Staff

Dec	Employed vs Temporary Staff (%)	88.9 (0.0%)		"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 %	7.2 (22.4%)		% of temporary (Agency and Bank) staff of the total WTE
Dec	Bank Filled Hours vs Total Agency Hours	59 (-0.3%)		% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff

Highlights and Actions:

Temporary Staff

Total staff in post (WTE) remained almost the same as in November at 7013, which left a vacancy factor of approx. 753 wte across the Trust.

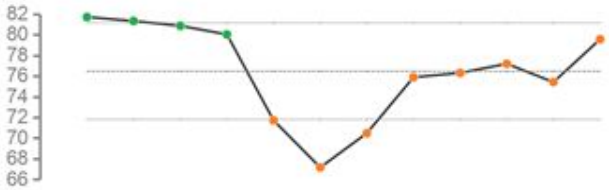
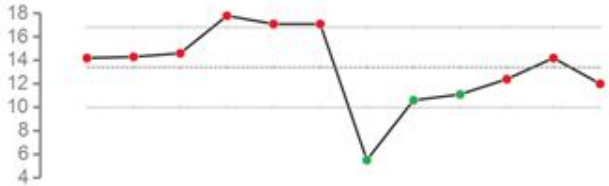
The average percentage of employed staff vs temporary staff over the last 12 months was 88.9% (88.8% last month), and remains lower than the previous 12 months.

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.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Dec	Statutory Training (%)	98 (1.8%)		"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 (%)	76.5 (-6.0%)		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	13 (7.3%)		"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."

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Human Resources

Dec

Total Staff In Post (SiP)

6996
(0.0%)

Count of total staff in post (WTE)

Highlights and Actions:

Workforce & Culture

Average Statutory training 12 month average is 90% and remained 90% in month for December. This remains above the target of 85%. Care Groups are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements.

The Trust staff average appraisal rate increased to 80% in month for December (75% in October), with Surgery & Anaesthetics achieving 90% compliance. Care Groups 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. Targeted work within the Urgent Care and General Medicine Care Groups has seen the appraisal compliance increase in the previous four months.

The average time to recruit is 11 weeks, which is an improvement on last month, and an improvement on the previous 12 months. The 12 month average time to recruit was 13 weeks. The Resourcing Team are on track to reduce time to recruit to below 8 weeks to ensure recruitment time meets the demands of our services.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Activity vs. Internal Business Plan

Key Performance Indicators

Dec

	Dec-18				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	11,629	11,444	185	2%	131,511	127,827	3,684	3%	131,511	129,803	1,708	1%	<=0%
Referral Non-Primary Care	12,041	10,913	1,128	10%	132,225	122,356	9,869	8%	132,225	123,037	9,188	7%	<=0%
OP New	14,094	16,760	(-2,666)	-16%	158,527	169,181	(-10,654)	-6%	158,527	164,012	(-5,485)	-3%	>=0%
OP Follow Up	30,186	37,436	(-7,250)	-19%	349,741	372,453	(-22,712)	-6%	349,741	356,011	(-6,270)	-2%	>=0%
Elective Daycase	5,435	6,180	(-745)	-12%	55,811	60,440	(-4,629)	-8%	55,811	55,503	308	1%	>=0%
Elective Inpatient	1,156	1,263	(-107)	-8%	11,455	12,254	(-799)	-7%	11,455	11,424	31	0%	>=0%
A&E	18,022	16,945	1,077	6%	166,074	158,445	7,629	5%	166,074	157,288	8,786	6%	>=0 & <5%
Non-Elective Inpatient	6,658	6,566	92	1%	60,945	60,684	261	0%	60,945	60,208	737	1%	>=0 & <5%
Chemotherapy	1,043	1,118	(-75)	-7%	10,817	10,620	197	2%	10,817	10,799	18	0%	>=0%
Critical Care	1,779	1,662	117	7%	15,981	14,751	1,230	8%	15,981	16,491	(-510)	-3%	>=0%
Dialysis	0	0	0	#DIV/0!	54,512	56,264	(-1,752)	-3%	54,512	62,546	(-8,034)	-13%	>=0%
Maternity Pathway	1,024	1,002	22	2%	10,104	10,585	(-481)	-5%	10,104	10,738	(-634)	-6%	>=0%
Pre-Op Assessments	2,666	2,950	(-284)	-10%	29,660	30,473	(-813)	-3%	29,660	26,624	3,036	11%	>=0%
Diagnostic	369,644	346,131	23,513	7%	4,096,065	3,916,529	179,536	5%	4,096,065	3,900,083	195,982	5%	<=0%
Other	4,520	4,776	(-256)	-5%	44,845	43,496	1,349	3%	44,845	43,363	1,482	3%	>=0%

The 2018/19 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2017/18 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

NHS
East Kent
Hospitals University
NHS Foundation Trust

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 2018/19. It should be noted that this does not reflect demand levels agreed within the 2018/19 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.

December 2018

Elective Care

In December Primary Care referrals were 2% (+185) above expected levels growing the YTD variance to +3% (+3,684). Following the initial implementation of the new PAS a number of data quality issues impacted the mapping of referral types, specifically ERS referrals. Significant work has been undertaken to rectify the issues, referrals are now back in line with planned levels and comparable with the same period last year. Demand into the Pain service remains significantly below expected levels as the referrers cannot refer into the Trust through the Electronic Referral Service (ERS). An administrative error within the Paediatric service has now been resolved however Paediatric Blood Clinics where the recording issue was identified remain in the YTD position.

The Trust under-achieved the new outpatient plan in December with appointments 16% below planned levels, generating a YTD variance of -6%. The biggest drivers behind the under-performance are Trauma and Orthopaedics, Urology, Paediatrics and Gynaecology. Following the introduction of the new PAS system on 10th September 2018, the Trust has experienced some delays in booking processes for Outpatient appointments. A recovery plan is now in place to maximise the utilisation of our capacity. Despite these challenges, services are continuing to actively produce quantified recovery plans intended to respond to specialty level underperformance and increase the run rate over the remainder of quarter 4.

The impact of the Virtual Fracture Clinic implemented in mid-February is likely to render the Orthopaedic plan unachievable due to high discharge rates that were not anticipated. The Paediatric service continue to actively produce quantified recovery plans to maintain their focus on reducing patient wait times for first outpatient appointment. The Ophthalmology service continues to provide additional weekend capacity at KCH delivered through an insourcing provider. It is expected this will deliver the Ophthalmology plan and support the RTT backlog recovery.

The Trust under-performed the Follow up plan in December (-19%) with YTD performance now underachieving by -6%. Following the introduction of the new PAS system on 10th September 2018, the Trust has experienced some delays with the timely recording of outpatient attend statuses. it is expected that the position will improve after all activity is administered with the appropriate outcome details. The biggest drivers behind the under-performance are Physiotherapy, Trauma and Orthopaedics and Rheumatology. The Rheumatology service are experiencing high levels of specialist nurse vacancies affecting the delivery of follow up activity.

In December the Trust under-achieved the Daycase plan by 745 patients with YTD performance now underachieving by -8%. A large number of specialties continue to experience significant workforce issues affecting the delivery of elective activity. T&O (-1,317), Dermatology (-1,289) and Pain Management (-963) continue to underperform the business plan. A mandated change in recording will render the Dermatology plan unachievable, it is anticipated an over performance in Outpatient procedures will offset the Daycase underperformance. Following the introduction of the PAS system the Trust experienced a small number of isolated recording issues, in the main these user issues have been addressed however Rheumatology still have a small number of records that were not entered onto the new PAS system following down time procedures effecting the YTD position.

Elective Admissions are 7% below plan YTD. Large underperformance remains in the Urology service (-449). Due to emergency pressures, elective inpatient activity was limited for the service at the start of the financial year. In order to ensure theatre utilisation was maximised additional daycase patients were booked. The Orthopaedic service have developed long term plans to address their underperformance (-129). Additional capacity commenced in November through the New Orthopaedic Centre at KCH.

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.

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 and in December the Bed occupancy of the Trust was at an overall position of 93.7% of funded beds (midnight Bed Occupancy). Queen Elizabeth the Queen Mother Hospital demonstrated the most challenge with the bed occupancy position at 101% for December,

NHS
East Kent
Hospitals University
NHS Foundation Trust

maintaining the same level as November. The William Harvey Hospital position was also largely unchanged, with an overall bed occupancy of 92% in 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 increased to a monthly average of 64 outliers across the Trust, an increase from the November level of 47 outliers. Individual site levels of medical outliers over the month were 17 at the Queen Elizabeth the Queen Elizabeth The Queen Mother Hospital (12 last month) and 42 at William Harvey Hospital (32 last month).

An increased volume of patients through the Accident & Emergency Department contributes to increased pressures in non-elective care. The demand on the department in December remains high with continued numbers of daily attends to the Queen Elizabeth the Queen Mother Hospital and William Harvey Hospital as seen in previous months (+6% growth on last year).

NHS
East Kent Hospitals University
NHS Foundation Trust

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	10,733	12,244	-12%	-1,511
300 - General Medicine	112	1,038	-89%	-926
120 - Ear, Nose & Throat	7,862	8,541	-8%	-679
502 - Gynaecology	7,565	8,163	-7%	-598
104 - Colorectal Surgery	6,904	6,390	8%	514
420 - Paediatrics	4,689	3,948	19%	741
103 - Breast Surgery	6,059	5,252	15%	807
410 - Rheumatology	3,099	2,282	36%	817
330 - Dermatology	11,184	9,852	14%	1,332
110 - Trauma & Orthopaedics	8,488	6,750	26%	1,738
Total	**131,511**	**127,827**	**3%**	**3,684**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	23,698	26,417	-10%	-2,719
650 - Physiotherapy	9,528	10,160	-6%	-632
191 - Pain Management	1,140	655	74%	485
301 - Gastroenterology	2,430	1,939	25%	491
655 - Orthoptics	1,812	1,104	64%	708
340 - Respiratory Medicine	2,666	1,925	38%	741
300 - General Medicine	2,785	1,593	75%	1,192
100 - General Surgery	3,678	2,282	61%	1,396
130 - Ophthalmology	13,020	9,367	39%	3,653
110 - Trauma & Orthopaedics	17,693	13,991	26%	3,702
Total	**132,225**	**122,356**	**8%**	**9,869**

OP New

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	12,020	14,113	-15%	-2,093
101 - Urology	6,346	8,170	-22%	-1,824
420 - Paediatrics	5,716	7,436	-23%	-1,720
502 - Gynaecology	10,262	11,663	-12%	-1,401
650 - Physiotherapy	13,079	14,468	-10%	-1,389
120 - Ear, Nose & Throat	9,829	10,928	-10%	-1,099
400 - Neurology	3,741	4,440	-16%	-699
100 - General Surgery	3,694	4,301	-14%	-607
301 - Gastroenterology	5,612	6,203	-10%	-591
330 - Dermatology	10,659	9,744	9%	915
Total	**158,527**	**169,181**	**-6%**	**-10,654**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
650 - Physiotherapy	43,521	48,317	-10%	-4,796
110 - Trauma & Orthopaedics	31,341	35,511	-12%	-4,170
410 - Rheumatology	7,437	10,505	-29%	-3,068
130 - Ophthalmology	37,944	40,968	-7%	-3,024
300 - General Medicine	1,557	3,781	-59%	-2,224
120 - Ear, Nose & Throat	12,006	13,499	-11%	-1,493
400 - Neurology	6,441	7,380	-13%	-939
420 - Paediatrics	7,355	8,181	-10%	-826
655 - Orthoptics	6,634	7,282	-9%	-648
191 - Pain Management	3,891	4,513	-14%	-622
Total	**349,741**	**372,453**	**-6%**	**-22,712**

NHS
East Kent Hospitals University
NHS Foundation Trust

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	3,527	4,844	-27%	-1,317
330 - Dermatology	2,683	3,972	-32%	-1,289
191 - Pain Management	1,625	2,588	-37%	-963
130 - Ophthalmology	3,494	4,038	-13%	-544
300 - General Medicine	15,311	15,791	-3%	-480
502 - Gynaecology	1,783	2,258	-21%	-475
120 - Ear, Nose & Throat	1,876	2,300	-18%	-424
320 - Cardiology	2,285	2,473	-8%	-188
301 - Gastroenterology	1,204	711	69%	493
800 - Clinical Oncology	4,436	3,763	18%	673
Total	**55,811**	**60,440**	**-8%**	**-4,629**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
101 - Urology	2,128	2,577	-17%	-449
502 - Gynaecology	861	1,250	-31%	-389
100 - General Surgery	814	964	-16%	-150
110 - Trauma & Orthopaedics	2,601	2,730	-5%	-129
320 - Cardiology	154	234	-34%	-80
107 - Vascular Surgery	260	317	-18%	-57
811 - Interventional Radiology	136	80	69%	56
104 - Colorectal Surgery	392	313	25%	79
503 - Gynaecology Oncology	310	208	49%	102
303 - Clinical Haematology	192	86	123%	106
Total	**11,455**	**12,254**	**-7%**	**-799**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	18,409	19,326	-5%	-917
430 - HCOOP	7,335	8,070	-9%	-735
560 - Midwifery	1,691	2,139	-21%	-448
502 - Gynaecology	1,776	1,928	-8%	-152
420 - Paediatrics	6,989	6,829	2%	160
340 - Respiratory Medicine	493	322	53%	171
301 - Gastroenterology	479	293	63%	186
104 - Colorectal Surgery	337	65	416%	272
101 - Urology	3,264	2,870	14%	394
100 - General Surgery	5,202	4,443	17%	759
Total	**60,945**	**60,684**	**0%**	**261**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	4096065	3916529	5%	179,536
A&E	166074	158445	5%	7,629
Dialysis	54512	56264	-3%	-1,752
Other	44845	43496	3%	1,349
Critical Care	15981	14751	8%	1,230
Pre-Op	29660	30473	-3%	-813
Maternity Pathway	10104	10585	-5%	-481
Chemotherapy	10817	10620	2%	197

NHS
East Kent
Hospitals University
NHS Foundation Trust

4 Hour Emergency Access Standard

Key Performance Indicators

79.36%

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
4 Hour Compliance (EKHUFT Sites) %*	69.33%	73.75%	75.08%	76.93%	80.80%	82.73%	79.18%	80.04%	77.15%	80.89%	81.74%	79.36%
4 Hour Compliance (inc KCHFT MIUs)	74.09%	77.76%	78.78%	81.73%	83.95%	85.81%	82.95%	83.52%	81.02%	83.88%	84.50%	82.25%
12 Hour Trolley Waits	2	0	2	1	0	0	0	0	0	0	0	0
Left without being seen	2.77%	2.26%	2.61%	2.70%	2.39%	2.05%	2.75%	2.44%	3.52%	3.09%	2.77%	3.03%
Unplanned Reattenders	9.01%	8.92%	9.11%	9.69%	9.12%	9.31%	9.84%	9.91%	10.23%	9.82%	9.56%	9.46%
Time to initial assessment (15 mins)	93.3%	95.3%	94.4%	94.2%	95.3%	93.2%	94.4%	91.4%	72.8%	71.4%	70.9%	65.0%
% Time to Treatment (60 Mins)	54.0%	48.0%	42.5%	46.4%	49.5%	51.6%	42.7%	48.1%	45.7%	50.7%	52.7%	48.7%

2018/19 Trajectory (NHSI return 2nd May)

-9.21 %

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Trajectory	78.6%	77.5%	78.5%	83.9%	85.4%	85.4%	87.4%	89.9%	88.6%	88.4%	87.6%	87.6%
Performance	76.9%	80.8%	82.7%	79.2%	80.0%	77.1%	80.9%	81.7%	79.4%			

*The historic 4 Hour compliance position differs slightly from that previously published. While this means that the figures contained here from those submitted nationally, they have been re-stated to be reflective of EKHUFT site performance and in order to align against the NHSI trajectory over 2018-19.

The above table shows the ED performance, including the health economy MIU activity and also with EKHUFT only performance. 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

NHS
East Kent
Hospitals University
NHS Foundation Trust

December performance for the organisation against the 4 hour target was 79.36%; against the NHS Improvement trajectory of 88.6%.This represents a decrease in performance compared to the previous month. There were no 12 Hour Trolley Waits in December. The number of patients who left the department without being seen remained compliant at 3.03%. The unplanned re-attendance position remains high at 9.46%. Time to treatment reduced below 50% to 48.7% in December; from 52.7% the previous month.

