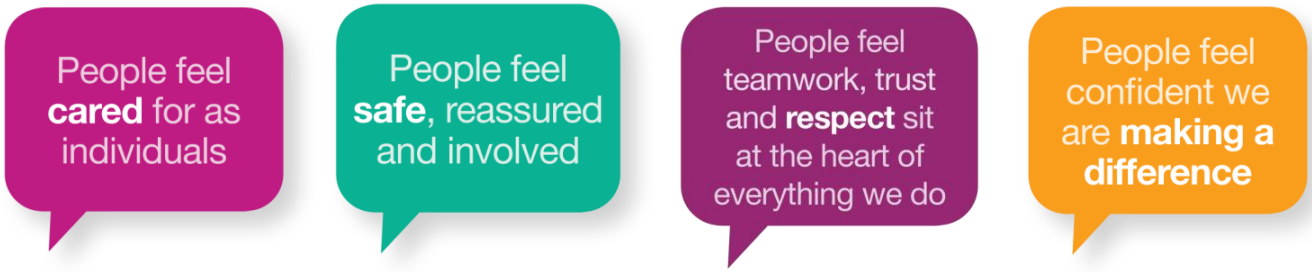
East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS MEETING – THURSDAY 7 MARCH 2019

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place in the **Lecture Theatre, Education Centre, Queen Elizabeth the Queen Mother Hospital, St Peters Road, Margate, Kent, CT9 4AN**, commencing at **9:45 a.m. to 12:35 p.m**.

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



AGENDA

18/

OPENING MATTERS				
124	Chairman's welcome		**09:45**	Chair
125	Apologies for Absence			
126	Declaration of Interests			
127	Minutes of Previous Meeting held on 7 February 2019			
128	Matters Arising from the Minutes on 7 February 2019			
129	Chair's Report	**Discussion**	**10:00** **10 mins**	Chair
130	Chief Executive's Report	**Discussion**	**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				
131	Patient Experience Story	**Discussion**	**10:20** **30 mins**	Chief Nurse and Director of Quality/ Medical Director

East Kent Hospitals University NHS Foundation Trust

132	Care Quality Commission (CQC) Update	**Information**	**10:50** **20 mins**	Chief Executive/ Chief Nurse and Director of Quality
133	Medical Director's Report	**Discussion**	**11:10** **10 mins**	Medical Director
134	Quality Committee - Chair Report	**Approval**	**11:20** **5 mins**	Chair Quality Committee – Barry Wilding
	TEA/COFFEE BREAK		**11:25** **10 mins**	
	PEOPLE: Attracting the best people to our team, who are passionate, motivate and feel able to make a difference and investing in them.			
135	Nominations and Remuneration Committee – Chair Report	**Approval**	**11:35** **5 mins**	Chair Nominations and Remuneration Committee – Wendy Cookson
136	Strategic Workforce Committee – Chair Report • Terms of Reference • Equality Information	**Approval**	**11:40** **5 mins**	Chair Strategic Workforce Committee – Jane Ollis
	PROVISION: The provision of high quality care through the use of technology, research, education, innovation and intelligence.			
137	Finance and Performance Committee – Chair Report	**Approval**	**11:45** **5 mins**	Chair Finance and Performance Committee – Sunny Adeusi
138	Corporate Reporting		**11:50** **30 mins**	
	138.1 Integrated Performance Report	**Discussion**		Chief Executive / Executive Team
	138.2 Full Corporate/Highest Mitigated Strategic Risks Report	**Discussion**		Chief Nurse and Director of Quality/ Executive Team
	138.3 Board Assurance Framework, Quarter 3	**Discussion**		Trust Secretary

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East Kent Hospitals University NHS Foundation Trust

CLOSING MATTERS

139 Any other business

140 **QUESTIONS FROM THE PUBLIC** **12:20**
15 mins

Date of Next Meeting
Friday 4 April 2019 in the Board Room, William Harvey Hospital, Ashford.
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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

UNCONFIRMED MINUTES OF THE NINETY-FIRST MEETING OF THE BOARD OF DIRECTORS
THURSDAY 7 FEBRUARY 2019 AT 09:45 AM
BOARD ROOM, WILLIAM HARVEY HOSPITAL, ASHFORD

PRESENT:

Professor S Smith	Chair	StS
Ms S Acott	Chief Executive Officer	SAc
Mr S Adeusi	Non-Executive Director	SA
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
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
Mr D Baines	Deputy Finance Director (representing Mr P Cave, Director of Finance and Performance Management)	DB
Ms J Cristall	Interim Head of Critical Care and Outreach Services (for Agenda Number 18/112)	JCr
Mrs A Fox	Trust Secretary	AF
Mr N Goodger	Deputy Medical Director (representing Dr P Stevens, Medical Director)	NG
Mrs D Otite	Programme Manager, Trust Secretariat (Minutes)	DO
Dr M Webb	Associate Medical Director for Patient Safety (for Agenda Number 18/112)	MW
Ms N Yost	Director of Communications and Engagement	NY

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs S Andrews
Mr K Rogers
Mrs J Whorwell
Mr Z Al-Wattar
Mrs M Smith
Mr J Ransley
Mr W Wastall
Mrs J Chittenden
Dr J East
Dr J Sewell
Mr B Thew
Mrs C Heggie

MINUTE NO.		ACTION
18/105	**CHAIRMAN'S WELCOME**	

CHAIR'S INITIALS ……

The Chair welcomed attendees to the meeting. Condolences were passed to John Smith on the passing of his wife, Frances Smith.

18/106 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Dr P Stevens (PS), Medical Director; Mr P Cave (PC), Director of Finance and Performance Management; and Ms Sandra Le Blanc (SLB), Director of Human Resources.

18/107 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

18/108 **MINUTES OF THE PREVIOUS MEETING HELD ON 6 DECEMBER 2018**

The minutes of the Board meeting on 6 December 2018 were adopted as an accurate record.

18/109 **MATTERS ARISING FROM THE MINUTES ON 6 DECEMBER 2018**

015/18: Information relating to accommodation for parents - LM reported that accommodation for families had been built into the Women's and Children's Care Group business plan for 2019/20.

016/18: Circulation of paper highlighting commercial growth opportunities for the Trust - **Action closed.**

017/18: Circulation of the productivity and recovery plan for electives and finances - **Action closed.**

018/18: Review of the IPR Report – The executives had met with Simon Bailey who would construct a new streamlined performance report.

The Board **NOTED** the updates provided; the closed actions and those for future Board meetings.

18/110 **CHAIR'S REPORT**

The Chair reported that he had attended the Annual Chairs' Conference. It was the intention of the health service that all Acute Trusts would break even during the next three years. The number of Foundation Trusts would be reduced by one half over the next year or two, which mirrored the changes at NHS England and NHS Improvement where all senior posts were being merged.

There would be no control total at the Trust as of 4 April, but there would be a shared system control total across East Kent.

The Chair had visited Frimley Park Hospital, a Trust rated by the Care Quality Commission as an outstanding trust, and noted that it had never had a deficit in its history, although it was situated in the highest socio-economic part of the United Kingdom.

The Deed of Variation for 2gether Support Solutions had been authorised. The Trust would have a part to play in ensuring that the performance was satisfactory.

SRe was congratulated on his appointment to the Military Division's Most Honourable Order of the Bath as a CB - Companion.

The Haemophilia Centre had received a grant of £250,000 for research, reflecting the Trust's excellence in that clinical area.

The Council of Governors had held an away day to discuss the Trust's strategy and a strategy document would be made available by April 2019. The joint site visits with the Governors were continuing.

SA queried what messages the Chair had taken from Frimley Park visit. The Chair highlighted that Frimley Park had been a single site institution when it was rated outstanding. SAc noted that there was a continuity of leadership and a strong family-oriented culture that put staff first.

NM queried what positive action the Executives would take as a result of the visit. SAc noted that it had been useful to test the Trust's strategy development and learning from the Quality Improvement processes. Further discussions in this regard were underway with the Frimley Park Chief Executive.

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

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

SAc informed the Board that the Trust had been the host for the advertisement for the NHS with one film focusing on the role of support staff. A short video-clip was played for the Boards viewing.

ACTION: Circulate the video clip to the Board. NY

The observation ward had opened in Margate a few weeks ago and the observation ward would open at the William Harvey during the week of 11 February. The resus area had opened at the William Harvey.

SAc had met with Tracey Kerly, the Leader of Ashford Borough Council, to discuss joint working opportunities with the Trust.

There were 10 Listening into Action projects that were at the stage of holding events to gather ideas from staff.

SAc reported her attendance at a presentation by staff members who participated in the Kent Programme (a programme for empowering participants with the knowledge and skills to implement change and improvement within the Trust).

SAc had attended the National Institute for Health and Care Excellence (NICE) Annual General Meeting, and noted that they had been transparent about their work.

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

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

Ms Cristall, Acting Senior Matron in Critical Care, and Dr Webb, Renal Consultant were introduced by SSm as the current Freedom to Speak Up Guardians. Mr Nitin Shrotri, the third guardian, was unable to attend.

Ms Cristall reported that the key themes being brought to the Guardians were around lack of leadership and lack of opportunity for staff to raise concerns at a local level. Active listening was poor and some environments did not support open and honest conversations.

A dedicated telephone number had been provided and a new icon on desktops would be available as of 1 March 2019 to allow anonymous reporting.

WC suggested considering how to reward people who came forward. AA stated that a culture shift was taking place due to Listening into Action and Freedom to Speak Up was part of the induction training.

SRe highlighted that reluctance to speak up was symptomatic of a poor culture, and emphasised the need to promote a culture of 'polite challenge'. There would be a focus on applauding people who spoke up and showing how this had made a difference.

MW suggested that more training around active listening was needed, because those speaking up had not been listened to at a local level.

LM highlighted the need to ensure that the night team had access to the Guardians.

The Board discussed and **NOTED** the Freedom to Speak Up Guardians Annual Report.

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

NG informed the Board that the Kent and Medway Medical School had passed its stage three accreditation process with the General Medical Council (GMC). The GMC would visit the school in the summer.

Duty of Candour compliance had increased to 80% for the initial letter and 68% for the final letter. The legal requirement was 100%, and the aim was to hit that as soon as possible. The Board required assurance that the Trust was acting legally.

ACTION: Board to be informed of the deadline for achieving 100% Duty of Candour compliance. PS

The child safeguarding compliance across the Trust was 90% for all staff, and 77% for medical staff. There was weekly reporting to the Medical Director's office of non-complaint staff and time was booked for them to attend training. A lot of the non-compliance related to junior doctors who had completed safeguarding training in other organisations.

WC highlighted that the number that had not been trained was not clear. WC stated that the Board could not accept the incomplete training for doctors any further. SSm noted that CQC had given external assurance that the child safeguarding activities were positive and no adverse incidents had been reported.

It was confirmed that the standard was 85% paediatric safeguarding training, and the deadline to achieve this was the end of March 2019.

ACTION: Confirmation to be provided to the Board of levels of child safeguarding training required and trajectory for achieving this. — SSm

The feedback from the National Lung Cancer Audit 2018 highlighted two areas where the Trust was an outliner compared to the national means: in systemic anti-cancer therapy in advanced non-small cell lung cancer, and in chemotherapy of small-cell lung cancer. The Trust was not an outlier for one year survival.

A significant number of patients had either declined chemotherapy or were not fit for chemotherapy. This was due to the length of the lung cancer pathway, so work was underway to ensure that patients were aware of the importance of attending their two week wait appointments.

The Board required confirmation of when the Trust would reach the national mean.

ACTION: Board to be assured of Trust's trajectory for reaching the national mean. — LM/PS

LM explained that the Trust was compliant in two week wait and 31 days, and had been for six weeks. The main concern was ensuring the two week wait patients received their appointment to detect the patients who could have surgery. The Chair confirmed that the Trust had only just become compliant with the two week wait, so it would take some time for that to feed through the system, but the necessary changes had been made for patients to be seen and treated as quickly as possible.

WC noted the importance of highlighting the lead indicators that were improving in the report.

The uptake of the influenza vaccination programme by clinical staff was 77%. There had been small norovirus outbreaks across three sites involving 26 patients and eight staff.

The William Harvey Hospital neonatal intensive care pseudomonas incident had been closed by Public Health England and the actions had been completed.

A stocktake visit by the Kent & Medway Director of Infection Prevention and Control had fed back informally that there were areas of good practice, and some work to be done around exchanging fabric materials for single use devices. WC queried why the Trust still had linen curtains. SAc would consult Val Harman about practices in other hospitals. LM noted that in critical areas disposable curtains were used.

ACTION: Obtain advice from Val Harmon about practices in other hospitals. — SAc

The Chair queried whether the C.diff and MRSA rates were compliant. NG confirmed that the C.diff rate was 36 at the end of January and the NHS trajectory was 37. The MRSA rate goal was zero, and the post-48 hours MRSA bacteremia was five, of which four were avoidable. There had been no cases since November 2018.