ED Summary Actions

- Continue to implement ED Improvement Plan and Winter Capacity plan actions.
- Maintain health economy focus on patient flow.
- Continue the daily focus on internal and external delays to reduce stranded and super stranded patients.
- For December, compared to last year, East Kent Hospitals has improved to 37th place from the lowest place last year which was the 2nd to last place in the country

NHS
East Kent
Hospitals University
NHS Foundation Trust

Cancer Compliance

Key Performance Indicators

82.21 %

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Green
62 day Treatments	74.87%	73.40%	71.88%	66.32%	65.16%	65.79%	65.52%	66.13%	71.30%	77.05%	71.73%	82.21%	>=85%
>104 day breaches	21	23	30	27	31	34	36	24	12	9	4	8	0
Demand: 2ww Refs	3,009	2,734	3,250	3,193	3,406	3,243	3,204	3,101	2,875	3,485	3,307	2,656	2990 - 3305
2ww Compliance	95.76%	97.10%	91.42%	89.06%	93.81%	94.22%	94.94%	93.64%	90.96%	83.54%	93.29%	96.76%	>=93%
Symptomatic Breast	89.84%	98.50%	90.28%	75.16%	84.46%	94.12%	93.18%	86.32%	94.39%	68.70%	84.17%	95.00%	>=93%
31 Day First Treatment	94.06%	97.74%	96.08%	95.22%	96.37%	96.50%	95.71%	94.57%	96.81%	97.49%	96.95%	96.02%	>=96%
31 Day Subsequent Surgery	87.23%	91.43%	89.47%	86.11%	80.49%	82.61%	94.87%	95.65%	96.00%	93.22%	100.00%	96.97%	>=94%
31 Day Subsequent Drug	98.85%	98.33%	98.21%	97.94%	98.91%	98.13%	99.19%	98.98%	97.87%	99.21%	98.11%	98.81%	>=98%
62 Day Screening	90.91%	79.31%	100.00%	93.75%	84.09%	100.00%	81.63%	94.37%	81.48%	87.50%	83.78%	86.67%	>=90%
62 Day Upgrades	85.00%	77.27%	100.00%	89.19%	77.42%	84.38%	85.00%	94.87%	76.00%	82.14%	84.85%	75.00%	>=85%

2018/2019 Trajectory

-0.91 %

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Green
STF Trajectory	65.08%	61.38%	61.13%	55.57%	57.87%	62.76%	73.66%	79.01%	83.12%	85.31%	85.24%	86.17%	Jan
Performance	66.32%	65.16%	65.79%	65.52%	66.13%	71.30%	77.05%	71.73%	82.21%				Jan

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.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Summary Performance

December 62 day performance is currently 82.21% against the improvement trajectory of 83.12%, validation continues until the beginning of February in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,589 and there were 4 patients waiting 104 days or more for treatment or potential diagnosis.

Summary Actions:

- Continue daily monitoring of 2ww pathways to ensure patients are offered an appointment within 48 hours of referral being received and are offered a first appointment at day 7 ideally.
- Continue daily monitoring of all patients over 73 to 104 days and progress the patients next key event.
- Progress action plans to complete new timed pathways for each tumour site.

62 Day Performance Breakdown by Tumour Site

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
01 - Breast	88.9%	83.3%	100.0%	92.9%	96.6%	92.0%	93.8%	81.5%	88.6%	74.5%	72.4%	89.2%
03 - Lung	90.3%	100.0%	81.0%	62.8%	91.7%	73.0%	70.6%	73.3%	60.0%	56.0%	59.4%	90.3%
04 - Haematological	75.0%	33.3%	33.3%	50.0%	25.0%	54.5%	70.6%	13.3%	61.1%	54.5%	71.4%	100.0%
06 - Upper GI	70.0%	64.3%	73.3%	69.0%	69.2%	79.3%	93.3%	66.7%	62.5%	70.6%	60.0%	100.0%
07 - Lower GI	65.9%	43.8%	63.2%	61.1%	46.5%	64.6%	68.3%	75.0%	68.4%	84.8%	45.2%	55.0%
08 - Skin	92.7%	100.0%	88.9%	88.0%	88.2%	97.2%	97.7%	97.1%	100.0%	100.0%	90.0%	96.8%
09 - Gynaecological	80.0%	63.6%	75.0%	30.8%	32.0%	42.1%	55.6%	75.0%	85.2%	71.4%	100.0%	80.0%
10 - Brain & Nervous System				100.0%					100.0%			
11 - Urological	52.0%	63.5%	63.2%	59.3%	50.0%	38.2%	39.4%	51.0%	52.0%	70.5%	69.6%	76.9%
13 - Head & Neck	66.7%	85.7%	78.6%	20.0%	43.8%	94.1%	50.0%	60.0%	60.0%	100.0%	60.0%	84.6%
14 - Sarcoma	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%			100.0%		
15 - Other	0.0%	0.0%			0.0%	100.0%	100.0%	100.0%	100.0%	100.0%		73.9%

NHS
East Kent
Hospitals University
NHS Foundation Trust

18 Week Referral to Treatment Standard

Key Performance Indicators

72.42 %

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Green
Performance	77.62%	77.03%	76.08%	76.66%	78.56%	79.02%	79.65%	79.06%	76.27%	74.88%	72.16%	72.42%	>=92%
52w+	108	141	201	222	218	201	167	125	129	120	102	74	0
Waiting list Size	52,942	54,306	54,519	54,979	54,964	53,411	53,193	53,552	54,712	55,607	54,492	53,169	<38,938
Backlog Size	11,847	12,474	13,039	12,830	11,785	11,207	10,824	11,212	12,983	13,966	15,170	14,662	<2,178

2018/2019 Trajectory

-8.98 %

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Green
Performance Trajectory	77.03%	78.20%	79.31%	80.21%	81.02%	81.32%	81.69%	81.84%	81.40%	81.16%	80.87%	80.76%	87%
Performance	76.66%	78.56%	79.02%	79.65%	79.06%	76.27%	74.88%	72.16%	72.42%				Sept

-76

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Green
52w Trajectory	250	241	225	225	200	175	150	125	150	125	115	99	Sept
Performance	222	218	201	167	125	129	120	102	74				Sept

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 during 18/19 with a focus on reducing waiting times and decreasing the number of 52 week waits by over 50%.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Summary Actions

- Elective care recovery plan to be delivered.
- Patient Service Centre (PSC) actions are to ensure that all outstanding clinic templates have been rebuilt to ensure full clinic utilisation of appointment slots.
- PSC and other areas which book their own appointments are to ensure that all clinics are fully booked, prioritising new outpatient appointments.
- PSC and Care Groups are to ensure that outpatient clinic outcome forms are completed to ensure that outpatient activity is cashed up.
- Validation of active 18 week waiting lists to be prioritised.
- Director led review of all 52 week wait patients to progress next key event in the patient's pathways.
- Director led daily review of 6-4-2 theatre booking, to monitor theatre capacity and productivity.
- Care Group leadership team to complete weekly review of production plans to confirm delivery of stated schemes and develop new schemes to close the gap.
- PSC to confirm process for managing Electronic Referral Service (ERS) OPD clinic cancellations.
- Additional internal and external capacity to be sourced.

NHS
East Kent
Hospitals University
NHS Foundation Trust

6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.56 %

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Green
Performance	99.45%	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%	98.57%	99.31%	99.65%	99.56%	>=99%
Waiting list Size	13,637	14,125	14,174	14,597	15,192	16,350	16,888	15,126	12,750	12,820	13,329	12,235	<14,000
Waiting > 6 Week Breaches	75	62	49	91	106	149	264	298	182	88	46	54	<60
Average Wait													<4

2018/19 Trajectory

0.46 %

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	
STF Trajectory	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.11%	Dec-18
Performance	99.45%	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%	98.57%	99.31%	99.65%	99.56%	Dec-18

Summary Performance

The standard has been met for December 2018 with a compliance of **99.56%**. The number of patients waiting has decreased by 1094. As at the end of the month there were **54** patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 10
- Cardiology: 5
- Urodynamic: 35
- Sleep Studies : 0
- Cystoscopy : 0

NHS
East Kent
Hospitals University
NHS Foundation Trust

- Colonoscopy : 2
- Gastroscopy : 2
- Flexi Sigmoidoscopy: 0

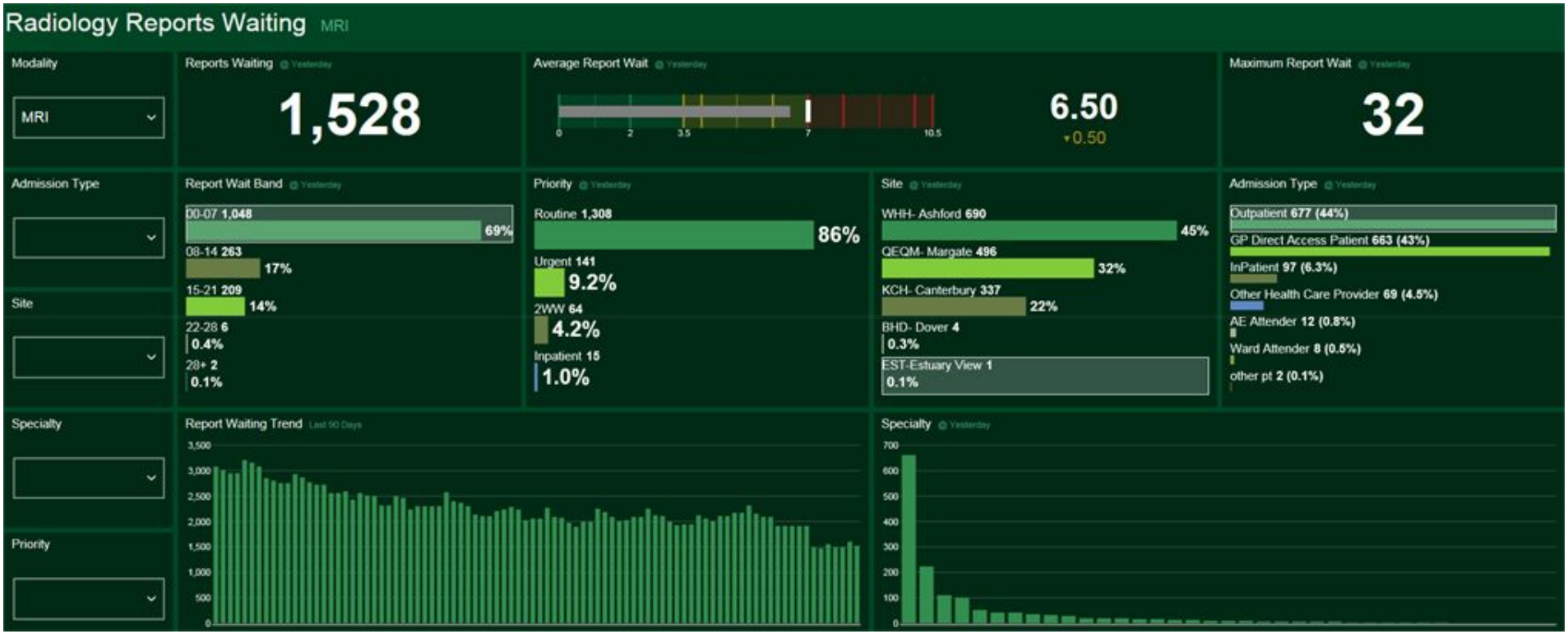
There remains a continued demand for Sleep Studies; however, the robust plan which was developed in June 2018 in response to the increased demand is having a positive impact.

Actions:

- Continue recruitment to respiratory and cardiology technician posts.
- Providing additional capacity through outsourcing and internal additional lists for Cardiac CT whilst a sustainable solution is developed.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Reporting backlogs:

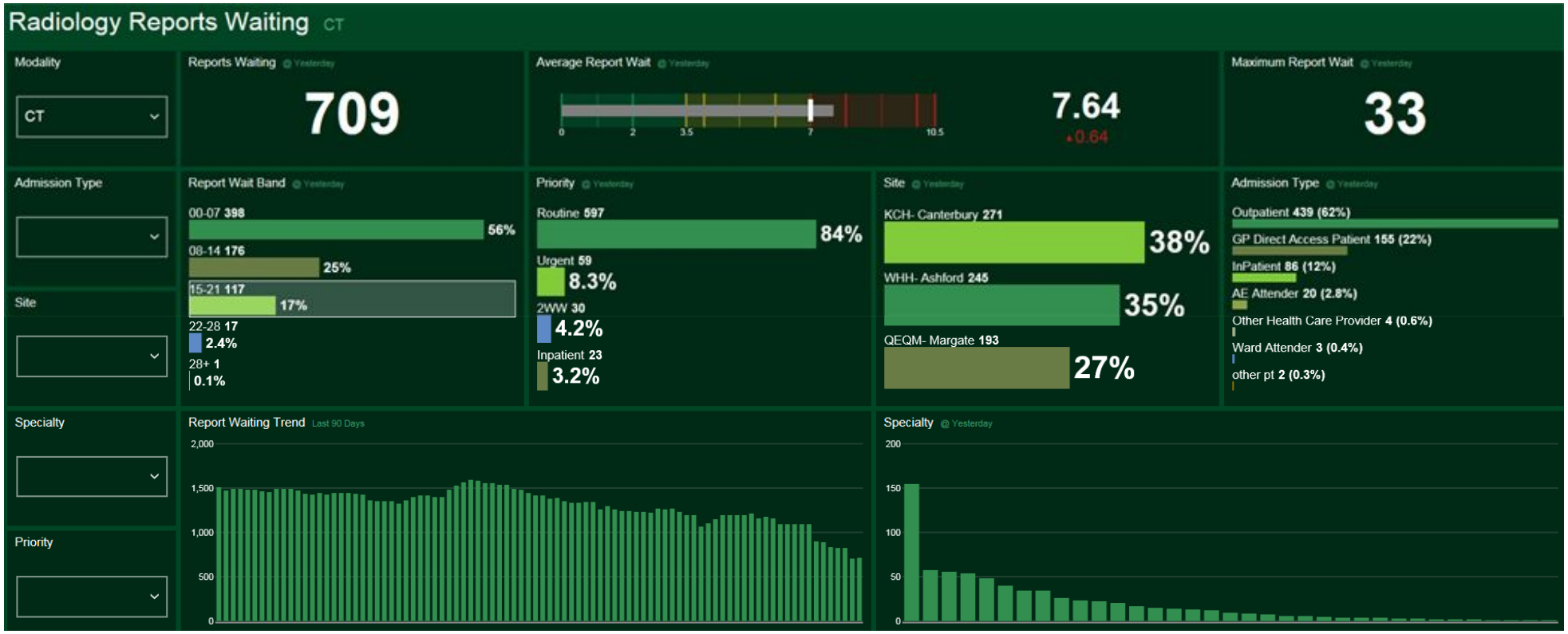


Total MRI backlog reporting position as of 12/03/18: (N.B. this data excludes written exams sent to third party reporters ~ 227 exams)

MRI has improved its large number of reports outstanding by 522 examinations overall compared to the January report (2,050).

Whilst numbers waiting over 2 weeks have improved significantly over the last 3 months there is still a very small number waiting over 28 days.

NHS
East Kent
Hospitals University
NHS Foundation Trust



The total CT backlog reporting position as of 12/03/18:

For CT, the total waiting for a report has decreased by 395 examinations overall compared to the January report (1,104).

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. However there has been a significant improvement in this tail by ~310 examinations since the last report.

NHS
East Kent
Hospitals University
NHS Foundation Trust

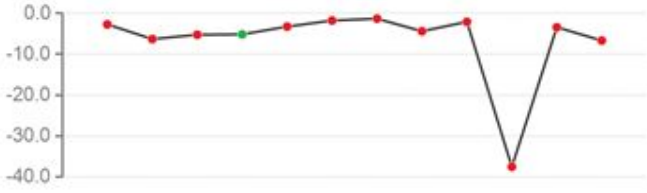
Actions taken to mitigate risk and sustain performance:

- 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.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Finance

Finance

Dec	I&E £m (Trust Only)	-65.5 (95.1%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.Month 7 includes a £34.3m impairment due to revaluation of Trusts assets prior to transfer to 2Gether. NHSI add back this impairment in evaluating the Trust.
Dec	Cash Balance £m	8.7 (159.3%)		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 (Trust Only)	-53.4 (0.8%)		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.Mth 7 includes a £34.7m impairment, see I&E note above.
Dec	Forecast £m	-41.8 (39.9%)		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.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Finance

Highlights and Actions:

As the Trust is in FSM it is measured against its performance excluding technical adjustments. After these are removed the Trust's in month deficit it £6m, £2m behind plan and the YTD I&E deficit to Month 9 (December) was £29.5m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £23m, £6.5m worse than plan. The main drivers of the deficit in month are the continuing themes whereby operational pressures are leading to significant Agency spend on Medical and Nursing staff but Elective activity and income are increasingly falling behind a plan which was based on increasing inpatient elective activity in Q3 and 4 as well as a slowing down of outpatient work following the PAS implementation .The main specialties showing performance behind plan are Trauma & Orthopaedic (T&O), ENT, Ophthalmology, Pain Management, Dermatology and Gynaecology. Whilst non elective work is over performing it is insufficient to make up for the elective shortfall. Reserves now remaining are very small and the financial position relies on the delivery of increased elective and outpatient activity over the coming three months which, if not delivered, will lead to a failure to deliver the revised financial forecast.