The Board discussed and **NOTED** the Medical Director's report.

18/114 **MEDICAL DIRECTOR'S MORTALITY REPORT**

NG reported that the crude mortality rate two year trend was 0.2% higher than the peer trend at 1.4% over the last 12 months. The hospital standardised mortality rate fell between the 25th and 50th percentile of acute trust peers at a rate of 95.7, below the peer group at 97.6. The risk associated mortality index was 89.1, slightly higher than the peer value of 86.7. The summary hospital mortality index stood at 1.05, which as 'as expected'.

There was a rollout of the national learning from avoidable deaths programme. There were 79 trained reviewers who had completed 269 reviews, which was 6%. The goal was to reach 30% of deaths. The number of patients with a palliative care code was low compared to the average at 24.6% versus 32.5%. The Chair requested assurance that the Trust was at the 50th centile for coding for palliative deaths.

ACTION: Confirmation that the Trust was at the 50th centile for coding palliative deaths. PS/NG

The Board discussed and **NOTED** the Medical Director's Mortality report.

18/115 **QUALITY COMMITTEE – CHAIR REPORT**

BW reported that the Quality Committee would become a forum in which to demonstrate the continuous improvement of the service and care to patients. The Terms of Reference and membership had been reviewed to ensure they were appropriate.

DECISION: The Board discussed and **APPROVED** the Quality Committee Chair report.

18/116 **INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC) – CHAIR REPORT**

- **REVISED RISK MANAGEMENT STRATEGY AND POLICY**
- **BOARD ASSURANCE FRAMEWORK (BAF)**
- **ANNUAL PRIORITIES 2018/19**
- **IAGC TERMS OF REFERENCE**

BW explained that the number of high and extreme risks remaining on the Risk Register made it almost inevitable that some would crystallise in the coming year.

WC noted the lack of improvements by the health and safety team. BW and KP had a meeting scheduled with LS to discuss this.

There plan was to move towards a risk management system that would show improvement in the mitigation actions and risk scores over the coming months. The revised governance structure would support this process.

SRe recommended separating out the risks that had crystallised and had to be tolerated and those that could be mitigated.

There would be a move to look at the leading risk indicators rather than the lagging ones, so that action could be taken.

SAc advised that the Chief Nurse should not be a member of the IAGC. AF would look at other NHS Foundation Trusts (FTs) to determine the precedent.

ACTION: Look across the NHS FTs and revert to Board with a recommendation in line with standard membership practice. AF

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

i) The Integrated Audit and Governance Committee Chair report;
ii) The revised Risk Management Strategy and Policy; and
iii) The revised IAGC Terms of Reference.

18/117 **FINANCE PERFORMANCE COMMITTEE – CHAIR REPORT**

SA informed the Board that the Trust was currently £6.5m adverse to plan in terms of the run rate, largely due to electives operating £7-8m behind plan and spending above the agency cap. The agency cap was £19m, with £13-14m above that level. The COO had a plan to bridge the gap on the elective activity, but there was not time to close it. The current end of year forecast was £42.2m deficit revised from the original £3m.

The monthly overspend had been £0.5 m, but this had increased to £2m for the final four months. DB explained that the agency problem had been present through the year, but the increase had been driven by the lack of elective work.

LM highlighted three issues that explained the lack of elective work. The gap in orthopaedic capacity; the heavy workload scheduled for the winter months; and the production plans based on a run rate that had required recruitment and improvements that had not come to fruition. LM was trying to drive elective surgery activity as much as possible to the end of the year, but the inpatient load might have to slow if there was bad weather.

LM confirmed that orthopaedics had hit the sessions required and was now ensuring that the utilisation was achieving above plan in a cost-effective manner.

LM noted that there were audits of PAS underway that would be completed by the following week. The audit would be repeated at the end of year. LM did not think that any income would be lost.

SA suggested that the Executives should give some consideration to the theatre programme for the new year. LM noted that there was an immediate programme, and the bigger programme would be completed in the first quarter.

AA explained that a positive working relationship had developed between finance,

HR and Ops around the controls on agency and there had been a step change in the level of challenge of agency use.

SRe queried how much of the unbudgeted winter plan cost had contributed to the cost pressure. DB confirmed that the additional infrastructure had cost around £12m, which had been offset by an increase in non-elective income resulting in a true net cost of £4-5m to the organisation. LM noted that if the 40 beds had been closed as expected and the capacity in the community working as it could, the escalation wards would not have had to be opened.

A review was being completed to understand whether the extra capacity added for winter pressures could be dialled back. LM noted they would try to reduce capacity daily, but it was difficult without the extra health economy capacity.

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

18/118 **STRATEGIC WORKFORCE COMMITTEE – CHAIR REPORT**

JO reported that the SWC was focused on a strategic outlook for workforce requirements in the future. At a National level, the results of the Test of English Language as a Foreign Language (TOEFL) review was due shortly and the Trust should be leading the implementation of the findings. JO highlighted that all staff should be trained and aware of the Quality Improvement (QI) methodology the Trust would be using.

NHSI had visited and had been keen to look at the Trust's grip and control. AA noted that it had been a positive conversation and the Trust had provided evidence of controls.

SAc noted that now the GMC hurdle had been passed, the Trust should ensure that the next steps for the medical school were being taken at pace.

SAc queried when a smart and intelligent workforce strategy could be expected. AA stated that a strategy that was more aligned to new ways of working would be produced in the next couple of months.

SAc advised that there should be quality oversight of the new clinical roles to ensure they were maintained in the right way.

LM highlighted that the work was underway to help clinical directors to think about patient need and whether care can be provided in a different way.

DECISION: The Board discussed and **APPROVED** the Strategic Workforce Committee Chair Report.

18/119 **CHARITABLE FUNDS COMMITTEE – CHAIR REPORT**

KP noted that following the Dementia Appeal there were now over 300 Dementia Friends in the Trust. The Charitable Funds Committee would be working in partnership with the League of Friends on the Critical Care Garden Project.

DECISION: The Board discussed and **APPROVED** the Charitable Funds Committee Chair Report.

18/120 **CORPORATE REPORTING**

18/120.1 **INTEGRATED PERFORMANCE REPORT**

SAc highlighted that there continued to be good relative performance and significant improvement around access targets. The 52 week wait continued to reduce, there was improvement around cancer, and A&E was performing better than last year. The falls rate had increased and there were issues with hand hygiene.