Trust unconsolidated pay costs in month of £31.5m are £0.4m less than November. Although substantive costs have increased £0.1m as we become more successful at recruitment (net 62 WTE increase in month) temporary staffing costs have decreased £0.6m in month due to a lower levels of Agency and Bank costs for Nursing and Medical staffing. During the Christmas period it is normal for these staffing groups to reduce as workers are less willing to cover the holiday period. This is not therefore expected to be a long term trend. When measured against Budget, pay is over spent by £0.9m. The main driver for the overspend continues to relate to above plan usage of clinical agency and bank staff. All Care Groups contribute to the overspend. The pay spend includes £3.6m year to date and £0.4m year to date of pay awards relating to Agenda for change not previously budgeted for. Agency costs are now £13.3m more than plan YTD driven by operational pressures. Permanent staff costs (including Overtime and waiting list work) are £3m less than plan YTD driven by all staff groups other than HCA's.

Clinical income was behind plan by £1.7m in month. Once the impact of pay awards income funding (£0.4m, not included in the plan) is adjusted the net position in £2.1m less than plan for the month. The YTD position is now £3.2m ahead of plan but once pay awards income funding (YTD £3.7m) and prior year reserve releases (£3m) are removed the net position is £3.5m behind plan. The key drivers remain over performance of non-electives, A&E and ITU offset by under performance in pass through drugs, elective and Outpatient activity. Month on month income has decreased £3.9m as activity in almost all areas, other than A&E, has decreased during the Christmas period. Other income is £1.7m ahead of plan in month (driven by one off gains from property sales and capital goods scheme benefits) and above plan £5.9m YTD driven by the month 9 drivers as well as the SERCO termination payment and the impact of Trust charges to 2Gether which are offset in expenditure by higher non pay charges from the subsidiary.

Against the full year £30m CIP target, including income, £21.6m of CIPS have been delivered YTD against a target of £20.1m, £1.5m ahead of plan. CIPs achieved in Month 9 were £4m and £1m ahead of plan due to the one off benefits of property sales and the capital goods scheme VAT reclaim. Agency and Procurement schemes slightly under delivered in month. CIPs in December amounted to £2.2m recurrent and £1.8m on a non-recurrent basis. The YTD position is recurrent £13.3m and non-recurrent £8.3m.

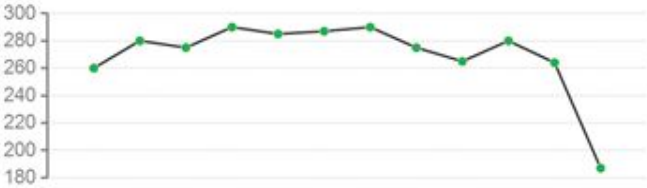
The Trusts cash balance as at the end of September was £8.7m. The Trust's total cash borrowing is now £70.7m and is forecast at £81.6m by the year end.

The Trust Board has agreed to change the Trust forecast to a £42.2m deficit (consolidated after NHSi adjustments). As a result risks have been restated in relation to the new forecast. An estimated £4.4m of risk remains in regard to the revised year end Forecast. The main risks relate to CIP delivery and the delivery of elective activity. The Trust will seek to mitigate these risks as we move through the remainder of the year.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

Dec	Representation at H&S	772 (5.2%)		"% of Clinical Divisions representation/attendance at each site's Health & Safety Committee.
Dec	RIDDOR Reports (Number)	14 (-26.3%)		"RIDDOR reports sent to HSE each month.
Dec	Formal Notices	0 (-100.0%)		"Formal notices from HSE (Improvement Notices, Prohibition Notices).
Dec	Health & Safety Training	3238 (19.0%)		H&S Training includes all H&S and risk avoidance training including manual handling

Highlights and Actions:

Representation at committees declined in December for a successive month partly reflecting the activity being seen at sites over December. The Strategic Health & Safety Committee is discussing in January meeting how it can support the Care Groups further and what support is needed to improve their attendance at the committees.

There where 2 RIDDORS reported in month both staff related incidents which involved patient activity. The H&S committee continue to monitor trends and themes and have identified a need to reinforce the timing guidance standards for reporting. This will ensure that the Trust has a minimal backlog for reporting RIDDORs each month to the HSE.

Training decreased in December again partly to do with operational pressures and the holiday period and is expected to improve in January 2019.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

Dec	Accidents	322 (4.2%)		"Accidents excluding sharps (needles etc) but including manual handling.
Dec	Fire Incidents	114 (-11.6%)		"Fire alarm activations (including false alarms).
Dec	Violence & Aggression	350 (-12.5%)		"Violence, aggression and verbal abuse.
Dec	Sharps	113 (-15.0%)		"Incidents with sharps (e.g. needle stick).

Highlights and Actions:

The number of accidents increased in the month for December, whilst this is still green and relatively low, we will continue to monitor trends, particularly over Q4 when the Trust activity is at its highest.

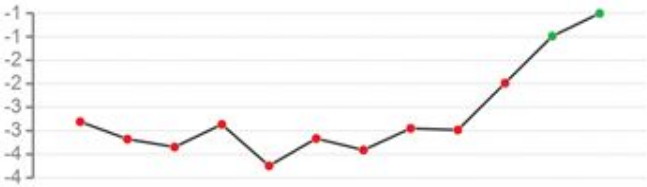
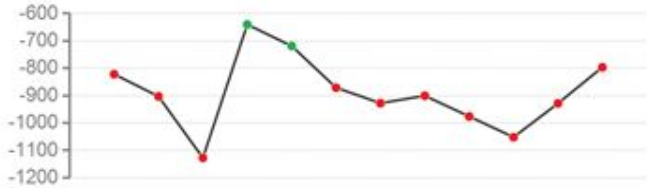
The number fire alarm incidents increased in December, largely due to false alarms within the staff residences and fire exits being blocked by the movement and storage of beds on the acute sites due to the activity levels. The Trust plans to raise awareness of the important of not blocking fire exists in January.

Both Violence & Aggression and Sharp incidents increased slightly in month but remain in Green.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

Dec	Payroll Pay £m	-27.6 (0.5%)		Payroll Pay (Permanent+Overtime). 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	-0.5 (-49.1%)		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			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	-797 (-14.2%)		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.

Highlights and Actions:

Pay performance is adverse to plan in December by £0.9m and by £11.6m ytd (4.24%). Pay CIPs are adverse to plan in month by £0.5m and by £3.6m ytd. The estimated AfC pay award excess impact not included in the base plan (funded in-year by the DOH in Clinical Income) is c£0.4m in month and £3.7m ytd.

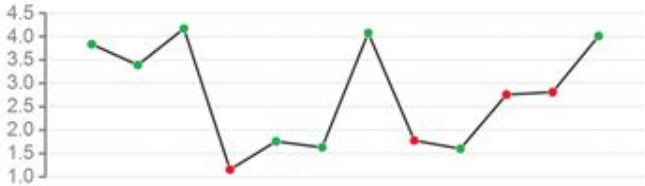
Total expenditure on pay in December was £31.5m, £0.4m lower than in November with all of the reduction relating to expenditure on medical agency staff.

The main driver for the pay overspend in month continues to relate to above plan usage of agency staff, totalling £0.6m in month and £13.2m ytd. All Care Groups contribute to the overspend .

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Use of Resources

Balance Sheet

Dec	CIPS £m	21.6 (42.8%)		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	70.8		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Strategic Theme: Use of Resources

Dec

Capital position £m

8.8
(26.0%)

Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow.

Highlights and Actions:

DEBT
Total invoiced debtors have decreased from the opening position of £28.5m by £8.2m to £20.3m. The largest debtors at 31st December were East Kent CCGs £5.2m, East Kent Medical Services £2.2m and 2gether support solutions £1.7m

CAPITAL
Total YTD expenditure for Mth 9 2018/19 is £3.3m below plan mainly driven by slower than planned delivery of the observation bays.

EBITDA
The Trust is reporting a year to date deficit EBITDA of £12.7m

CASH
The closing cash balance for the Trust as at 31st December was £3.4m

FINANCING
£1.5m of interest was incurred in respect of the drawings against working capital facilities to 31st December 2018.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Improvement Journey

		Aug	Sep	Oct	Nov	Dec	
MD02 - Emergency Pathway	ED - 4hr Compliance (incl KCHFT MIUs) %	83.52	81.02	83.88	84.50	82.25	>= 95
	ED - 1hr Clinician Seen (%)	48	45	51	52	48	>= 55 & <55
MD04 - Flow	DToCs (Average per Day)	52	48	48	55	53	>= 0 & <35
	IP - Discharges Before Midday (%)	13	17	14	15	15	>= 35
	Medical Outliers	51	51	57	49	63	
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	66.13	71.30	77.05	71.73	82.21	>= 85
MD07 - Maternity	Midwife:Birth Ratio (%)	28	27	28	25	24	>= 0 & <28
	Staff Turnover (Midwifery)	13	13	14	13	13	>= 0 & <10
	Vacancy (Midwifery) %	6	5	4	5	5	>= 0 & <7
MD08 - Recruitment & Staffing	Staff Turnover (%)	13.9	14.2	14.6	14.4	14.4	>= 0 & <10
	Vacancy (%)	14.2	13.8	13.2	12.6	12.7	>= 0 & <7
	Staff Turnover (Nursing)	13	14	14	14	14	>= 0 & <10
	Staff Turnover (Medical)	13	14	14	14	14	>= 0 & <10

MD08 - Recruitment & Staffing	Vacancy (Nursing) %	16	17	15	15	15	>= 0 & <7
	Vacancy (Medical) %	13	13	13	12	12	>= 0 & <7
MD09 - Workforce Compliance	Appraisal Rate (%)	75.9	76.3	77.2	75.4	79.6	>= 85
	Statutory Training (%)	98	98	97	97	96	>= 85
KF01 - Complaints	Complaint Response within 30 days %	30.6	16.0	21.4	36.8	13.3	>= 85
	Complaint Response in Timescales %	90.2	75.7	72.1	81.6	94.6	>= 85
KF09 - Medicines Management	Pharm: Drug Trolleys Locked (%)	99	99	48	97	99	>= 90 & <90
	Pharm: Resus. Trolley Check (%)	95	92	94	96	96	>= 90 & <90
	Pharm: Drug Cupboards Locked (%)	88	78	74	86	88	>= 90 & <90
	Pharm: Fridges Locked (%)	85	86	78	83	84	>= 95
	Pharm: Fridge Temps (%)	89	82	82	91	95	>= 100

NHS
East Kent
Hospitals University
NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 4hr Performance (EKHUFT Sites) %	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge for only Acute Sites (K&C, QEQM, WHH, BHD). No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 95	1 %
	ED - 1hr Clinician Seen (%)	% of A&E attendances seen within 1 hour by a clinician	>= 55 & <55	
	ED - 4hr Compliance (incl KCHFT MIUs) %	No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 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.	>= 0 & <92	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	>= 0 & <35	30 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	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: 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 %
	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	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 %
Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90 & <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 & <90	5 %
	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.	>= 0 & <15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	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 - selecting 'Prompt Surgery%'. 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 & <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.	>= 0 & <2.75	20 %
Culture	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.		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	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	>= 0 & <0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %

Data Quality & Assurance	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 %
	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 & <0.2	25 %
Demand vs Capacity	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	>= 0 & <7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments	>= 0 & <7	
	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.	>= 0 & <7	
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	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.	>= 0	10 %
	I&E £m (Trust Only)	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.Month 7 includes a £34.3m impairment due to revaluation of Trusts assets prior to transfer to 2Gether. NHSI add back this impairment in evaluating the Trust.	>= 0	30 %
	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown ir the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	20 %
	Total Cost £m (Trust Only)	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.Mth 7 includes a £34.7m impairment, see I&E note above.	>= 0	20 %
Health & Safety	Accidents	"Accidents excluding sharps (needles etc) but including manual handling.	>= 0 & <40	15 %
	Fire Incidents	"Fire alarm activations (including false alarms).	>= 0 & <5	10 %
	Formal Notices	"Formal notices from HSE (Improvement Notices, Prohibition Notices).	>= 0 & <1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	Violence & Aggression	"Violence, aggression and verbal abuse.	>= 0 & <25	10 %
	Representation at H&S	"% of Clinical Divisions representation/attendance at each site's Health & Safety Committee.	>= 76	20 %

Health & Safety	RIDDOR Reports (Number)	"RIDDOR reports sent to HSE each month.	>= 0 & <3	20 %
	Sharps	"Incidents with sharps (e.g. needle stick).	>= 0 & <10	5 %
Incidents	All Pressure Damage: Cat 2	"Number of all (old and new) Category 2 pressure ulcers. Data source - Datix."	>= 0 & <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."		
	C. Diff Infections (Post 72h)	"The number of Clostridium difficile cases recorded at greater than 72h post admission. Data source - VitalPAC (James Nash)."	>= 0 & <1	0 %
	Clinical Incidents: Moderate Harm			
	Clinical Incidents: No Harm	"Number of Non-Clinical Incidents, recorded on DATIX, per 10,000 FTE hours. Bandings based on total numbers of incidents (corporate level) is: Score1: <= 140, Score2: > 140 & <= 147, Score3: > 147 & <= 155, Score4: > 155 & <= 163, Score5: > 163"		
	Clinical Incidents: Total (#)	"Number of Total Clinical Incidents reported, recorded on Datix.		
	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."	>= 0 & <5	20 %
	Falls: Total	"Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix."	>= 0 & <3	0 %
	Harm Free Care:All Harms (%)	"Percent of inpatients deemed free from harm as measured by the Safety Thermometer audit ie free from old and new harms: - Old and new pressure ulcers (categories 2 to 4) - Injurious falls - Old and new UTI - Old and new DVT, PE c Other VTE. Data source - Safety Thermometer (old and new harms)."	>= 94	10 %
	Medication Missed Doses	Number of missed medication doses recorded on Datix		
	Medicines Mgmt. Incidents	"The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Never Events (STEIS)	"Monthly number of Never Events. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."	>= 0 & <1	30 %
	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."	>= 0 & <1	10 %
	Serious Incidents Open	Number of Serious Incidents currently open according to Datix		
	Clinical Incidents closed within 6 weeks (%)	Percentage of Clinical Incidents closed within 6 weeks		
	Clinical Incidents: Minimal Harm			

Incidents	Clinical Incidents: Severe Harm			
	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 %
	Medication Incidents with Harm	Number of Medication Incidents recorded on Datix with a Moderate/Severe/Death Harm		
	Medication Missed Critical Doses	Number of missed doses for critical drugs / medications		
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls		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 & <0.15	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	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	>= 0 & <1	
	Commode Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95 & <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."	>= 0 & <44	10 %
	E. Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	>= 0 & <44	
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	>= 0 & <1	
	Bare Below Elbows Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95 & <95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	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.	>= 0 & <1	40 %
	Hand Hygiene Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95	

Infection	MSSA	"The total number of MSSA bacteraemia recorded, post 48hrs.	>= 0 & <1	10 %
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 & <0.33	10 %
	Number of SJR's Completed	Number of Structured Judgement Reviews (Mortality Case Record Reviews) completed		
	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."	>= 0 & <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.	>= 0 & <90	35 %
	Number of Avoidable Deaths > 50%	Number of deaths that were more than 50% likely to have been Avoidable (Categories: 'Definitely Avoidable','Strong evidence of avoidability','Probably avoidable (more than 50:50)')		
	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.	>= 0 & <87.45	30 %
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 %
	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 (%)	VitalPac Observations are untaken in a timely manner according to clinical need. Patients who have an early warning score of less than three are excluded, as well as patients on respiratory wards and patients on an End of Life Pathway.	>= 90	25 %
	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 %
	Obs. On Time - 8pm-8am (%)	VitalPac Observations are untaken in a timely manner according to clinical need. Patients who have an early warning score of less than three are excluded, as well as patients on respiratory wards and patients on an End of Life Pathway.	>= 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	AE Mental Health Referrals	A&E Mental Health Referrals		5 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Complaints received with a 30 Day time frame agreed	Number of complaints received with an agreed time frame of 30 days		
	IP FFT: Recommend (%)		>= 90	30 %

Patient Experience

Number of Complaints	"The number of Complaints recorded overall . Data source - Patient Experience Team"	>= 0 & <1	0 %
Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	5 %
Complaints acknowledged within 3 working days	Complaints acknowledged within 3 working days		
Complaints Open <= 30 Days	Number of complaints open for less than 30 days		
Complaints Open > 90 Days	Number of Complaints open for more than 90 Days		
Complaints Open 31 - 60 Days	Number of Complaints open between 31 and 60 Days		
Complaints Open 61 - 90 Days	Number of Complaints open between 61 and 90 Days		
Complaints received with a 45 Day time frame agreed	Number of complaints received with a agreed time frame of 45 days		
Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
IP 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."	>= 0 & <1	10 %
IP 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 %
IP Survey: Are you aware of which nurse is in charge of your care each shift? (%)	IP Survey: Are you aware of which nurse is in charge of your care each shift? (%)	>= 89	4 %
IP Survey: Encouraged to get up and wear own clothes (%)	Responses taken from the Inpatient Survey. Question: "Have you been encouraged to get up during your hospital stay and wear your own clothes?"		3 %
IP Survey: Help from Staff to Eat Meals (%)	Responses taken from the Inpatient Survey. Question: "Did you get enough help from staff to eat your meals?"		3 %
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."	>= 0 & <1	10 %