SSm noted that 'get up: get moving' would result in a greater number of falls, but the Trust was aiming for 'no harm' falls. There had been 99% harm free care in December. The mixed sex breaches had increased as a result of pressures in ED.

The experience in ED remained a hot spot. Peer reviews and observations of practice were taking place cross the ED. There was assurance in place to check hand hygiene compliance.

VTE assessment over the past 12 months had dipped to 92.6% overall. The prevalence of new VTEs was 0.58%, lower than the national average. The prevalence of new pressure ulcers was 0.1% compared to a national average of 0.78%.

SAc requested that there was a push to close the StEIS never events. SSm would take this to Quality Committee.

A&E performance in December stood at 79.3%. The ED flow coordinators were in place. There were two hourly conversations with SECAmb. The community capacity and flow of inpatient beds had caused delays. The ED performance in January was lower with some very difficult days due to the colder weather.

On RTT there were about 3,000 tasks that had come out of the PAS validation exercise. The Trust had increased its performance by 5% in the past two weeks. The Trust was on trajectory to reduce its 52 week waiters; currently 74 patients were waiting longer than 52 weeks against a plan of 150.

Cancer had improved significantly over the last six months. The waiting list had reduced from 3,500 to under 2,000. There were three patients waiting longer than 104 days who would be treated outside the Trust. In December diagnostics had performed at 99.2% and 99.7% in January.

KP noted the daily A&E figures for QEQM were always worse than William Harvey. LM noted that there was a shortage of community packages at QEQM.

NM queried the increased number of delayed transfer of care patients (DTOCs) and did not attends (DNAs). LM noted that the DNAs were related to the system not coming back on line quickly enough after PAS. There were currently 112 DTOCs, due to the increase in seven day patients that were now tripping into 21 days. Spot purchase community beds were being utilised.

WC noted that the statutory training had breached the lower control limit. The clinical directors were monitoring mandatory training and holding people to account at a local level. There had been some problems with the ESR package that was a

national issue.

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

18/121 **BRIBERY ACT COMPLIANCE**

DB introduced the Bribery Act Compliance Report. The Board adopted the Bribery Act Statement. AF confirmed that the statement had been scheduled to go out to staff.

DECISION: The Board **APPROVED** and adopted the Bribery Act Compliance Statement.

18/120.2 **FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**

SSm reported that the Trust was carrying two extreme risks and eight high risks on the corporate register; and four extreme and two high risks on the strategic risk register. The residual score of the safeguarding training risk had been reduced based on the external assurance received from CQC around good practice.

SAc highlighted that the care hours on the nursing side were all red. There were five ward areas that were below 80% actual staffing versus planned staffing. The ward staffing establishment review would take place in May 2019.

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

18/122 **ANY OTHER BUSINESS**

There was no other business.

18/123 **QUESTIONS FROM THE PUBLIC**

Mr Rogers requested clarity around the extra cost of the agency staff as compared to Trust staff. DB stated that the net difference was £4 – £5m cost to the Trust. It was confirmed that the Trust had not gone over the FTE budget.

Mrs Cole queried whether the Trust had calculated the cost difference between an employee and an agency worker. AA confirmed that the costs could be mapped.

Mrs Whorwell asked whether Ashford Borough Council and East Canterbury City Council had any plans to construct accommodation for the medical school students. SAc noted that the students would be accommodated on the university, but the issue of housing for keyworkers had been discussed.

Mrs Heggie highlighted that 13 cases for the Freedom to Speak Up Guardian over a year for 8,000 staff was not a success. SSm noted that the Trust benchmarked its speak-ups nationally and it was not an outlier. There was work underway to gain feedback on what prevented people from speaking up.

The Chair closed the meeting at 12:48 p.m.

Date of next meeting in public: Thursday 7 March 2019 in the Lecture Theatre, Queen Elizabeth the Queen Mother Hospital, Margate.

Signature _____

Date _____

CHAIR'S INITIALS ……

OPEN ACTIONS **18/128**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 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 HELD ON 7 FEBRUARY 2019**

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/015/18 - Gather information relating to accommodation for parents at other hospitals to feed into the business planning process.
   - B/018/18 – Circulate video clip to Board.
   - B/024/18 – Chief Nurse membership of IAGC.

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

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 7 FEBRUARY 2019

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	Accommodation for families had been built into the Women's and Children's Care Group business plan for 2019/20. **Action recommended for closure.**
B/018/18	06.12.18	136.1/18 Integrated Performance Report	The EMT to review the IPR report with a view to simplifying it.	SAc	March 2019	The executives had met with Simon Bailey who would construct a new streamlined performance report. Further verbal updates to be provided at the 7 March Board meeting. **On 7 March 2019 agenda.**
B/019/18	07.02.19	18/111 Chief Executive's Report	Circulate the video clip to Board	NY	February 2019	Video clip has been circulated to Board. **Action recommended for closure.**
B/020/18	07.02.19	18/113 Medical Director's Report	Duty of Candour – Board to be informed of the deadline for achieving 100% Duty of Candour compliance.	PS	March 2019	Update will be in the Medical Director's report. **On 7 March 2019 agenda.**
B/021/18	07.02.19		Child Safeguarding – Confirmation to be provided to the Board of levels of child safeguarding training required and trajectory for achieving this.	SSm	March 2019	Verbal update to be provided at the 7 March Board meeting.
B/022/18	07.02.19		National Lung Cancer Audit 2018 - Board to be assured of Trust's trajectory for reaching the national mean.	LM/PS	March 2019	Verbal update to be provided at the 7 March Board meeting.
B/023/18	07.02.19		Linen drapes around beds – Obtain advice from Val Hammond	SAc	March 2019	Verbal update to be provided at the 7 March Board meeting.
B/024/18	07.02.19	18/114 Medical Director's Mortality Report	Confirmation that the Trust was at the 50th centile for coding palliative deaths.	PS/NG	March 2019	Mortality update which includes coding is in the Medical Director's report. **On 7 March 2019 agenda.**

ACTION NUMBER	DATE OF MEETING	MINUTE NUMBER	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
B/024/18	07.02.19	18/116 IAGC Chair Report – IAGC ToR	Chief Nurse membership of IAGC – Look across the NHS FTs and revert to Board with a recommendation in line with standard membership practice.	AF	March2019	AF contacted her counterparts in other Foundation Trusts and the feedback received was that the Director of Finance and Trust Secretary attended all IAGC meetings. The Chief Nurse and other Executives attended IAGC meetings when needed. AF has informed the Chair of IAGC and will amend the IAGC ToR accordingly. **Action recommended for closure.**

CHAIR'S REPORT **18/129**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 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

- **Kent and Medway Sustainability and Transformation Partnership Events**

I, along with the Chief Executive Officer (CEO) continue to attend Kent and Medway Sustainability and Transformation Partnership (STP) events.