Patient Experience	Number of Compliments	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge for only Acute Sites (K&C, QEQM, WHH, BHD)	>= 1 & <1	0 %
Productivity	EME PPE Compliance %	EME PPE % Compliance	>= 80	20 %
	Theatres: On Time Start (% 15min)	The % of cases that start within 15 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 %
	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use– allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Compliance	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 80 & <80	
	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 & <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.	>= 0 & <5	10 %
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	>= 0	
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency & Locum Spend	Total agency spend including NHSP spend		
	Agency Orders Placed	"Total count of agency orders placed.	>= 0 & <100	
	Agency Staff WTE (Bank)	WTE Count of Bank Hours worked		
	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.	>= 85	

Staffing

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.	>= 0 & <28	2 %
Overtime (WTE)	Count of employee's claiming overtime		1 %
Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). 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.	>= 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.	>= 0 & <3.3	10 %
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 & <99	
Agency %	% of temporary (Agency and Bank) staff of the total WTE	>= 0 & <10	
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 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		
Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. 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.		
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.	>= 0 & <10	
Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). 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.	>= 80	15 %
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."	>= 0 & <10	15 %
Staff Turnover (Medical)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Medical Staff. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in directior of arrow and %) against the previous 12 months."	>= 0 & <10	

Staffing	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."	>= 0 & <10	
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Vacancy (%)	"% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown ir graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <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."	>= 0 & <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."	>= 0 & <7	
	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 (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 directior of arrow and %) against the previous 12 months."	>= 0 & <10	
	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."	>= 0 & <10	
	Total Staff Headcount	Headcount of total staff in post		
	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.	>= 0 & <100	5 %
	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."	>= 0 & <7	
Training	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	
	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 %

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.	>= 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	
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow.	>= 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		
	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). 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

NHS
East Kent Hospitals University
NHS Foundation Trust

Human Resources Heatmap

	CAN (Cancer)	CSS (Clinical Support Services)	GSM (General and Specialist Medicine)	S&A (Surgery & Anaesthetics)	SHN (Surgery Head & Neck)	UEC (Urgent and Emergency	Unknown	W&C (Womens and Childrens)
Agency %	2.0	1.6	12.5	6.8	4.9	22.7	3.8	5.3
Employed vs Temporary Staff (%)	89.0	90.3	83.9	94.2	96.3	75.9	91.7	92.3
Sickness (%)	4.8	4.5	4.4	4.7	2.4	5.5	4.1	4.9
Statutory Training (%)	94	93	98	97	98	98	95	97
Total Staff In Post (SiP)	176	943	1418	1445	145	399	1580	889
Vacancy (%)	11.0	9.7	17.5	6.4	3.7	24.1	15.9	7.7

Apdx.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Patient Safety Heatmap - DECEMBER 2018

KEY

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

	Harm Free Care: New Harms (%)	Hand Hygiene Audit	C. Diff Infections (Post 72h)	Number of Cardiac Arrests	Number of Complaints	Number of Compliments	IP FFT: Response Rate (%)	IP FFT: Recommend (%)	IP FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
K&C - KENT & CANTERBURY HOSPITAL													
Specialist													
KBRA - K&C BRABOURNE WARD	100.0	96.3	0	0	0	10	50	100	0.0	96.0	84	103	16
KCADU - K&C CATHEDRAL UNIT	N/A	4.3	0	0	0	0	N/A	N/A	N/A	76.1	NULL	NULL	NULL
KDOLP - K&C DOLPHIN WARD	N/A	NULL	0	0	0	185	N/A	N/A	N/A	101.2	NULL	NULL	NULL
KMARL - K&C MARLOWE WARD	95.0	93.8	0	1	0	123	55	98	2.0	93.7	99	95	7
Surgical													
KCLK - K&C CLARKE WARD	96.2	84.6	0	0	0	116	6	100	0.0	85.4	85	89	6
KITU - K&C INTENSIVE CARE UNIT	91.7	100.0	0	0	0	91	N/A	N/A	N/A	82.6	86	83	26
KSLA - K&C ST LAWRENCE WARD	100.0	NULL	0	0	0	0	NULL	NULL	NULL	NULL	NULL	NULL	NULL
KWURO - K&C UROLOGY SUITE	N/A	NULL	0	0	0	0	N/A	N/A	N/A	91.4	NULL	NULL	NULL
Urgent & Long Term													
KACU - K&C AMBULATORY CARE UNIT	N/A	NULL	0	0	0	0	N/A	N/A	N/A	87.8	NULL	NULL	NULL
KHAR - K&C HARBLEDOWN WARD	95.0	100.0	0	0	0	61	33	95	5.3	72.7	81	116	5
KINV - K&C INVICTA WARD	100.0	100.0	0	0	1	0	37	100	0.0	93.0	114	113	6
KKIN - K&C KINGSTON WARD	100.0	100.0	0	1	0	0	11	50	25.0	72.5	81	110	6
KMM - K&C MOUNT MCMASTER WARD	100.0	100.0	0	0	1	0	33	100	0.0	80.0	103	106	5
KNRU - K&C EAST KENT NEURO REHAB	100.0	100.0	0	0	0	0	43	100	0.0	NULL	85	101	5
KTRE - K&C TREBLE WARD	90.0	NULL	0	0	0	0	33	100	0.0	86.5	83	94	8
QEQM - QUEEN ELIZABETH QUEEN MOTHER HOSPITAL													
Specialist													
KIN - QEQM KINGSGATE WARD	100.0	98.1	0	0	1	0	N/A	N/A	N/A	85.9	89	94	21
QBIR - QEQM BIRCHINGTON WARD	100.0	NULL	0	0	0	42	13	100	0.0	96.9	94	127	6
QRAI - QEQM RAINBOW WARD	100.0	NULL	0	0	0	0	17	100	0.0	93.8	95	111	12
QSCB - QEQM SPECIAL CARE BABY UNIT	100.0	NULL	0	0	0	0	N/A	N/A	N/A	95.1	104	96	13

Apdx.

KEY

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

	Harm Free Care: New Harms (%)	Hand Hygiene Audit	C. Diff Infections (Post 72h)	Number of Cardiac Arrests	Number of Complaints	Number of Compliments	IP FFT: Response Rate (%)	IP FFT: Recommend (%)	IP FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
QVDM - QEQM VIKING DAY UNIT	N/A	NULL	0	0	0	0	N/A	N/A	N/A	108.4	NULL	NULL	NULL
Surgical													
QBIS - QEQM BISHOPSTONE WARD	100.0	NULL	0	0	1	0	84	100	0.0	76.6	77	89	7
QCSF - QEQM CHEERFUL SPARROWS WAR	100.0	81.8	0	0	0	0	79	99	1.3	111.4	110	122	7
QCSM - QEQM CHEERFUL SPARROWS WA	100.0	NULL	0	0	1	0	30	100	0.0	86.9	119	129	7
QDSU - QEQM DAY SURGERY WARD	NULL	73.5	0	0	0	0	NULL	NULL	NULL	NULL	NULL	NULL	NULL
QITU - QEQM INTENSIVE CARE UNIT	100.0	100.0	0	0	0	45	N/A	N/A	N/A	87.4	91	115	23
QSAL - QEQM SURGICAL ADMISSIONS LO	NULL	NULL	0	0	0	0	NULL	NULL	NULL	0.0	NULL	NULL	NULL
QSB - QEQM SEA BATHING WARD	100.0	NULL	0	0	0	0	50	97	0.0	82.9	109	112	6
Urgent & Long Term													
QAMUB - QEQM ACUTE MEDICAL UNIT B	100.0	NULL	0	1	0	0	NULL	NULL	NULL	NULL	NULL	NULL	NULL
QCCU - QEQM CCU	100.0	NULL	0	2	0	10	29	100	0.0	78.9	98	100	8
QDEA - QEQM DEAL WARD	100.0	98.9	0	0	0	0	25	100	0.0	108.0	126	144	6
QFOR - QEQM FORDWICH WARD	95.0	94.9	0	0	1	0	38	100	0.0	87.9	88	128	7
QMW - QEQM MINSTER WARD	100.0	NULL	0	2	0	1	1400	100	0.0	52.9	102	94	11
QQX - QEQM QUEX WARD	100.0	77.8	0	0	0	58	46	94	0.0	106.8	111	122	6
QSAN - QEQM SANDWICH WARD	100.0	97.9	0	0	0	1	48	97	2.9	96.7	123	153	7
QSTA - QEQM ST. AUGUSTINES WARD	96.3	96.8	0	0	0	1	64	100	0.0	81.0	93	122	5
QSTM - QEQM ST. MARGARETS WARD	91.3	93.0	0	0	0	1	23	100	0.0	77.9	99	115	5
WHH - WILLIAM HARVEY HOSPITAL													
Specialist													
FF - WHH FOLKESTONE WARD	NULL	83.3	0	0	2	1	N/A	N/A	N/A	88.6	91	92	39
WCBC - WHH CELIA BLAKEY CENTRE	N/A	NULL	0	0	0	0	N/A	N/A	N/A	103.4	NULL	NULL	NULL
WKEN - WHH KENNINGTON WARD	100.0	71.7	0	0	0	0	51	94	1.5	77.8	102	134	8
WPAD - WHH PADUA WARD	100.0	NULL	0	0	2	0	6	100	0.0	76.3	86	91	5
WSCBU - WHH THOMAS HOBBS NEONATA	100.0	100.0	0	0	0	0	N/A	N/A	N/A	99.0	96	94	16
Surgical													
WITU - WHH INTENSIVE CARE UNIT	100.0	96.5	0	0	0	71	N/A	N/A	N/A	98.8	79	88	24
WKA2 - WHH KINGS A2 WARD	100.0	100.0	0	0	0	278	43	97	3.3	108.4	108	115	6
WKB - WHH KINGS B WARD	100.0	100.0	2	0	0	348	90	96	2.1	98.8	109	115	6
WKC1 - WHH KINGS C1 WARD	100.0	39.3	0	0	0	172	55	96	4.2	86.4	118	99	6

Apdx.

KEY

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

	Harm Free Care: New Harms (%)	Hand Hygiene Audit	C. Diff Infections (Post 72h)	Number of Cardiac Arrests	Number of Complaints	Number of Compliments	IP FFT: Response Rate (%)	IP FFT: Recommend (%)	IP FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
WKC2 - WHH KINGS C2 WARD	NULL	NULL	1	0	2	0	0	NULL	NULL	22.8	29	35	3
WKDF - WHH KINGS D FEMALE	100.0	100.0	1	0	0	327	48	100	0.0	102.7	N/A	N/A	N/A
WKDM - WHH KINGS D MALE	88.0	100.0	0	0	0	0	51	98	2.3	N/A	110	101	7
WROT - WHH ROTARY WARD	100.0	100.0	0	0	0	51	35	98	2.2	94.6	99	112	8
WSEAU - WHH SEAU	N/A	NULL	0	0	0	0	150	98	0.0	109.5	NULL	NULL	NULL
WSURA - WHH SURGICAL ADMISSIONS LO	N/A	NULL	0	0	0	0	N/A	N/A	N/A	107.8	NULL	NULL	NULL
Urgent & Long Term													
WAMUB - WHH ACUTE MEDICAL UNIT B	100.0	NULL	0	1	0	0	NULL	NULL	NULL	NULL	NULL	NULL	NULL
WBAR - WHH BARTHOLOMEW WARD	100.0	NULL	0	0	0	0	95	99	0.0	85.7	101	97	12
WCCU - WHH CARDIAC CARE UNIT	100.0	NULL	0	0	0	0	83	98	0.0	N/A	N/A	N/A	N/A
WCDU - WHH CLINICAL DECISION UNIT	100.0	NULL	0	2	0	59	NULL	NULL	NULL	73.3	75	96	NULL
WCJ - WHH CAMBRIDGE J WARD	100.0	100.0	0	0	0	0	13	80	0.0	82.3	127	146	7
WCK - WHH CAMBRIDGE K WARD	100.0	100.0	0	0	2	35	67	88	7.7	63.5	95	92	6
WCL - WHH CAMBRIDGE L WARD	100.0	100.0	1	3	1	56	32	93	0.0	77.1	95	105	6
WCM1 - WHH CAMBRIDGE M1 WARD	100.0	95.3	0	2	0	0	18	100	0.0	60.1	N/A	N/A	N/A
WCM2 - WHH CAMBRIDGE M2 WARD	100.0	87.5	0	0	1	36	39	96	0.0	88.6	102	104	6
WOXF - WHH OXFORD WARD	100.0	100.0	0	0	0	0	23	100	0.0	94.0	88	103	7
WRSU - WHH RICHARD STEVENS WARD	100.0	84.2	0	0	0	42	43	100	0.0	86.1	98	116	8

Apdx.

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**07 FEBRUARY 2019**
SUBJECT:	**FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**RISK MANAGER**
PURPOSE:	**DISCUSSION**
APPENDICES:	- **APPENDIX 1: CORPORATE RISK REGISTER (BY RESIDUAL RISK RANKING) DATED 01 FEBRUARY 2019** - **APPENDIX 2: HIGHEST MITIGATED STRATEGIC RISKS DATED 01 FEBRUARY 2019**

BACKGROUND AND EXECUTIVE SUMMARY

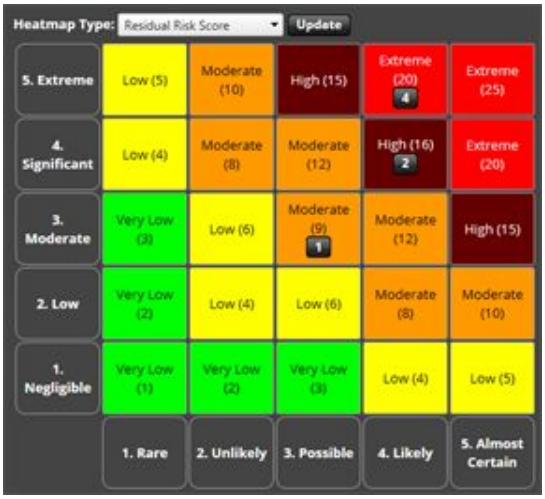
This report provides the Board of Directors with an update of the full Corporate/Highest Mitigated Strategic Risks at 01 February 2019. The risks rated as “high” post mitigation (residual) on the Strategic and the full Corporate Risk Register were last reviewed by the Board on 06 December 2018. The highest mitigated risks on the Strategic and Corporate Risk Registers were last reviewed by the Integrated Audit and Governance Committee (IAGC) on 17 January 2019. The highest mitigated Quality risks were last reviewed and discussed at the Quality Committee on 18 December 2018.

During the period under review, progress notes have been added for majority of the actions in the Principal risks report. Reminders have been sent to action owners from whom the remaining updates are required.

Current Risk Register Heat Map (by Residual risk score)

Corporate Risks (25)

Strategic Risks (7)



Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register

1 There were no changes to the residual or target risk scores in the period under review. Some actions have been completed and no additional strategic risks added.

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 rationale for the change:

Risk Ref.	Risk Title	Residual Score Oct 18	Residual Score Nov 18	Direction of travel	Target Score
CRR 36	Inadequate safeguarding training arrangements Trust-wide (adult and children) *Residual score reduced due to external assurance received from the CQC regarding good practice, plus the fact that there have not been reported any harm events.*	**16 High**	**12 Moderate**		**4 Low**

Risks approved for closure on the Corporate Risk Register (January 2019 - Clinical Executive Management Group)

3 There were was one risk approved for closure on the Corporate Risk Register at the Clinical Executive Management Group; this will be monitored on the Radiology Risk Register.

CRR 39 – Delays in radiological reporting was closed as the major fluctuations have been reduced, the current backlog is in a good position and monitored closely.

4 There was one risk approved for de-escalation from the Corporate Risk Register to a local risk register.

CRR 31 – Exposure to Cyber Security attacks as sufficient controls are now in place to mitigate the risk to a tolerable level.

New Corporate Risks approved by the Clinical Executive Management Group (January 2019)

5 There were no new risks added to the Corporate Risk Register in January 2019.

Risks approved for merging on the Corporate Risk Register

6 There were no risks proposed for merging by the Clinical Executive Management Group.

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

7	A full review of the strategic and corporate risk registers will be undertaken with the Executive Team to determine whether the risks remain at a corporate level and whether the risk scoring gives an accurate reflection of the risk posed to the Trust. During this review an assessment will be undertaken of the risks to the 2019/20 annual objectives and current risks will be aligned to the objectives.
8	A meeting has been scheduled with the senior independent non-executive director to review the risk reporting format to the Quality Committee. This is to ensure the committee are fully sighted to the risks and are provided with assurance as to the mitigating actions being taken to address these.

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 the Clinical Executive Management Group reviews 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 are 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	01 Feb 2019
Comparison Date	In the past 30 Day(s)

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 19	Delays in the cancer pathway of over 100 days **Risk Owner:** Lee Martin **Delegated Risk Owner:** Sarah Collins **Last Updated:** 01 Feb 2019 **Latest Review Date:** 01 Feb 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed and additional actions added	24 Apr 2016	**Cause** Non implementation of timed pathways Skill mix issues in key specialities Poor pathway decisions Specialist Oncological support to pathway decision making Early access to Diagnostics Non compliance to access policy offering Choice Insufficient GP preparation of patients in early pathways * Lack of treatment capacity Radiotherapy/Relph **Effect** * Regulatory concerns *Possible harm to Patients * Reputational damage *	AO3: Provision: Provide the services needed and do it well	I = 5 L = 4 Extreme (20)	Cancer 62 day treatment recovery plan **Control Owner:** Elizabeth Mount	Limited	I = 5 L = 4 Extreme (20)	Implement Timed pathways and track to delivery. Daily active Monitoring of all risk patients Implement front end transformation Increased leadership by clinical leads **Person Responsible:** Sarah Collins **To be implemented by:** 29 Mar 2019	High		I = 5 L = 2 Moderate (10)
						Diagnostic capacity is reviewed at the KPI meeting and also within the Clinical Support Care Group **Control Owner:** Elizabeth Mount	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		Implement cancer 62 day treatment recovery plan. Achievement of trajectory to date. Will continue to monitor against trajectory to the end of the financial year. **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Good progress is being made and the standard compliance is improving.	
						Process outlined for clinicians to complete initial screening of pathway delays **Control Owner:** Lee Martin	Adequate					
						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:** Elizabeth Mount	Adequate		Urology team to implement improvement action plan. **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2019	High	**14 Nov 2018** Cancer Improvement Plan in place.	
						Tracking system in place with an updated position disseminated weekly. **Control Owner:** Lee Martin	Adequate					
						Use of Datix incident reporting for all delayed cancer patients to improve visibility of patient affected. **Control Owner:** Helen Goodwin	Adequate		Complete accredited training for surgeons undertaking endoscopy **Person Responsible:** Richard Kingston **To be implemented by:** 31 Mar 2019	High	**22 Oct 2018** QEQMH surgeons signed off (x3) WHH surgeons signed off (x3)	
						WHH endoscopy unit JAG accredited **Control Owner:** Lisa Neal	Substantial					

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:** Syed Gilani **Last Updated:** 09 Oct 2018 **Latest Review Date:** 14 Jan 2019 **Latest Review By:** Paul Stevens **Latest Review Comments:** The 2 observation wards are allied to A&E and their purpose is to decongest the A&E and promote flow through the department. An arbitary date in mid-February has been set to assess whether the new observation wards are working sufficiently well to constitute a control	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 Plan in place with work streams for Admission Avoidance, A&E Streaming, Improved Flow, Discharges and Workforce **Control Owner:** Lee Martin	Limited	I = 5 L = 4 Extreme (20)	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:** Syed Gilani **To be implemented by:** 28 Feb 2019	High	**05 Dec 2018** Weekly senior management meetings to address the KPIs in place. Also, talks with relevant care groups to improve engagement with the acute floor and improved in-reach to help decongest the acute floor and make the acute medical model workable.	I = 4 L = 3 Moderate (12)
						Accident and Emergency Delivery Board in place **Control Owner:** Susan Acott	Limited					
						Acute Medical Model in place **Control Owner:** Syed Gilani	Limited		Introduction and Evaluation of a Surgical Emergency unit at QEQM **Person Responsible:** Vanessa Purday **To be implemented by:** 29 Mar 2019	High	**05 Dec 2018** A limited SEAU is in operation at the QEQM, operating Monday to Friday for GP referrals to ED with suspected surgical criteria. A business case to mirror and extend the SEAU model at WHH will be presented to SIG in January 2019.	
						Daily intensive review/bed matching for emergency admissions not placed at time of review **Control Owner:** Lee Martin	Adequate					
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Lee Martin	Limited		Recruitment of acute physicians and specialty doctors establishment **Person Responsible:** Syed Gilani **To be implemented by:** 28 Jun 2019	High	**05 Dec 2018** On-going interviews for increasing special doctor numbers. JDs for ED consultants revamped and third party recruitment agencies i.e. Veredus involved in recruitment.	
						Health Economy Plan in place. Intensive work on relationship management and lateral integrations and partnership working. **Control Owner:** Lee Martin	Limited					
						Increased acute medical bed capacity through moving the cardiology ward to the Arundel suite as part of creating a cardiology inpatient area including CCU and general cardiology beds. Vacated space becomes an acute medical area **Control Owner:** Lesley White	Adequate					
						Increased opening hours of the surgical emergency assessment unit **Control Owner:** Christine Hudson	Adequate					
						Interim Hospital Directors in place at WHH and QEQM to support a greater site focus **Control Owner:** Lee Martin	Limited					
						Internal PMO service in place to manage the delivery of the A&E Improvement Plan **Control Owner:** Lee Martin	Adequate					
						Introduction of Bristol safety checklist in the EDs **Control Owner:** Elisa Steele	Adequate					
						Medical assessment areas are now in place as part of the emergency floor at both QEQMH and WHH. **Control Owner:** Tara Laybourne	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
						Primary care service in place at QEQMH and WHH for a minimum of 12 hours per day, **Control Owner:** Syed Gilani	Adequate					
						Review of Emergency Care Pathway and revised Improvement Plan **Control Owner:** Lee Martin	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					
						Weekly site based meetings in place designed to improve ownership of the emergency care pathway and reduce overcrowding in the emergency department **Control Owner:** Syed Gilani	Adequate					
CRR 48	Challenges in embedding a mature and developed Patient safety culture across Obstetrics and Maternity **Risk Owner:** Sally Smith **Delegated Risk Owner:** Elhussein Rfidah **Last Updated:** 09 Oct 2018 **Latest Review Date:** 17 Jan 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions updated.	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 * Never Event in maternity within past 12 months.	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 = 4 High (16)	Ensure mandatory training is prioritised and staff undertake the required training **Person Responsible:** Ursula Marsh **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Compliance update awaited. Training delivery continues.	I = 3 L = 2 Low (6)
						Maternity Services Patient Safety Plan is in place and being implemented and monitored by the Care Group and Executive and CCGs. **Control Owner:** Sharon Curtis	Adequate		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:** Ursula Marsh **To be implemented by:** 31 Mar 2020	High	**17 Jan 2019** The programme continues to be on track.	
						Monthly performance meetings are in place as well as support meetings by the Executive Team. **Control Owner:** Sally Smith	Adequate					
						Never Event Action Plan is in place **Control Owner:** Ursula Marsh	Limited					
						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					

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:** Lee Martin **Delegated Risk Owner:** Lesley White **Last Updated:** 12 Dec 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions updated and risk reviewed.	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 Care Groups *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 = 5 L = 4 Extreme (20)	2020 in place to focus on length of stay and supporting bed occupancy **Control Owner:** Lee Martin	Adequate	I = 4 L = 4 High (16)	Recruitment of acute physicians and specialty doctors establishment **Person Responsible:** Richard Kingston **To be implemented by:** 31 Jan 2019	High	**09 Oct 2018** Successful middle grade recruitment - the plan continues to be effected.	I = 4 L = 3 Moderate (12)
						A&E Delivery Board in place **Control Owner:** Lee Martin	Adequate					
						A&E Improvement Director in place to support the delivery of the A&E Improvement Plan **Control Owner:** Lee Martin	Adequate		Continue to deliver the actions to improve and sustain ED performance through the weekly meetings chaired by the COO. **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	High	**14 Nov 2018** ED Improvement Plan in place focussing on triage, UCC, ED escalation. Focussed work continues with partners on length of stay (stranded and super stranded patients). Winter Taskforce in place to monitor key projects linked to flow and ED Improvement: Staffing, observation wards, orthopaedic plan, ED rapid response, length of stay, Rapid Transfer of Care Service, Medical Wards, AMU, Frailty, Access Team and Health and Social Care Village Beds.	
						Delivery plan in place with clear milestones **Control Owner:** Lee Martin	Adequate					
						Interim Hospital Directors in place at WHH and QEQM to support a greater site focus **Control Owner:** Lee Martin	Limited					
						Internal PMO service in place to manage the delivery of the A&E Improvement Plan **Control Owner:** Lee Martin	Adequate					
						Operational meetings in place **Control Owner:** Lee Martin	Limited					
						Programme management documentation (including risk log) developed **Control Owner:** Lee Martin	Limited					
						Robust Communications Strategy in place **Control Owner:** Natalie Yost	Adequate					
						Service Improvement Team in place **Control Owner:** Sarah Maycock	Adequate					
						Single oversight meetings in place **Control Owner:** Lee Martin	Limited					
						Trajectory in place identified by scheme and the monitoring of metrics that have been identified by NHSI **Control Owner:** Lee Martin	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 59	Potential delays in new and follow-up patient appointments **Risk Owner:** Lee Martin **Delegated Risk Owner:** Julia Bournes **Last Updated:** 14 Nov 2018 **Latest Review Date:** 24 Dec 2018 **Latest Review By:** Julia Bournes **Latest Review Comments:** Risk reviewed, no change	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)	Annual review of capacity and demand using Production Plans as part of the Business planning process **Control Owner:** Philip Cave	Adequate	I = 4 L = 4 High (16)	Surgery and Anaesthetics Care Group to use the follow-up framework to assess their follow-up gap **Person Responsible:** Julie Barton **To be implemented by:** 31 Dec 2018	High	**03 Dec 2018** Improvement work continues to reduce backlog	I = 4 L = 2 Moderate (8)
						Outpatient Improvement Programme in place **Control Owner:** Christine Hudson	Limited					
						Process in place for data validation **Control Owner:** Lee Martin	Adequate		Surgery - Head and Neck Care Group to use the follow-up framework to assess their follow-up gap **Person Responsible:** Sarah Hyett **To be implemented by:** 31 Dec 2018	High	**11 Jan 2019** Ophthalmology - Continuing to insource activity at weekend to deliver year end plan. ENT - Additional speciality doctor in post plus agency ENT consultant. Predicting year end underperformance in follow ups.	
						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					
						Regular review of capacity and demand by specialty reported in performance meetings **Control Owner:** Lee Martin	Limited		Cancer Care Group to use the follow-up framework to assess their follow-up gap **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Dec 2018	High	**03 Dec 2018** Improvement work continues to reduce backlog	
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Christine Hudson	Limited					
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Elizabeth Mount	Limited		Implement tiers of care for agreed specialties **Person Responsible:** Lesley White **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Rheumatology has been implemented.	
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Lesley White	Limited					
									Develop a plan to ensure efficiencies in all clinics (for specialties that have implemented partial booking) **Person Responsible:** Lee Martin **To be implemented by:** 31 Dec 2018	High	**14 Nov 2018** A review of OPD pathway, electronic systems, patient information and experience is underway. This is to assist with the development of a OPD transformation plan.	
									General and Specialist Medicine Care Group to use the follow-up framework to assess their follow-up gap **Person Responsible:** Amanda Hallums **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Backlog work continues as part of the improvement plan.	
									Women's and Children Care Group to use the follow-up framework to assess their follow-up gap **Person Responsible:** Ursula Marsh **To be implemented by:** 29 Mar 2019	High	**02 Jan 2019** Interim operational manager Zena Jacobs in post and improvement work continues. RTT improved position curently	

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
									Support the Specialties to improve and transform their outpatient pathways via the Outpatient Improvement Programme **Person Responsible:** Julia Bournes **To be implemented by:** 31 Mar 2020	High	**24 Dec 2018** The COO is sponsoring the continuation of the outpatient transformation programme. this work will be ongoing throughout the 2019- 2020 financial year and onwards	
CRR 65	Risk of prosecution by the CQC for a breach of parts 20(2)(a) and 20(3) of the Duty of Candour regulation without first serving a Warning Notice **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 22 Oct 2018 **Latest Review Date:** 14 Jan 2019 **Latest Review By:** Paul Stevens **Latest Review Comments:** Weekly reporting of Duty of Candour compliance continues from the Care Groups but is not fully embedded in the practice of the 2 medical care groups.	20 Feb 2018	**Cause** * Continued poor compliance with Duty of Candour * Delay or uncertainty regarding the severity of the incident reported contributes to lack of compliance * A lack of clarity regarding responsibility for completing the formal letters confirming the Duty of Candour conversation * Concerns regarding the 'right' time to fulfil requirements – this is more of a concern when there has been a delay in identifying the incident or completing the Duty of Candour conversation * Concerns that the patient or family questions cannot be answered immediately * Limited formal Duty of Candour training available * Low training attendance for Duty of Candour training **Effect** * Reputational damage * Missed opportunities to engage with patients and families regarding an adverse event leading to complaints and subsequent claims * Professional misconduct * Breach of contractual obligations to provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs (a 'reportable patient safety incident' is one which could have or did result in moderate or severe harm or death). * Potential fines for non-compliance	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Appointment of Duty of Candour guardian with responsibility for overseeing Duty of Candour Trustwide **Control Owner:** Jonathan Purday	Limited	I = 4 L = 4 High (16)	Implement the Duty of Candour Action Plan **Person Responsible:** Richard Kingston **To be implemented by:** 29 Mar 2019	High	**14 Nov 2018** A change in Care Group Leadership, performance concerns have been escalated as the Care Group is not meeting its trajectory	I = 4 L = 2 Moderate (8)
						Circulation of Action Against Medical Accidents (AvMA) and NHS Resolution Duty of Candour Leaflets to Care Groups and at Clinical Induction **Control Owner:** Melinda Brewer	Limited					
						Compliance updates provided to the Patient Safety Board **Control Owner:** Melinda Brewer	Limited					
						Duty of Candour Action Plan in place for Surgery **Control Owner:** Vanessa Purday	Adequate					
						Duty of Candour Action Plan in place for Urgent Care & LTC **Control Owner:** Syed Gilani	Limited					
						Duty of Candour presentations provided at the QII Hubs **Control Owner:** Melinda Brewer	Limited					
						Duty of Candour training in place **Control Owner:** Melinda Brewer	Limited					
						Each Care Group reviews their Duty of Candour performance at the monthly performance review meetings **Control Owner:** Paul Stevens	Limited					
						Trust-specific Duty of Candour leaflets in place and disseminated to Governance teams **Control Owner:** Melinda Brewer	Adequate					
						Updated Datix Duty of Candour page. This page has been updated to enable easy and rapid completion of the Duty of Candour with links to patient information leaflets and to the Trust Duty of Candour webpage for further information **Control Owner:** Melinda Brewer	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 44	Failure to meet the Referral to Treatment (RTT) Standard for the Trust **Risk Owner:** Lee Martin **Delegated Risk Owner:** Vanessa Purday **Last Updated:** 14 Nov 2018 **Latest Review Date:** 14 Nov 2018 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** RTT Improvement Plan in place Stage 1 - Establish appropriate structure, skills and competencies to deliver high performing care group Stage 2 - Drive efficiency in capacity Stage 3 - Develop and implement long term sustainability and improvement plan	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:** Julie Barton	Limited	I = 4 L = 4 High (16)	Review of 1st appointment booking capacity and booking processes **Person Responsible:** Vanessa Purday **To be implemented by:** 31 Dec 2018	High	**14 Nov 2018** Stage 2 of RTT improvement plan focuses on driving efficiency in capacity	I = 4 L = 2 Moderate (8)
						Action plans in key specialties to ensure improved performance **Control Owner:** Julie Barton	Limited					
						Escalations of capacity for outpatients and theatres happen as required **Control Owner:** Julie Barton	Limited		Surgical Specialties to develop and implement action plans "Get it right first time" which will include meeting RTT **Person Responsible:** Vanessa Purday **To be implemented by:** 31 Mar 2019	High	**14 Nov 2018** RTT improvement plan in place - see review comment	
						Focused management of undated pathways waiting over 30 weeks and risks to 52 weeks, particularly within General Surgery, ENT and Gynaecology **Control Owner:** Julie Barton	Adequate					
						Improved Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots **Control Owner:** Julie Barton	Limited		Each Care Group is required to review the capacity and demand plan in line with RTT achievement and submit business cases for any additional capacity (if required)" **Person Responsible:** Victoria Harrison **To be implemented by:** 31 Mar 2019	High	**14 Nov 2018** RTT improvement plan in place	
						Recovery trajectory in place **Control Owner:** Julie Barton	Limited					
						Saturday working in new consultants contracts across the trust to improve utilisation of theatre capacity and increase capacity **Control Owner:** Julie Barton	Adequate		Each Care Group is required to review the capacity and demand plan in line with RTT achievement and submit business cases for any additional capacity (if required)" **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2019	High	**14 Nov 2018** RTT improvement plan in place	
						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:** Julie Barton	Limited					
						The Surgical Care Group continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations **Control Owner:** Julie Barton	Limited		Each Care Group is required to review the capacity and demand plan in line with RTT achievement and submit business cases for any additional capacity (if required) **Person Responsible:** Karina Greenan **To be implemented by:** 31 Mar 2019	High	**14 Nov 2018** RTT improvement plan in place	
						Validation in place **Control Owner:** Louise Pallas	Limited		Increase theatre utilisation to 50 weeks per year **Person Responsible:** Vanessa Purday **To be implemented by:** 30 Apr 2019	High	**14 Nov 2018** Theatre Efficiency Managers appointed for WHH and QEQM. Theatre Efficiency meetings taking place weekly on each site reporting in to Theatre Steering Committee. Escalation in place to resolve any blocks to theatre management.	