This is a video clip link from recent engagement events for your viewing: Improving Care East Kent

- **Integrated Care System Workshop**

I attended the Kent and Medway Inter-Great Project (Simulating Integrated Care Systems for Kent and Medway) along with the CEO on 13 February. The programme was designed to help us learn about Integrated Care Systems and what they might mean for commissioners, providers and the public across Kent and Medway.
The potential benefits of integrated care systems (ICSs) are becoming accepted across the country. But no matter how strong our ambitions, designing integrated health and care arrangements that suit the needs and circumstances of our communities is extremely complex. Because of that, a collaborative approach is needed to design our ICSs, drawing on the experience and judgement of a wide range of people with diverse expertise and interests.

Given the complexity and risks involved in transforming the whole health and care system, it would pay dividends if we could find a way to 'bench test' or simulate how the arrangements might work before we started doing it for real. The Inter-Great process was designed to do just that.

The overall project was designed and facilitated by simulation experts, the Realisation Collaborative, with technical advice and support from the STP group and many others. A key output from the event was agreeing some practical actions that we can take over the next 12 months or so that move us toward making integrated health and care a reality across Kent and Medway.

CHAIR'S REPORT **18/129**

Council of Governors

- **Council meetings**

The Council held a meeting in public on 14 February 2019 in the Margate area. The Chairs of the Board of Directors' Finance and Performance Committee and Strategic Workforce Committee provided reports on their work. Non-Executive Director (NED) attendance at Council meetings is one of the key ways for the Council to meet its responsibilities to hold them to account for the performance of the Board. During the discussions on these items Council sought assurance from the NED Chairs on a range of issues including: controls on spending on agency staff; plans for managing the impact of the EU exit; risks relating to increasing elective activity; and encouraging nursing staff development.

The Council also considered and agreed a recommendation that the terms of reference of their Audit Committee be expanded to include receiving auditors plans, timetables and reports, working with the Trust Secretary to ensure that the Trust's constitution complies with legislation and also to take responsibility for drafting the Governors' commentary on the Trust's Quality Account. The Committee will be renamed the Audit and Governance Committee.

Reports were also presented at the meeting on: the work of the Council's Membership Engagement and Communication Committee; plans for the annual election for Lead Governor and review of Committee membership; and revisions on three policies relating to the work of Council, including guidance on the Chair and NED Appraisal process.

Another key item at the meeting was an update report from the Task and Finish group working on drafting the next Membership Engagement Strategy – 2019/22. The discussion on this item was extended into the afternoon session that day which was the annual joint meeting between the Council and NEDs. Some valuable points were raised during the discussions and the Task and Finish Group will be presenting the first full draft of the Strategy to the next meeting of Council.

The Joint session also considered the draft of the Trust's Organisational Strategy, particularly with respect to whether it reflected public expectations and concern, feedback from the Governors' constituents. Governors and NEDs also began to think about how the Council will work over the coming year in order to hold the NEDs to account for delivery of the Strategy.

Although the day was long, and taxing, I felt that it was time well spent with some very helpful and valuable outcomes.

- **Joint site visits**

There have been two joint site visits since my last report to the Board. Visits are made to all departments across the Trust including those managed by the League of Friends and 2gether Support Solutions (e.g. EME and the Restaurant). Both teams were impressed by the staff they met and felt that there was some strong leadership apparent. The reports from the visits are shared with the relevant member of the Executive Management Team for action to be taken as appropriate.

The first was at the William Harvey Hospital on 13 February and took place in the evening. The team visited the Electrical and Mechanical Engineers Department (EME), the League of Friends shop, the Pathology Department and the Clinical Decision Unit (CDU). The EME team were pleased to receive the visit as this is a department with a very low public profile, yet one which delivers an absolutely essential service – maintaining clinical equipment across the Trust. The staff spoke about the negative impact of changes in the induction process relating to procedures for dealing with

equipment faults which need to be reviewed.

The second visit was on 19 February at the QEQM Hospital and covered Day Surgery, the Diabetes Centre and the Restaurant. One theme from this visit was poor décor in various areas; this needed to be addressed. In the restaurant area, the staff expressed their willingness to undertake the work themselves. In both the clinical areas, the staff talked about their ideas for making best use of the resources in their areas.

Non-Executive Directors' Visits and Commitments

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

Chairman	13 February – Integrated Care System Workshop at Kent Cricket Ground 22 February – Tour of new theatres and day surgery theatres, Kent & Canterbury Hospital (K&CH)
Non-Executive Directors	11 February – Consultant Obstetrics and Gynaecology Interview Panel 13 February – Joint Site Visit with Governors, WHH 14 February – Joint meeting NEDs and Council of Governors, Margate 15 February – Cambridge Ward, William Harvey Hospital (WHH), hosting British Red Cross CEO Mike Adamson 15 February – Consultant Microbiology Interview Panel, WHH 19 February – Joint Site Visit with Governors, Queen Elizabeth the Queen Mother Hospital (QEQMH) 1 March – Dementia Virtual Tour, WHH

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
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 **18/130**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**7 MARCH 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

The Board will remember that In October last year, the **Care Quality Commission** carried out an unannounced inspection of services for children and young people provided at the William Harvey and Queen Elizabeth The Queen Mother hospitals. The inspectors raised a number of concerns, including the lack of children's nurses in the ED after midnight. The CQC required a number of immediate actions to be taken by the Trust. We received the CQC's final report in which the children's services are rated good for caring but inadequate overall.

The Board will be aware of the immediate actions taken in response to the issues including recruiting more specialist children's staff, implementing a thorough regime of daily safety checks, re-training staff in recognising and responding to early warning signs that a child may be becoming unwell, and improving the environment children are cared for within, particularly in our emergency departments. The report focussed on areas of concern but I should make it clear that the neonatal service, the special care baby unit, the surgical services, assessment services and community services were not of concern to the CQC.