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 3	Inability to respond in a timely way to changing levels of demand for elective services **Risk Owner:** Lee Martin **Delegated Risk Owner:** Mary Tunbridge **Last Updated:** 01 Feb 2019 **Latest Review Date:** 01 Feb 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed and updated	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. High N/FUP ratios * Inability to recruit into Consultant, middle grade and speciality posts. *Backlog rollover from previous years *Demand from CCG's higher in some specialities than agreed BP *Failure to complete job planning In some specialties *Referral management mechanisms in CCGs have resulted in a higher conversion rate to Surgery ITU availability Long Polling ranges in OPD /all specialties impacting on 18w pathways. PAS and carryover of Incomplete pathways **Effect** * Breach of licence Failure to meet Constitutional RTT Standard * Potential Clinical risk extending by 18 week pathways of Patients * Regulatory concerns * Reputational damage Increased Agency cost to service delivery and locums *Financial loss and penalties due to extended pathways and having to outsource of activities to the independent sector to bridge gaps.)	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)	Weekly KPI performance reviews across all specialties Detailed recovery plan at speciality level Daily oversight of production plans to meet RTT EPR to review speciality level metrics Focus meeting in key Specialities **Person Responsible:** Mary Tunbridge **To be implemented by:** 29 Mar 2019	High		I = 3 L = 2 Low (6)
						Annual business plan in place **Control Owner:** Lee Martin	Adequate					
						Daily intensive review/bed matching in place for elective admissions **Control Owner:** Lee Martin	Adequate					
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Lee Martin	Adequate					
						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:** Lee Martin	Adequate					
						Escalations of capacity for outpatients and theatres happen as required **Control Owner:** Christine Hudson	Limited					
						Inpatient bed requirements for Surgical Care Group completed **Control Owner:** Christine Hudson	Adequate					
						Numerical table of residual gap analysis in terms of capacity reported to Finance & Performance Committee **Control Owner:** Lee Martin	Adequate					
						Regular review of Performance for RTT where improvement plans have not delivered the required results **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					
						The Surgical Care Group continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations **Control Owner:** Christine Hudson	Limited		Chronological booking of patients. **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2019	High	**14 Nov 2018** Production plans are being reviewed. This will inform contract discussions and internal business planning. Specialty delivery plans based on capacity, demand and staffing levels are under way.	

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 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:** 01 Oct 2018 **Latest Review Date:** 14 Jan 2019 **Latest Review By:** Paul Stevens **Latest Review Comments:** Risk updated with an additional control. It is certain that implementation of the clinical strategy through the STP will not start this financial year	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 = 3 High (15)	Fully implement the acute medical model on WHH & QEQM sites **Person Responsible:** Richard Kingston **To be implemented by:** 31 Dec 2018	High	**14 Jan 2019** The action is overdue but is also dependent on recruitment to key posts required to implement the action, making it unachievable at present.	I = 5 L = 2 Moderate (10)
						Oversight group in place **Control Owner:** Lee Martin	Adequate					
						Patients return to the K&C site only once medically optimised **Control Owner:** Lee Martin	Adequate		Implementation of the East Kent Clinical Strategy through the STP process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 29 Mar 2019	High	**09 Oct 2018** Public consultation is reliant on the pre-consultation business case (PCBC). Clinical Commissioning Groups now identified the timeline PCBC to be drafted by December 2018.	
						The frequency of senior review, record keeping, escalation and response to escalation for non-elective admissions to the Vascular Surgical Unit at the Kent and Canterbury was reviewed by a notes review conducted by the Medway FT Medical Director & EKHUFT Medical Director. No deficiencies in care were identified. **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 58	Failure to embed Risk Management within the Care Groups **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 11 Dec 2018 **Latest Review Date:** 01 Feb 2019 **Latest Review By:** Helen Goodwin **Latest Review Comments:** Training at Care Group leadership level continues and the risk registers are being updated. The revised Quality and Risk EPRs are in place but the risk element requires further embedding and reporting.	21 Aug 2017	**Cause** *The need for improved engagement from Care Groups 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 Care Groups *Ineffective risk management support structure at Care Group level *Poor usage of risk system (4Risk) *Failure to prioritise risk management training *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:** Helen Goodwin	Adequate	I = 4 L = 3 Moderate (12)	Complete the governance review by the Good Governance Institute **Person Responsible:** Alison Fox **To be implemented by:** 31 Jan 2019	Medium	**17 Jan 2019** The team have been working with the Board of Directors during December and January. On track.	I = 4 L = 1 Low (4)
						4Risk Training resources in place (training videos, guidance and help manuals) **Control Owner:** Helen Goodwin	Adequate		Review of risk management at monthly Risk and Governance Executive Performance Reviews **Person Responsible:** Lee Martin **To be implemented by:** 28 Feb 2019	High	**17 Jan 2019** Part way through the three month implementation - on track.	
						Annual Risk Management Refresher Training/Workshop for Care Group Leaders **Control Owner:** Helen Goodwin	Limited		Care Groups to review their Risk Management Governance arrangements to ensure alignment with the Trust Risk Management Policy **Person Responsible:** Helen Goodwin **To be implemented by:** 28 Feb 2019	High	**17 Jan 2019** Reviewed in the new Quality & Risk Performance meetings. The Governance structures are currently being developed.	
						Annual Risk Maturity Assessment in place **Control Owner:** Helen Goodwin	Adequate		Carry out and implement actions from Internal Audit review of Risk Management arrangements in Care Groups when audit report is approved. **Person Responsible:** Helen Goodwin **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Implementation is being worked up. Some actions in progress.	
						Care Group risk registers on the 4Risk system **Control Owner:** Helen Goodwin	Limited		Consider introducing the role of Care Group/Local Risk Champions in 2018/19 to support embedding Risk Management across Care Groups **Person Responsible:** Helen Goodwin **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** The date has been extended due to the embedding of the Care Group structure and the development of the Governance roles as part of the restructure.	
						Dedicated Risk Management resource in place for the Trust (at Corporate level) **Control Owner:** Helen Goodwin	Limited					
						Local Risk Registers on the 4Risk system **Control Owner:** Helen Goodwin	Limited					
						Quarterly risk review meetings with Care Group Risk Owners **Control Owner:** Helen Goodwin	Adequate					
						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:** Helen Goodwin	Adequate					
						Risk Management Governance arrangements in place at Risk Group, EPR, Management Board, Strategic H&S Committee, Care Group Governance Board, IAGC and Board **Control Owner:** Helen Goodwin	Limited					
						Risk Management Handbook in place that provides detailed guidance on the Trust Risk Management process **Control Owner:** Helen Goodwin	Adequate					
						Risk Management Strategy and Policy in place **Control Owner:** Helen Goodwin	Adequate					
						Trust Risk Leadership Behaviours in place **Control Owner:** Helen Goodwin	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 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:** 16 Nov 2018 **Latest Review Date:** 17 Jan 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions updated.	07 Nov 2016	**Cause** *Increased number of long-stay Patients/delayed discharge *National shortage of Mental Health Nurses *Mental Health Liaison and Crisis teams are unable to recruit into their current vacancies and have relied on agency cover to maintain their rotas. *There is a national shortage of in-patient mental health beds **Effect** *Potential harm to Patients, Staff and Visitors *Patients with recognised mental health disorders may not be treated in a timely way. *There is an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. *Other patients are put at risk of harm from violent episodes. *Patients who require in-patient Mental Health Services are managed in acute facilities which are not fit for this purpose.	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Agency RMN used **Control Owner:** Lee Martin	Adequate	I = 3 L = 4 Moderate (12)	Monitor compliance with the Smart tool usage through the Safeguarding & Dementia teams **Person Responsible:** Sally Hyde **To be implemented by:** 29 Mar 2019	High	**17 Jan 2019** Contact with the audit team has been made to complete this audit.	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, then HCA if the others are not available **Control Owner:** Sally Smith	Adequate					
						Dementia friendly services, environment and specialist team **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 commission intentions up to this date. **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Update received at the A&E Delivery Board from KPMT - work still in progress.	
						Increase in cover arrangements for a 12 hour period across all 3 sites in place **Control Owner:** Lee Martin	Adequate					
						Nominated consultant psychiatrist cover for each site with Band 7 RMN and 5 x Band 6 support to cover 08:00 to 20:00 hours. **Control Owner:** Lee Martin	Adequate		CQC registration is being explored. **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2019	Medium	**17 Jan 2019** We are meeting on the 22 January to agree next steps.	
						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		Implementation of the new guidance for caring for mental health patients in an acute hospital **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** We are joining up the SafeAssist work, Specialling policy work, and Nurse Pool work to describe the model and agree the contract.	
						Regular escalation and meeting between the Trust COO and the COO of KMPT and the CCG is in place. **Control Owner:** Lee Martin	Adequate		KMPT to deliver training to high risk departments. Kate Button and Maddy McCarthy liaising with Sally Hyde **Person Responsible:** Sally Hyde **To be implemented by:** 31 May 2019	High	**17 Jan 2019** MAYBO training commenced on December 19th. First session to teach 200 staff over 3 years, in high risk departments, how to deescalate and control challenging behaviour in the confused patient.	
						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 though GPs and NHS111 **Control Owner:** Lee Martin	Adequate		Review of the policy and action cards to manage challenging behaviour in the clinical areas. The review includes the services that support staff in the workplace and the development of the services and/or contract required to keep people safe. **Person Responsible:** Sally Smith **To be implemented by:** 30 Jun 2019	Medium	**14 Jan 2019** This action has developed into a new action which will be described. A review of the whole service that supports staff with people who display challenging behaviour is underway that includes the action cards. This will be completed by the Summer.	
						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 46	Delays in signing off and implementing Consultant job plans **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 14 Jan 2019 **Latest Review Date:** 14 Jan 2019 **Latest Review By:** Paul Stevens **Latest Review Comments:** Overall compliance with consultant job planning to full sign off is at 81.3% this month	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 new care group compliance with completion of job plans with a view to achieve 100% at the financial year end **Person Responsible:** Jonathan Purday **To be implemented by:** 04 Apr 2019	High	**14 Jan 2019** Overall this month 81.3% of consultant job plans have been fully signed off. Performance by care group underlying that is variable ranging from 100% and 93.6% in the cancer and clinical support services care groups respectively to 68.4% and 63.4% in the 2 medical care groups. The 2 surgical care groups were at 88.2% and 76.8%	I = 3 L = 2 Low (6)
						Job planning policy in place **Control Owner:** Paul Stevens	Limited					
						Job Plans in place **Control Owner:** Andrea Ashman	Limited					
						Monthly compliance reports produced and distributed by the Medical Directors office **Control Owner:** Paul Stevens	Limited					
						Process in place for implementing pay changes as agreed by EMT and Management Board **Control Owner:** Andrea Ashman	Adequate					
CRR 16	Poor complaints management **Risk Owner:** Sally Smith **Delegated Risk Owner:** Jane Christmas **Last Updated:** 11 Dec 2018 **Latest Review Date:** 17 Jan 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions updated.	24 Apr 2016	**Cause** -There is an increasing complexity in the scope and nature of concerns raised. - The processes in the Care Groups and within the Patient Experience Team have resulted in delays across the whole pathway. - The Care Group teams do not always receive timely notification of written complaints. - Staff shortages are impacting on the management of complaints. **Effect** - The ability of the Trust to respond 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 Policy and Process in place **Control Owner:** Jane Christmas	Limited	I = 3 L = 4 Moderate (12)	Implementation of detailed action plan. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Action Plan has been reviewed in January. Improvement seen in acknowledgement times, responses, backlog and PALS timeliness. Still requires focus.	I = 3 L = 3 Moderate (9)
						Complaints team in place with staff based on the three main sites. **Control Owner:** Jane Christmas	Adequate					
						Detailed action plan in place monitored by the Complaints and Patient Feedback Group. **Control Owner:** Jane Christmas	Limited		Review of the complaints process and make recommendations. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Benchmark and governance review in progress. We have met with other similar organisations and have noted similarities in how we function. Review and confirmation of complaints policy / process concluding (anticipated ratification of policy Q4.	
						Process is in place to prevent data capture anomalies **Control Owner:** Jane Christmas	Adequate					
						Regular review of the complaint KPIs with Care Group leads **Control Owner:** Jane Christmas	Adequate		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 2019	Medium	**17 Jan 2019** This will be implemented now the Care Groups are in place.	
						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 Care Groups. **Control Owner:** Sally Smith	Limited					
						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					

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:** Lee Martin **Delegated Risk Owner:** Lesley White **Last Updated:** 01 Feb 2019 **Latest Review Date:** 01 Feb 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Risk reviewed and updated	24 Apr 2016	**Cause** Lack of compliance to the performance standards Process delay in correspondence Gaps in administration workforce Variable compliance with digital technology and outsourcing. **Effect** * Failure to meet Constitutional standard * Patients ongoing care and treatment could be delayed * Reputational damage *Backlog of letters awaiting processing *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)	Collaborative approach with CCGs and GPs regarding outpatient department improvement **Control Owner:** Lee Martin	Adequate	I = 3 L = 4 Moderate (12)	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	**24 Oct 2018** Roll out across the sub-specialities continues with good progress made and letters being generated automatically. Some sub-specialties remain and are actively being progressed.	I = 3 L = 2 Low (6)
						Deep-dives carried out with corresponding action plans in place - these require further review in colorectal and general surgery. **Control Owner:** Susan Travis	Adequate		Monitoring Access Policy against constitutional standards performance **Person Responsible:** Amanda Hallums **To be implemented by:** 31 Jan 2019	Medium	**03 Dec 2018** Access Policy will be presented at the Policy and Compliance Group in December for ratification. Monitoring will be undertaken against constitutional standards.	
						Dual reporting in place **Control Owner:** Julia Bournes	Adequate					
						Performance standards for response times agreed and monitored against the standards **Control Owner:** Christine Hudson	Adequate		Develop an outpatient improvement plan for delivery in 2019/20. **Person Responsible:** Christine Hudson **To be implemented by:** 29 Mar 2019	High		
						Process for Vacancy Panel approval in line with agreed priority in place **Control Owner:** Lee Martin	Adequate					
						Regular feedback from GPs highlighting concerns **Control Owner:** Christine Hudson	Adequate					
						Trust-wide Administrative review to ensure design of new roles to focus on patients pathway (including ensuring correspondence are delivered in a timely way) has been implemented. **Control Owner:** Christine Hudson	Limited					
						Typing of letters outsourced to an external provider with clear turnaround targets. This risk control is effective for the specialities covered, however the contract and funding is in sufficient to support general surgery / colorectal **Control Owner:** Julie Barton	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 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:** 22 Oct 2018 **Latest Review Date:** 16 Jan 2019 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** The programme is configuring and building the system ready for Go Live in November 2019.	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 = 3 Moderate (12)	The programme is configuring and building the system ready for Go Live in November 2019. **Person Responsible:** Lindsey Shorter **To be implemented by:** 30 Nov 2019	Not Set	**16 Jan 2019** The development plan has been agreed and a charge request has been agreed with Allscripts.	I = 4 L = 3 Moderate (12)
						Clinical Safety Risk Management Strategy and Plan in place in line with NHS Digital Guidance **Control Owner:** Lindsey Shorter	Adequate					
						External Assurance Process in place for T3 **Control Owner:** Lindsey Shorter	Substantial					
						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					
						Readiness of the Trust for the T3 Programme has been reviewed **Control Owner:** Richard Earland	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 34	Inadequate Health & Safety (H&S) systems embedded within the Care Groups **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Marion Clayton **Last Updated:** 16 Jan 2019 **Latest Review Date:** 18 Dec 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Persons responsible will be moving from Fin Murray to Marion Clayton in January 2019.	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)	Ensure the new Care Groups achieve compliance with the H&S training KPIs. **Person Responsible:** Rachael Westerman **To be implemented by:** 29 Mar 2019	High	**18 Dec 2018** Meeting being arranged with COO to establish process with Care Groups.	I = 4 L = 2 Moderate (8)
						Care Group deep-dives presented to IAGC by the Care Group **Control Owner:** Elizabeth Shutler	Limited					
						Care Group H&S Improvement Trajectory in place **Control Owner:** Marion Clayton	Limited		Strategic H&S Committee will monitor improvement in Care Group Audit scores for the H&S tool kit. **Person Responsible:** Rachael Westerman **To be implemented by:** 29 Mar 2019	High	**18 Dec 2018** Audit scores reviewed at last meeting in December 2018. Progress to be reviewed at next Strategic Health and Safety Meeting.	
						Care Group H&S structures in place **Control Owner:** Marion Clayton	Adequate					
						Care Group nominated H&S Link workers **Control Owner:** Marion Clayton	Adequate					
						H&S KPIs reported to Board monthly via the IPR **Control Owner:** Marion Clayton	Adequate		To improve attendance at committees, we are combining Site H&S meetings with Site Governance Meetings, chaired by the Site Director. **Person Responsible:** Rachael Westerman **To be implemented by:** 31 Mar 2019	Medium	**18 Dec 2018** Attendance of Care Group representatives to be established following meeting with COO.	
						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:** Ursula Marsh						
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Julie Barton	Adequate					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Heather Munro						
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Karina Greenan	Limited					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Elizabeth Mount	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:** Tara Laybourne						
						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					

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
						Training programme in place **Control Owner:** Fin Murray	Adequate					
CRR 56	Inadequate critical care capacity **Risk Owner:** Sally Smith **Delegated Risk Owner:** Vanessa Purday **Last Updated:** 14 Nov 2018 **Latest Review Date:** 17 Jan 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Action updated.	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 = 3 L = 5 High (15)	Admissions, Discharge and Transfer policy in place **Control Owner:** Deborah Higgs	Limited	I = 3 L = 4 Moderate (12)	Deliver the agreed business case to increase capacity **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Implementation of the business case is in progress.	I = 2 L = 3 Low (6)
						Capacity and demand is known **Control Owner:** Deborah Higgs	Limited					
						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					

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	Operational impact on RTT of new PAS system post implementation **Risk Owner:** Lee Martin **Delegated Risk Owner:** Mary Tunbridge **Last Updated:** 01 Feb 2019 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and the action updated. Date changed as the team are still validating and gathering information from during this time.	04 Oct 2016	**Cause** New PAS has caused sever operational process delays and disruption Training and education of the new system for system users. Duplication of efforts for multiple pathways Carry over of invalidated data Requirement to updated templates for all OPD clinics Cleaning up of the whole live PTL. **Effect** *Regulatory concerns (linked to Trust License) *Significant drop in performance in RTT Potential clinical risk due to convoluted pathways. *Reputational damage *Financial loss *Negative impact on Workforce	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 = 3 Moderate (12)	Implementation of Staff Training plan to ensure no disruption in activities during go-live period **Person Responsible:** Debbie Lowes **To be implemented by:** 31 Dec 2018	High	**14 Nov 2018** Weekly PAS Steering Committee continues to monitor the PAS validation dashboard including training plans for staff.	I = 4 L = 2 Moderate (8)
						Lessons learned/Advise received from other Trusts that have implemented PAS **Control Owner:** Julia Bournes	Adequate		Maintaining the PAS validation dashboard. Assessing the impact on activity and finance. **Person Responsible:** Simon Bailey **To be implemented by:** 29 Mar 2019	High	**14 Nov 2018** SOPs being developed to improved PAS effectiveness and efficiency.	
						Validation and closure of open out patient pathways , so that a reduced volume are transferred over to the new system - this will support delivery of RTT pathways and minimise time taken to validate. **Control Owner:** Lee Martin	Adequate		Complete standard operating procedures for data validation **Person Responsible:** Debbie Lowes **To be implemented by:** 29 Mar 2019	Medium	**14 Nov 2018** Weekly PAS Steering Committee is developing standard operating procedures to improve PAS efficiency	

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 Safeguarding training arrangements Trust-wide (adult and children) **Risk Owner:** Sally Smith **Delegated Risk Owner:** Carol Tilling **Last Updated:** 17 Jan 2019 **Latest Review Date:** 17 Jan 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Residual score reduced due to external assurance received from the CQC regarding good practice, plus the fact that there have not been reported any harm events.	09 Sep 2016	**Cause** *Lack of access to current training data *Failure to prioritise training attendance * Lack of clarity as to what level of training people require (the staff themselves) **Effect** *Regulatory concerns *Legal challenge *Reputational loss *Failure to meet performance standard	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 5 Extreme (20)	4 weekly reporting to CQC for monitoring of safeguarding children training figures across the Trust **Control Owner:** Carol Tilling	Adequate	I = 4 L = 3 Moderate (12)	A cleansing of ESR to ensure accurate reporting **Person Responsible:** Carol Tilling **To be implemented by:** 31 Mar 2019	Medium	**17 Jan 2019** In progress. The plan is to go through this with the Chief Nurse and C&YP team for sign off by March 19.	I = 2 L = 2 Low (4)
						Adult Safeguarding training delivered by e-Learning with face to face training every 3 years at level 2 (Adult) **Control Owner:** Helen Goodwin	Adequate		Care Groups are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Ursula Marsh **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Child Safeguarding - Level 1 is 71%. Level 2 79%. Level 3 85%. The Care Group is mapping non compliant staff against dates. Compliance expected asap for level 1 and 2.	
						Child Safeguarding training delivered by e-Learning with face to face training every 3 years at level 2 (Children) **Control Owner:** Carol Tilling	Adequate		Care Groups are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Tara Laybourne **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** Child Safeguarding - Level 1 is compliant. Level 2 79%. Level 3 65%. The Care Group is mapping non compliant staff against dates. Compliance expected asap.	
						Improvement plans and trajectory in place (Adult) **Control Owner:** Sally Hyde	Adequate		Care Groups 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 2019	High	**15 Jan 2019** Reviewed but awaiting confirmation of December data	
						Improvement plans and trajectory in place (Children) **Control Owner:** Carol Tilling	Limited		Care Groups 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 2019	High	**17 Jan 2019** Child Safeguarding - Level 1 is 91%. Level 2 81%. Level 3 58%. The Care Group is mapping non compliant staff against dates. Compliance expected asap.	
						Monthly training sessions on all sites (Adult) **Control Owner:** Helen Goodwin	Limited		Consider reduction of wards that children and young people are placed across each site to reduce amount of staff requiring training at level 3 **Person Responsible:** Carol Tilling **To be implemented by:** 30 Jun 2019	High	**17 Jan 2019** These discussions are commencing and will be linked to the C&YP's Improvement Plan for monitoring.	
						Non compliant staff are known by name on a monthly basis and followed up. **Control Owner:** Sally Smith	Adequate					
						Safeguarding Team in place **Control Owner:** Sally Smith	Adequate					
						Training needs analysis and Training Programme in place. Training support provided using QII Hubs (Adult) **Control Owner:** Helen Goodwin	Adequate					
						Training needs analysis in place at ward/department level (Children) **Control Owner:** Carol Tilling	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 47	Inability to prevent deterioration in the number of healthcare associated infection metrics **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Valerie Harmon **Last Updated:** 22 Oct 2018 **Latest Review Date:** 14 Jan 2019 **Latest Review By:** Paul Stevens **Latest Review Comments:** Following the visit from the new K&M DIPC and her counterpart in NHSI there are some recommendations to be implemented which will be actioned over the next few months	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)	Check that the diarrhoea assessment tool is both understood and implemented correctly in the Trust inpatient areas **Person Responsible:** Valerie Harmon **To be implemented by:** 31 Dec 2018	High	**22 Oct 2018** The team are site based and work with the staff to ensure competence of the tool. Any non compliance is followed up.	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		To implement the recommendations stemming from the "Stock Take" visit undertaken by the new Kent and Medway Director of Infection Prevention and Control in December 2018. **Person Responsible:** Valerie Harmon **To be implemented by:** 31 Mar 2019	High		
						Environmental cleaning audits in place **Control Owner:** Valerie Harmon	Adequate					
						In December 2018 and January 2019 the Kent and Medway Director of Infection Prevention and Control undertook a visit to review IP&C in East Kent Hospitals over a three day period (one day at QEQMH, one day at WHH and one day at K&CH). There were a number of recommendations which together constitute the actions arising from these visits. **Control Owner:** Paul Stevens	Adequate		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 Mar 2019	High	**22 Oct 2018** The refreshed action plan will be reviewed at the CCG/NHSI Oversight meeting and the Trust IPC.	
						Infection prevention and control work plan in place which encompasses reporting on indicators, mandatory training etc. **Control Owner:** Valerie Harmon	Adequate		Fully implement the recommendations from the anti-microbial stewardship with respect to antibiotic prescribing, especially prescription of Co-amoxiclav **Person Responsible:** Stephen Glass **To be implemented by:** 04 Apr 2019	High		
						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					

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:** Ursula Marsh **Last Updated:** 16 Nov 2018 **Latest Review Date:** 02 Jan 2019 **Latest Review By:** Ursula Marsh **Latest Review Comments:** Failsafe Clerk post going to recruitment following approval of Banding on job description Additional Band 6 has joined the screening team Direct Line manager is Consultant midwife QA ANNB report received and action plan developed	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)	Action plan in place to reduce the NBS Avoidable repeat rate in East Kent **Control Owner:** Rachael Chapman	Limited	I = 3 L = 3 Moderate (9)	Request that the ANNB screen e-learning become mandatory for all MW and midwifery staff. **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Jan 2019	Medium	**17 Jan 2019** In place and staff are being trained.	I = 3 L = 2 Low (6)
						ANNB screening, mandatory training and education regarding antenatal and newborn screening programmes is in place for midwives across the Trust. This is an annual session for midwives plus adhoc sessions as needed. **Control Owner:** Rachael Chapman	Adequate		Explore the need for a dedicated 'failsafe' clerk, who will oversee the tracking of women through the programmes, monitor database, compliance and collate information for KPI's, in turn collating evidence that the Trust has a robust ANNB screening service. **Person Responsible:** Rachael Chapman **To be implemented by:** 28 Feb 2019	Medium	**24 Jan 2019** Job description has been agreed at Midwifery Management requires banding	
						Antenatal and postnatal screening guidelines incorporating new standards are in place. **Control Owner:** Rachael Chapman	Limited		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 2019	High	**17 Jan 2019** Recruitment underway - await update on figures.	
						Antenatal Screening administrator in post **Control Owner:** Sharon Curtis	Limited		Recommence tracking women through the fetal anomaly screening programme. **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Mar 2019	High	**24 Jan 2019** Screening team have commence a basic tracking of women comparing list of women attending ultrasound for NT scan and cross checking with DART.	
						Antenatal Screening Steering Group in place for all stakeholders of the Screening Programme **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	**17 Jan 2019** Electronic pathway being implemented during January 19.	
						Electronic referral system for US scan in place **Control Owner:** Rachael Chapman	Adequate		E3 to be updated to reflect national standards across all screening programmes, both in consenting of tests and recording of results for these tests. **Person Responsible:** Madeleine Harris **To be implemented by:** 31 May 2019	High	**24 Jan 2019** Recent meeting with Jat from EKHUFT Euroking Team. Euroking to be developed to enable recording of consent for different trisomy screening. To be implemented in test mode soon. Other developments to enable recording relating to all screening programmes have been discussed between Rachael Chapman Screening Coordinator and Jat.	
						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	Adequate					
						FASP - Fail safe tracking system for combined screening for chromosomal abnormalities (Down's or Edwards'/Patau's syndromes) **Control Owner:** Rachael Chapman	Limited					
						IDSP/SCT - Community midwives keep a form of log book to check screening results within the recommended period. **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
						Maternity Information Task and Finish Group in place to review the Maternity Pathway **Control Owner:** Rachael Chapman	Limited		Deliver the PHE Screening Action Plan **Person Responsible:** Ursula Marsh **To be implemented by:** 31 Dec 2019	Not Set	**17 Jan 2019** The PHE review report has been received. They suggest an action plan that has target dates at 3, 6 and 12 month intervals. The draft action plan is being finalised and also actioned.	
						Newborn bloodspot, Fail safe tracking system for the New born blood spots screening programme (National/Local database) **Control Owner:** Rachael Chapman	Adequate					
						NIPE Smart System in place (tracking fail safe system for new born examination and referral for any abnormalities including hips) **Control Owner:** Rachael Chapman	Adequate					
						NIPE, 2 nominated person appointed to oversee the NIPE screening program. One midwife and one neonatologists **Control Owner:** Jeanett Salisbury	Adequate					
						NIPE, Tracking of babies who require referral for abnormalities of the heart, eyes, hips and testes following NIPE screening **Control Owner:** Rachael Chapman	Adequate					
						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					
						There is a central results 'log book' database that will ensure CMW are checking and following up results as per national standard **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 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:** Marion Clayton **Last Updated:** 16 Jan 2019 **Latest Review Date:** 18 Dec 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Annual Planning process is identifying Care Group priorities for review.	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:** Marion Clayton	Adequate	I = 3 L = 3 Moderate (9)	SIG to sign off the annual medical equipment priority list. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 May 2019	High	**16 Jan 2019** All Care Groups are on track to meet 21st January deadline for equipment prioritisation.	I = 3 L = 2 Low (6)
						Prioritised list of replacement equipment for 2017/18 in place **Control Owner:** Marion Clayton	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:** Marion Clayton	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:** Marion Clayton	Adequate					
CRR 67	Sustained high level of Ambulance conveyance activity to the QEQM Hospital results in delayed treatment and an inability to stream patients safely **Risk Owner:** Lee Martin **Delegated Risk Owner:** Melissa Blinston **Last Updated:** 16 Nov 2018 **Latest Review Date:** 14 Nov 2018 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** QEQM live audit report received. SECAMB improvement plan in place. SECAMB attend ED leadership group on a monthly basis and one element of the plan is ambulance flow and sharing predictive data.	03 May 2018	**Cause** *Ambulance activity over the past six months as regularly exceeded 100 ambulances conveying patients to the QEQMH. The forecast activity to the site has been set too high and without consultation with the Trust. Performance against this forecast appears to show the QEQM is below the level the department can manage safely and is inaccurate. * The estate and facility infrastructure of the ED at QEQMH in unable to meet the patient demand safely. * There has been an overall decrease in out of hours primary care services since 2016 **Effect** * There are too many patients within a crowded area with insufficient capacity to manage the most sick patients who require majors or resuscitation. * There has been statistically significant variation in activity over the past 7 months. * The ability to segregate paediatrics from the adult population is being affected adversely. * There has been a corresponding increase in activity since the out of hours primary care provision reduced	AO3: Provision: Provide the services needed and do it well	I = 3 L = 3 Moderate (9)	Performance reviewed at Board to Board and monthly performance meetings with Commissioners **Control Owner:** Lee Martin	Limited	I = 3 L = 2 Low (6)	Review of Estate and Facilities and foot print of ED at QEQMH and identify opportunities to develop a plan for building work. **Person Responsible:** Finbarr Murray **To be implemented by:** 31 Dec 2018	High	**22 Oct 2018** New Vangard Theatres have arrived and the Observation Wards are being installed.	I = 3 L = 1 Very Low (3)
						Staff working within agreed policy, SOPs and clinical guidelines to manage patients safely **Control Owner:** Tara Laybourne	Limited					
						Systems wide, multi agency meetings with commissioners and regulators as part of the ED recovery programme **Control Owner:** Lee Martin	Limited		Work with East Kent and North Kent commissioners to agree activity and reporting criteria **Person Responsible:** Tara Laybourne **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Awaiting feedback on aggregated RCA into ambulance activity; responsibility transferred to operational and Care Group management.	
									Explore the opportunity for emergency capital funding from NHSI to cover the potential re-building costs **Person Responsible:** Susan Acott **To be implemented by:** 31 Dec 2018	High	**22 Oct 2018** Observation Wards have been funded and in the process of being installed at WHH and QEQM.	