The Chief Nurse has established an improvement programme to support staff to deliver excellence and best practice within the hospital children's and young people's services. This programme is based on our successful BESTT programme (Birthing Excellence Success Through Teamwork). We know, from the way the maternity teams have transformed the quality of maternity services here in east Kent – and were cited in the CQC's 2018 report on the Trust as examples of outstanding practice - that we can achieve quick and sustainable staff-led change here in East Kent Hospitals,

In its report, the CQC recognises the consistently high numbers of families who would recommend the care they have received at our hospitals to friends and family, but this is clearly a watershed moment for us to raise the overall quality, safety and offer for families who require care, diagnoses and treatment at our hospitals.

Also at the forefront of everyone's minds is the **pending EU Exit** on the 29th March. We are actively planning for the consequences of this along with other health and social care providers. There is detailed multi agency work on-going and we have produced wide ranging business continuity plans for all scenarios.

Our **business continuity plans** were called into operation this month when essential cables from the mains and generator electrical supply at QEQM were damaged. A+E, ITU and CCU plus several wards lost electrical power. There was an excellent response and senior staff went to site to coordinate the prioritisation of patients and the logistics to keep life support available. Ambulances were diverted to the William Harvey and minors were diverted to the MIUs at Canterbury and Dover. The trust received excellent support from SECAMB, Kent Fire and Rescue, and Kent Police which is also carrying out an ongoing investigation into the incident.

Work has got underway to create a **new reception area at Kent and Canterbury Hospital.** The works which are expected to be completed in around four weeks include the removal of the old desk area. New seating and a public information screen will be installed as part of the project to make the area more welcoming for patients and visitors.

Padua Ward – the children's ward at William Harvey Hospital – is being redesigned and redecorated this month, as part of our work to improve services for children and young people. The ward is being fully redecorated, the toilet and bathroom facilities are being refurbished and the Children's Assessment Unit is being relocated onto the ward to improve safety. The unit will be bigger, and the outpatient children's area is also being enlarged, to provide and extra clinic room and larger waiting area. Staff are working really hard to care for patients while the refurbishment is taking place.

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

Hyper acute stroke units at William Harvey Hospital, Darent Valley Hospital and Maidstone Hospital were given the go-ahead this month by a unanimous decision of the Joint Committee of Clinical Commissioning Groups for the Kent and Medway Review of Urgent Stroke Services. Once the new units are up and running, everyone having a stroke in Kent and Medway will be taken to their nearest hyper acute stroke unit, which will offer specialist stroke care round the clock every day of the year. The work now moves into the implementation phase. It is anticipated that the new stroke service will begin at Maidstone and Darent Valley hospitals in about a year's time, and at William Harvey Hospital in spring of 2021.

I was pleased to attend the launch of the Topol review at the Royal College of Physicians last week. The review seeks to start preparing the healthcare workforce to deliver the digital future, including how technology and other developments like genomics, AI and robotics are likely to see changes to clinical roles in the next two decades. In the same week I also met with the Dean of the Kent and Medway Medical School and we also discussed the role of digital in the curriculum and how we in East Kent could assist with this.

The Chairman and I attended the first formal meeting of the new East Kent partners including the Chairs of all 4 CCGs. We shared complete agreement regarding our strategic aims and objectives. I am also pleased to say that we made our first 'system wide' appointment of a Director of Frailty and Older Peoples Services. We hope this appointment will be able to lead the development of a vision and strategy for older peoples services across East Kent.

Trust Seal Activity

- Contract between EKHUFT and Alphabet (GB) LTD (Guarantee) Leasing (Parent Company Guarantee)
- Deed of Novation – equipment lease between EKHUFT and Skyguard LTD and 2gether Support Solutions
- Deed of Novation – minor/major works between EKHUFT and Carmelcrest LTD and 2Gether Support Solutions
- Deed of Novation – supply of parking meters between EKHUFT and Flow Bird Smart City UK LTD and 2Gether Support Solutions
- Deed of Novation – service agreement between EKHUFT and Lubron UK LTD and 2Gether Support Solutions
- Deed of Novation – maintenance contract between EKHUFT and Aquatronic Group Management PLC and 2Gether Support Solutions
- Deed of Novation – provision of disposable elastomeric pumps between EKHUFT and Vygon (UK) LTD and 2Gether Support Solutions
- Deed of Novation – uninterruptible power supply maintenance between EKHUFT and Power Saver LTD and 2Gether Support Solutions
- Deed of Novation – minor/major works framework between EKHUFT and Logan Construction (South East) LTD and 2Gether Support Solutions
- Deed of Novation – minor/major works framework between EKHUFT and Charlier Construction LTD and 2Gether Support Solutions
- Deed of Novation – supply of parking meters between EKHUFT and Flowbird Smart City UK LTD and 2Gether Support Solutions
- Deed of Novation – service contract between EKHUFT and Carl Zeiss LTD and 2Gether Support Solutions
- Deed of Novation – service and support between EKHUFT and Carl Zeiss LTD and 2Gether Support Solutions

- Deed of Novation – burglar alarm maintenance between EKHUFT and Stand-Fast Burglar Alarm Co (East Kent) LTD and 2Gether Support Solutions
- Deed of Novation – service agreement between EKHUFT and Lubron UK LTD and 2Gether Support Solutions
- Deed of Novation – service contracts between EKHUFT and Shastid Energy LTD and 2Gether Support Solutions
- Deed of Novation – minor/major works framework between EKHUFT and Cloud Offsite Construction LTD and 2Gether Support Solutions
- Deed of Novation – minor/major works framework between EKHUFT and Coombs(Canterbury) LTD and 2Gether Support Solutions
- Parent Company Guarantee between EKHUFT and Travis Perkins Trading Company
- Deed of Novation – provision of disposable elastomeric pumps between EKHUFT and Vygon (UK) and 2Gether Support Solutions
- Deed of Novation – preventative maintenance agreement between EKHUFT and Aether Medical Gases LTD and 2Gether Support Solutions
- Deed of Novation – preventative maintenance agreement between EKHUFT and Aether Medical Gases LTD and 2Gether Support Solutions
- Deed of Novation – preventative maintenance agreement between EKHUFT and Aether Medical Gases LTD and 2Gether Support Solutions
- Deed of Novation – maintenance contract between EKHUFT and JMH Repairs and Servicing LTD and 2Gether Support Solutions
- Deed of Novation – reactive repairs and maintenance between EKHUFT and Delron Services LTD and 2Gether Support Solutions for BH
- Deed of Novation – reactive repairs and maintenance between EKHUFT and Delron Services LTD and 2Gether Support Solutions for K&CH
- Deed of Novation reactive repairs and maintenance between EKHUFT and Delron Service LTD and 2Gether Support Solutions for RVH
- Deed of Novation – minor/major works framework between EKHUFT and Jenner (Contractors) LTD and 2Gether Support Solutions
- Deed of Novation – minor/major works framework between EKHUFT and Bauvill LTD and 2Gether Support Solutions
- Deed of Novation – minor/major works Framework between EKHUFT and BBS Construction LTD and 2Gether Support Solutions

Publications and Policy Developments of Note

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

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

APPENDIX 1

LATEST PUBLICATIONS:

NHSI

Operating theatres: opportunities to reduce waiting lists

Find out how theatre resources and clinical expertise can be best used to increase efficiency to improve care for patients in our new report, developed with the Royal College of Surgeons.

The report outlines measures, many of which are based on existing examples of innovation in the NHS, meaning 291,327 more operations could be carried out each year — as the right staff, beds and equipment will be available.

Learning from local non-executive community networks

Thursday 28 March, 10am-4pm, London

Hear from the local non-executive communities that were awarded funding to support the development of local networks at our joint event with NHS England and NHS Clinical Commissioners.

You will hear from representatives from each of the nine successful sites, who will share details of the challenges they faced and the lessons learned.

Find out more and register now.

PATIENT EXPERIENCE STORY **18/131**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 2019**
SUBJECT:	**PATIENT EXPERIENCE STORY**
BOARD SPONSOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PAPER AUTHOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PURPOSE:	**DISCUSSION**
APPENDIX	**APPENDIX 1 - CHARTER FOR BRITISH SIGN LANGUAGE**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month the Board of Directors are invited to hear from a member of the Deaf Awareness Association about the experiences of deaf people who use our services. The presentation gives the Board an insight into the barriers deaf people encounter which to a hearing person may not be an issue. The Board will hear about a cancer patient where the daughter required support but was used as a conduit for communication; and about a child with a broken arm who was asked to sign for his father. Simple systems and processes we have as the norm in our Trust can present difficulty for the deaf community. Our presenter will provide insight into these areas too. The final area to highlight for the Board to consider is the British Sign Language Charter. This is being considered and discussed at the Diversity and Inclusion Group at present. A proposal for the Board to consider will come via our governance processes in due course. The Charter is appended for information.

Thanks are extended to Mr Ash and Ms Lisa Brailsford, BSL interpreter for attending the Board of Directors meeting to tell the story.

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

PATIENT EXPERIENCE STORY **18/131**

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to note the key themes of these experiences and note the BSL Charter appended.

Charter for British Sign Language

BRITISH DEAF ASSOCIATION

Contents

Statement by Dr Terry Riley

The purpose of the British Sign Language (BSL) Charter is to promote better access to public services for Deaf communities and to help public agencies meet their legislative duties under the Equality Act 2010.

The UK Government ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2009. Local authorities, public services and agencies should support this by adhering to the CRPD. One way of supporting this is to adopt the BSL Charter.

Deaf people want to have equal access to services and access to BSL/English interpreters whenever they are needed. The Deaf community is a linguistic community with a rich history, identity, language and culture. The BSL Charter highlights good practice and will build capacity to eliminate unlawful discrimination, advance equality of opportunity and develop good relations with the Deaf community.

Recognition of British Sign Language

Deaf people in Britain campaigned for many years for the recognition of BSL considering this to be a human rights issue.

This campaign was for the right to positively identify with one's language(s), and for others to respect this identification. It asked for BSL to be recognised as a native indigenous language and for Deaf people to have the right to learn it, to develop in formal school settings by being taught through it and to have the right to use it in official contexts (schools, hospitals, police services, naming of children, religion).

The Disability Discrimination Act 1995 recognised that Deaf people, as part of the community of disabled people, have the right to use BSL/English interpreters and to receive equal access to services. However, Deaf people continue to feel that the Act does not recognise Deaf people as a linguistic minority and still campaign for a British Sign Language Act, similar to the Welsh Language Act 1993.

On 18th March 2003, the British Government recognised BSL as a language in its own right and as an indigenous language used in the UK. In March 2004, the Secretary of State for

Northern Ireland announced the formal recognition of BSL and ISL (Irish Sign Language) as languages in their own right in Northern Ireland.

The BSL Charter was launched in Bristol on the same day as the Government recognised BSL as a language in its own right; 18th March 2003.

2 Introduction to the BDA's Charter for British Sign Language (BSL)

The BDA is asking local and national services across the UK, in the public, private and voluntary sectors, to sign up to our Charter for British Sign Language (BSL). The Charter sets out a number of key pledges to improve access and rights for Deaf people who use sign language.

Each pledge requires a commitment to overcome the disadvantages that Deaf people using BSL face. The benefits that will ensue from achieving the stated objective are indicated.

The five pledges:

1. Consult formally and informally with the local Deaf community on a regular basis

2. Ensure access for Deaf people to information and services

3. Support Deaf children and families

4. Ensure staff working with Deaf people can communicate effectively using British Sign Language

5. Promote learning and high quality teaching of British Sign Language.

3 BSL Charter Pledge 1

Consult formally and informally with the local Deaf community on a regular basis

Rationale
Deaf people should have the right to be consulted on services or changes to services that affect them. (See 1.1 – 3.1 of the Local Government Association Equality Framework; "Knowing your Communities").

The objective
Deaf people who use BSL are able to have input into consultations either separately or alongside other forums and user groups, thus enabling the Deaf community to be a resource that can be used to improve the design of services for Deaf people and the wider community. Organisations that have a contractual obligation to provide public services should ensure that this is included as part of their business activity.

Benefits

- Access to services have better focus and it reduces the likelihood of poor access for Deaf people which often leads to wastage of resources.
- Deaf people are more involved in any decision-making processes with knock-on benefits such as improvements in access to services for Deaf people.
- In turn, Deaf people are empowered by improved access to services, freeing them to contribute more to the local community.

4 BSL Charter Pledge 2

Ensure access for Deaf people to information and services

Rationale

Deaf people face many barriers when trying to access information or services, either through lack of awareness or language barriers. Many Deaf people are often unable to access written information. Information linked to their health in England under NHS England is covered by the Accessible Information Standard – known officially as SCCI1605. Compliance with information standards of this type is a mandatory requirement for NHS Trusts and GP practices. This is set out in section 250 of the Health and Social Care Act. Information from other public services is covered by the Public Sector Equality Duty (Chapter 14, Part 11, Chapter 1, Section 149: Equality Act 2010). This also applies to the Justice system with regard to the Code of Practice for Victims of Crime (2015) and the Witness Charter (2013). Deaf people are classified as vulnerable and eligible for 'special measures'.