Strategic Risks Report (By Residual Risk Ranking)

Report Date	01 Feb 2019
Comparison Date	In the past 30 Day(s)

Strategic Risks Report (By Residual Risk Ranking)

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

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 5	Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime **Risk Owner:** Philip Cave **Delegated Risk Owner:** David Baines **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Jan 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** End of month nine we are £6.9 million off plan mainly driven by shortfalls in elective activity. If this trend continues which is likely we will be somewhere around £12 million off plan by year end which will require us to change our control total.	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 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 CCGs 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)	Revise 2019/20 Cost Improvement Plan following review from NHS Improvement **Person Responsible:** Philip Cave **To be implemented by:** 29 Mar 2019	Not Set		I = 5 L = 3 High (15)
						Clinical engagement in delivery of CIPs requiring Clinical Practice changes **Control Owner:** Paul Stevens	Limited		Care Groups to be mobilised to work with the Programme Management Office to deliver the 2019/20 Cost Improvement Programme **Person Responsible:** Lee Martin **To be implemented by:** 29 Mar 2019	Not Set		
						Cost Improvement Plan for 2019/20 developed **Control Owner:** Philip Cave	Adequate					
						Cost Improvement Plan targets in place with workstream in support **Control Owner:** Philip Cave	Adequate		Design and implement finance function training for clinicians **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	Medium	**05 Dec 2018** Commenced in November, General Manager and Matron development commencing in January.	
						Financial Improvement Director in place to provide support **Control Owner:** Susan Acott	Substantial					
						Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Philip Cave	Adequate		Ensure accountability for budgetary management by developing a standard objective for all budget holders **Person Responsible:** Philip Cave **To be implemented by:** 01 Apr 2019	High		
						Financial Recovery Plan in place **Control Owner:** Philip Cave	Substantial					
						Fortnightly confirm and challenge meetings with the Care Groups (including Corporate) **Control Owner:** Philip Cave	Adequate		Develop Trust wide financial culture training for budget holders **Person Responsible:** Philip Cave **To be implemented by:** 28 Jun 2019	High	**09 Jan 2019** An initial training session will be delivered to Care Group Directors on 30 January. A full package will be developed following this for wider dissemination.	
						HFMA training available for staff across the Trust **Control Owner:** Andrea Ashman	Adequate					
						Improved Business Planning process in place for 2019/20 **Control Owner:** Philip Cave	Adequate		Develop strong relationships with commissioners **Person Responsible:** Philip Cave **To be implemented by:** 28 Jun 2019	Medium	**09 Jan 2019** New Finance Director appointed for East Kent CCGs. Meeting arranged for January to begin developing relationships.	
						Local Vacancy Control Panel in place **Control Owner:** Philip Cave	Adequate					
						Monthly Financial Special Measures (FSM) review meetings with NHSI. This has now been combined with the local IAM meeting with NHS I. **Control Owner:** Philip Cave	Substantial					
						New approach to developing CIPs in place **Control Owner:** Philip Cave	Substantial					
						New Care Group (clinically led structure)implemented with action plans to deliver national standards and agreed trajectories. **Control Owner:** Lee Martin	Limited					
						Payment by results infrastructure (coding and data quality) **Control Owner:** Philip Cave	Adequate					
						Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Philip Cave	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						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					
						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					
						Signed MoU in place with commissioners that provides greater clarity on specific areas of agreement which were previously disputed **Control Owner:** Philip Cave	Adequate					
						Workforce and Agency Control Group in place **Control Owner:** Sandra Le Blanc	Limited					
SRR 2	Failure to maintain the quality and standards of patient care **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 17 Jan 2019 **Latest Review Date:** 17 Jan 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk cause amended and actions updated.	20 Jan 2016	**Cause** *The Trust came out of Quality Special Measures early 2017 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. * A particularly difficult and challenging Winter compounded an already pressurised system. * The most recent CQC inspection gave a rating of RI demonstrating a stable position. * Core services unannounced inspection of the Children's and Young People Services. **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 Care Group 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:** Lee Martin **To be implemented by:** 31 Mar 2019	High	**17 Jan 2019** New actions have been implemented in the Winter Plan to mitigate the increased demands over the festive period. QEQM Obs ward is open.	I = 4 L = 2 Moderate (8)
						External Consultancy and NHSI/E support in delivering the improvement programme. **Control Owner:** Lee Martin	Adequate		Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 30 Apr 2019	High	**17 Jan 2019** A refresh of the Quality Strategy is in progress with support from the NHSI Improvement Director. Q3 compliance is currently being assessed.	
						External help from Community Trust, social care, CCGs to deliver improvements in the emergency pathway. **Control Owner:** Lee Martin	Limited		Implementation of the system wide NHSI/NHSE/CQC - Safety Plan **Person Responsible:** Sally Smith **To be implemented by:** 30 Sep 2019	High	**17 Jan 2019** This plan is on-going with new actions included so the date for action completion has been extended. Current actions are on track.	
						Local improvement plan is in place meeting weekly to deliver an improvement plan. **Control Owner:** Lee Martin	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 Sep 2019	High	**17 Jan 2019** Date changed as the we know that the consultation will not be until the Autumn of 2019.	
						NHSI Improvement Director is working with the Trust. **Control Owner:** Sally Smith	Limited		Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 01 Sep 2020	High	**17 Jan 2019** Most actions are on track or completed. The three recording red have actions in place to complete. New actions are being developed to secure assurance of sustainability.	
						Quality Strategy is in place. **Control Owner:** Sally Smith	Limited					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 10	Non-delivery of a timely Sustainability and Transformation Partnership that can be resourced **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 16 Jan 2019 **Latest Review Date:** 18 Dec 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Reviewed	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 = 4 Extreme (20)	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:** 31 Jul 2019	High	**16 Jan 2019** New time line has been proposed by CCGs.	I = 5 L = 2 Moderate (10)
						East Kent Programme Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Susan Acott	Limited					
						Internal Clinical Strategy Group in place **Control Owner:** Elizabeth Shutler	Adequate		Produce Financial Plan linked to delivery of the STP **Person Responsible:** Philip Cave **To be implemented by:** 01 Aug 2019	High	**03 Dec 2018** The action date has been moved back to August in line with the latest guidance from NHS I which sets out that STPs should create a 5 year plan by Summer 2019. A new 10 year NHS plan is due out in December 2018 along with more detailed planning guidance.	
						Kent and Medway STP Programme Board 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:** 31 Oct 2019	High	**16 Jan 2019** Consultation now planned for October 2019.	

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 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:** 21 Dec 2018 **Latest Review Date:** 21 Dec 2018 **Latest Review By:** Simon Hayward **Latest Review Comments:** Agree a Transformation programme of work with clear owners and milestones that links to the Trust priorities - link this to the Trust objective planning for 2019 that is being delivered in January 2019	27 Feb 2017	**Cause** * Lack of experience / capability in the particular area of change * Lack of capacity of those who need to lead and embed the change * Lack of resources to deliver / implement and sustain change * Trust's lack of appetite for change in some areas to be implemented *Unavailability of the space and physical resources to implement and embed improvements * Mechanism / governance structures for Transformation is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to deliver the transformation required to meet Trust objectives * Licence restrictions *Regulatory concerns * Reputational damage	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 Dec 2018	High	**09 Oct 2018** LiA is in place and progressing although the NHSI leadership development business case has not yet been approved by NHSI.	I = 3 L = 2 Low (6)
						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 Trust priorities - link this to the Trust objective planning for 2019 that is being delivered in January 2019 **Person Responsible:** Simon Hayward **To be implemented by:** 22 Feb 2019	High	**13 Nov 2018** New TIG agenda and standard documentation agreed and now being taken to all Care Group leads for first submission by meeting on 14th December	
						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	Adequate					
						Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 4	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Elizabeth Shutler **Last Updated:** 18 Dec 2018 **Latest Review Date:** 14 Nov 2018 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** Clinical Commissioning Group timeline now identifies the Pre-Consultation Business Case (PCBC) to be drafted by December 2018.	20 Jan 2016	**Cause** - Backlog of work (£74million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Elizabeth Shutler	Adequate	I = 4 L = 4 High (16)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee **Person Responsible:** Elizabeth Shutler **To be implemented by:** 29 Mar 2019	High	**18 Dec 2018** PCBC now due for circulation to NHSI and NHSE March 2019.	I = 4 L = 2 Moderate (8)
						Interim Estates Strategy in place **Control Owner:** Elizabeth Shutler	Adequate					
						Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Adequate		The Trust has engaged with NHSI to agree priorities to spend in 18/19 and 19/20. This is with a view to reduce the Trust Backlog position further. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020	High	**18 Dec 2018** Business Case being prepared and will be completed in January 2019 for sign off at Trust Board in March 2019.	
						Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2017/18 **Control Owner:** Elizabeth Shutler	Adequate					
						Risk assessed condition survey carried out every 5 years (rolling interim plan every 18months) **Control Owner:** Elizabeth Shutler	Adequate					
						Statutory Compliance dashboard in place **Control Owner:** Elizabeth Shutler	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 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:** 21 Jan 2019 **Latest Review Date:** 21 Jan 2019 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Full record reviewed. Actions are on track for delivery but risk remains unaltered at this time.	23 Feb 2016	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff * Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) * Uncertainty due to the STP plans * Increase in service demand * Potential negative impact that may arise from the publication of the Staff Survey Results. * Reputation of some medical specialties * Split site organisation increases the intensity of on call rotas **Effect** * Potential negative impact on patient outcomes and experience * High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups * Patient safety * Service delivery * Turnover * Unsafe staffing * Overtime * Withdrawal of GMC support	AO2: People: Identify, recruit and develop talented staff	I = 5 L = 5 Extreme (25)	The Trust has a plan in place that supports the retention of newly qualified nursing staff locally. **Control Owner:** Sally Smith	Adequate	I = 5 L = 3 High (15)	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:** 28 Feb 2019	High	**23 Nov 2018** Working with the Chair of the Strategic Workforce Committee to develop the KPIs	I = 5 L = 3 High (15)
						Care Group Great Place to Work Action Plans in place **Control Owner:** Jane Waters	Adequate					
						Hard to recruit plan in place and being implemented **Control Owner:** Louise Goldup	Adequate		Revise and implement Care Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 29 Mar 2019	High	**22 Jan 2019** LiA project teams are holding their CrowdFixing events during January & February 2019. 'Pass it on' celebratory events are planned for late April/early May. LiA verbatim feedback will be provided to Care Group LTs at the same time as Staff Survey feedback (Feb/Mar)	
						Implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Adequate					
						Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Adequate		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	**09 Oct 2018** As per previous action - update received today at October's SWC. Some additional actions agreed to ensure we retain our staff and recruit the people we need as we expand for Winter.	
						Recruitment process in place **Control Owner:** Andrea Ashman	Adequate					
						Revised recruitment process has been implemented **Control Owner:** Andrea Ashman	Adequate					
						Staff Performance Appraisals in place **Control Owner:** Jane Waters	Substantial		Develop and implement a plan to recruit nurses from the UK and Europe **Person Responsible:** Louise Goldup **To be implemented by:** 30 Apr 2019	High	**09 Oct 2018** The plan is in place. The Board has approved the attract and retention initiatives. This is monitored monthly through the IPR.	
						Training plans in place in each Care Group / corporate area that supports staff development. **Control Owner:** Andrea Ashman	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 12	Insufficient capacity and capability of the leadership team (Executive and Care Group Clinical Directors) to develop and deliver key strategies and recovery plans **Risk Owner:** Susan Acott **Delegated Risk Owner:** Andrea Ashman **Last Updated:** 09 Jan 2019 **Latest Review Date:** 21 Jan 2019 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Date for delivery of leadership development against leadership framework amended to reflect roll out of current programme	01 Jun 2016	**Cause** *The Trust is not meeting its constitutional standards *Large number of complex priorities that need to be delivered including the sustainability and transformation plan, A&E recovery plan, Financial Special Measures turnaround plan, Cost Improvement Plans as well as business as usual *The Trust is under the Financial Special Measures regime *Those tasked with delivery have focus diverted due to other urgent external matters *The move of acute medicine, acute geriatric medicine and Stroke from the K&C site *Governance structure fails to support the delivery of CIPs *Increased Patient activity in A&E during the winter period **Effect** * Inability to achieve strategic priorities * Failure to come out of Financial special measures * Further Regulation action/concerns * Reputational damage * Financial loss * Negative impact on patient safety / care / experience * Reduced staff morale * Failure to meet operational performance standards (RTT/A&E/Cancer) * Failure to meet regulatory requirements (CQC / NHSI, GMC and HEKSS)	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 5 Extreme (20)	Chief Executive in place (experienced CEO in the NHS) **Control Owner:** Steven Smith	Adequate	I = 3 L = 3 Moderate (9)	To finalise the Trust–wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme. **Person Responsible:** Jane Waters **To be implemented by:** 31 Dec 2018	High	**22 Jan 2019** Work still on-going to complete the electronic framework. It is due to be presented at the Strategic Workforce Committee in April 2019.	I = 3 L = 2 Low (6)
						Business Partnering roles in place (Finance, HR & Information) together with support from central governance team. They are an integral part of the Care Group Leadership Team (Capacity) **Control Owner:** Lee Martin	Adequate		Develop operational leadership and tactical competencies at Clinical Director, Head of Nursing and Director of Operations level, General Manager and Matron level provided by external facilitator and NHS Elect. **Person Responsible:** Lee Martin **To be implemented by:** 29 Mar 2019	Not Set		
						Care Group Clinical Director responsible for the national Performance Standards e.g. Cancer, ED, 18weeks (Capacity) **Control Owner:** Lee Martin	Limited					
						Deputy Chief Operating Officers appointed with both site and portfolio responsibilities. **Control Owner:** Lee Martin	Limited		Review of key action plans in line with capacity and capability (A&E Improvement Plan and Cancer) **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	High	**05 Dec 2018** Action plans underway	
						Director of Finance in place with continuity in delivery of the FSM **Control Owner:** Susan Acott	Adequate					
						Experienced COO appointed **Control Owner:** Susan Acott	Adequate		Design and deliver the Executive Development and Leadership Development Programme **Person Responsible:** Andrea Ashman **To be implemented by:** 01 Apr 2019	High	**09 Oct 2018** Plum are working with the Trust to develop the new Care group leadership and management development.	
						External Consultancy Support (2020, Carnal Farrar, A&E Improvement Director, Financial Improvement Director) supporting Care Groups and the Corporate Team to deliver transformation programmes (Capacity) **Control Owner:** Lee Martin	Adequate					
						External training of Board aligned with the Well-led CQC standards. **Control Owner:** Alison Fox	Adequate		Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Dec 2019	High	**23 Nov 2018** The Leadership Framework was presented to Senior Leads in September at a Leadership Away Day. First cohort of Care Group Leadership teams commenced development programme Friday 16 November.	
						Leadership Development Plans and targeted development plans for individuals in place (Capability) **Control Owner:** Andrea Ashman	Adequate					
						Leadership development programme in place for Clinical staff all professions (Capability) **Control Owner:** Sally Smith	Adequate					
						New clinician development programme (now into the 6th cohort) (Capability) **Control Owner:** Paul Stevens	Adequate					
						Outline Programme Plan in place for the Leadership Development Programme (Capability) **Control Owner:** Andrea Ashman	Limited					
						Performance Reviews in place where delivery is challenged to support senior leadership team in prioritising and highlighting competing pressures (Capacity) **Control Owner:** Susan Acott	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Recent appointment to two key posts in the Trust below Executive Director level (Capability) **Control Owner:** Andrea Ashman	Adequate					
						Substantive staff in place for Executive and Care Group Clinical Director positions (Capacity) **Control Owner:** Andrea Ashman	Adequate					
						Succession Plan in place for Executive Directors, Care Group Clinical Directors, Care Group Directors and key posts to the organisation **Control Owner:** Andrea Ashman	Limited					
						Systems in place through the Nominations and Remuneration Committee for all Board level recruitment **Control Owner:** Andrea Ashman	Adequate					
						Targeted resources into key CIP schemes in place e.g. patient flow, Cardiology (Capacity) **Control Owner:** Philip Cave	Limited					
						Transformation Programme in place (designed and resourced) (Capacity) **Control Owner:** Simon Hayward	Limited					

BRIBERY ACT COMPLIANCE STATEMENT **18/121**

REPORT TO:	**BOARD OF DIRECTORS**
DATE:	**7 FEBRUARY 2019**
SUBJECT:	**BRIBERY ACT COMPLIANCE STATEMENT**
BOARD SPONSOR:	**DIRECTOR OF FINANCE AND PERFORMANCE MANAGEMENT**
PAPER AUTHOR:	**DIRECTOR OF FINANCE AND PERFORMANCE MANAGEMENT**
PURPOSE:	**APPROVAL**
APPENDICES	**APPENDIX 1 – BRIBERY ACT COMPLIANCE STATEMENT**

BACKGROUND AND EXECUTIVE SUMMARY

TIAA provide a service to the Board to put in place mechanisms to reduce and where required identify and investigate fraud. Part of this work relates to bribery and corruption and the Board are asked to agree the attached statement which will then be cascaded to staff.

The statement confirms that the Board has a zero-tolerance to fraud, bribery and corruption. The Integrated Audit and Governance Committee receive regular reports from TIAA on investigations in to any cases where fraud, bribery or corruption is suspected.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	There is a potential risk of staff exposure to fraud, bribery and corruption. The statement ensures the re-affirmation of the Board's zero-tolerance approach to fraud, bribery and corruption. The Trust has robust controls, policies and procedures in place to prevent fraud, bribery and corruption.
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	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Integrated Audit and Governance Committee (IAGC) have discussed the Bribery Act Statement

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board adopts the Bribery Act Statement and asks the Trust Secretary to arrange for it to be cascaded to staff.

Bribery Act: Statement of Executive Support

East Kent Hospitals University NHS Foundation Trust (hereafter referred to as "the Trust") is committed to delivering good governance and has always expected its directors and staff to meet the highest standards of business conduct.

The Bribery Act 2010 came into force on 1 July 2011. The aim of the act is to tackle bribery and corruption in both the private and public sector.

The Act defines the following key offences with regard to bribery:

- Active bribery (offering, promising or giving a bribe);
- Passive bribery (requesting, agreeing to receive or accepting a bribe); and
- Bribery of a foreign public official.

The Act also sets out a corporate offence of failing to prevent bribery by an organisation not having adequate preventative procedures in place.

One of the six principles of the Act demands that there is top level commitment in the organisation for preventing bribery. The Trust is committed to ensuring compliance with the Act and discussions have been held at both the Board and its Audit Committee to ensure that the requirements of the Act are fully complied with.

The Trust has robust controls, policies and procedures in place to prevent fraud, corruption or bribery. The Trusts Counter Fraud Specialist can be contacted if staff have any concerns of fraud, corruption or bribery and the Trust has an annual plan to mitigate the risks of fraud, corruption and bribery.

On behalf of the Trust I would like to re-affirm our commitment to ensuring that the Trust is free from fraud, corruption or bribery and that all staff are aware of their responsibilities in relation to the prevention of fraud, corruption or bribery.

Do you have concerns about a fraud taking place in the NHS?

NHS Fraud, Bribery and Corruption Reporting Line: 0800 028 40 60 calls will be treated in confidence and investigated by professionally trained staff. Online: www.reportnhsfraud.nhs.uk

Your Nominated Counter Fraud Specialist is, Steffan Wilkinson who can be contacted by emailing steffan.wilkinson@tiaa.co.uk or telephone on 07799 263 978.