The objective

The organisation recognises and values all its customers, including those who use BSL. It aims for its Deaf customers to have the same quality of provision, information, standards and right to be informed on a par with others in the wider community. Services should ensure that all contracts involving provision of information or services have clauses stipulating equality of access including access through BSL.

Benefits

- Services are accessible to a wider section of the local community, including those lacking good English.
- Customer care is improved with stress on staff and customers reduced.
- Deaf people can access services independently.
- Effective communication between the service and Deaf BSL users is maximised.
- Services become compliant with the Equality Act 2010 and SCCI1605.

5 BSL Charter Pledge 3

Support Deaf children and families

Rationale

Deaf children and their families require good communication from when the diagnosis of deafness is made and throughout their formative years. The BDA believes that the majority of Deaf children will realise their potential through a bilingual / bicultural approach to learning using both BSL and English. 40% of Deaf children and young people have additional needs requiring intensive communication support. (See Part 3 of the Children and Families Act 2014). Organisations that provide information or services need to be mindful that they should not exclude children who are difficult to reach. In particular, services that have a responsibility for safeguarding issues* must meet legal requirements.

The objective

Services that work with children and young people recognise the importance of Deaf children and young people being able to access information and support on a par with their hearing peers. Some services will be able to provide a bilingual / bicultural approach enabling full access for all children and young people meeting the aims of the Special Educational Needs and Disability (SEND) reforms.

Benefits

- Deaf children and young people have choices in how they can communicate and contribute to their local communities.
- The family life of deaf children is enhanced by the improved communication between the child and their parents/carers and siblings.
- More Deaf children and young people will achieve academically on a par with their hearing peers leading to more Deaf young people progressing to further and higher education and accessing job opportunities.
- Services such as police, health and social services will be able to deal with safeguarding issues by offering access for deaf children who need support or want to report issues.

* The BDA is a member of the NSPCC working group on Safeguarding for deaf children

6 BSL Charter Pledge 4

Ensure staff working with Deaf people can communicate effectively using British Sign Language

Rationale
All staff working in public services or local authorities that interact with the public should be able to communicate with all sections of the local community including Deaf people.

The objective
Staff providing frontline services can feel confident in being able to communicate with Deaf people and respond appropriately. Members of staff at all customer service points will have basic BSL skills and know how to call upon other staff with higher level skills or BSL/English interpreters using remote access such as Skype, FaceTime or VRS where available. Specialist workers with Deaf people should aim to for their own skills to be extensive enough to enable them to deliver a high level service to a wide range of Deaf people without needing BSL/English interpreters in non-complex situations.

Benefits

- There is good customer care.
- There is a reduced need for BSL/English interpreters in specialist services for Deaf people.
- Quality staff development for Deaf and hearing staff members contributes to good customer care.

7 BSL Charter Pledge 5

Promote learning and high quality teaching of British Sign Language

Rationale
There is a need for more BSL courses in order that more people have the opportunity to learn BSL.

The objective
The organisation recognises that it is essential to support the local infrastructure of teaching and assessment of BSL. It tackles this in conjunction with local economic development agencies and funding bodies. This is to ensure that anyone who wants to learn BSL, whether they are parents/guardians of deaf children, young people, local authority or public service employees, can do so. Everyone learning BSL should receive excellent quality teaching in BSL.

Benefits

- There are more BSL courses on offer leading to a range of opportunities for people wishing to learn BSL.
- More people using BSL leads to greater opportunities for Deaf people to be integrated within the wider community and have improved access to public services.
- Family members/guardians/carers of Deaf children and young people have an opportunity to learn BSL which will improve bonding and communication with their own deaf children and young people.

What is BSL?

British Sign Language (BSL) is the first or preferred language of many Deaf people in the UK. It is a language of space and movement using the hands, body, face and head.

BSL is the sign language of the Deaf community in the UK (in Northern Ireland, Irish Sign Language (ISL) is also used). BSL is a real, full and living language that is part of a rich cultural heritage. It is one of the UK's indigenous languages; others include English, Welsh, Scottish Gaelic, Irish Gaelic and Cornish. Many hearing people also use BSL; it has many users on a par with other indigenous languages such as Welsh or Gaelic.

It is a language that has evolved in the UK's Deaf community over hundreds of years. There is considerable research evidence that shows Deaf children who are exposed to BSL early can develop linguistically at the same rate and to the same linguistic levels as hearing children with spoken language. This kind of early access to language ensures the ability for learning throughout life, leading to improved life opportunities.

BSL is not just a language; it is also a gateway to learning, a path towards a sense of Deaf identity, and the means whereby Deaf people survive and flourish in a hearing world.

The British Deaf Association – BDA

The BDA stands for **D**eaf **E**quality, **A**ccess and **F**reedom of choice

Vision

Our vision is Deaf people fully participating and contributing as equal and valued citizens in wider society.

Mission

Our Mission is to ensure a world in which the language, culture, community, diversity and heritage of Deaf people in the UK is respected and fully protected, ensuring that Deaf people can participate and contribute as equal and valued citizens in the wider society. This will be achieved through:

- Improving the quality of life by empowering Deaf individuals and groups;
- Enhancing freedom, equality and diversity;
- Protecting and promoting BSL.

Values

The BDA is a Deaf people's organisation representing a diverse, vibrant and ever-changing community of Deaf people. Our activities, promotions, and partnerships with other organisations aim to empower our community towards full participation and contribution as equal and valued citizens in the wider society. We also aim to act as guardians of BSL.

1. **Protecting our Deaf culture and Identity** – we value Deaf peoples' sense of Deaf culture and identity derived from belonging to a cultural and linguistic group, sharing similar beliefs and experiences with a sense of belonging.

2. **Asserting our linguistic rights** – we value the use of BSL as a human right. As such, BSL must be preserved, protected and promoted because we also value the right of Deaf people to use their first or preferred language.

3. **Fostering our community** – we value Deaf people with diverse perspectives, experiences and abilities. We are committed to equality and the elimination of all forms of discrimination with a special focus on those affecting Deaf people and their language.

4. **Achieving equality in legal, civil and human rights** – we value universal human rights such as the right to receive education and access to information in sign language, and freedom from political restrictions on our opportunities to become full citizens.

5. **Developing our alliance** – we value those who support us and are our allies because they share our vision and mission, and support our BSL community.

About BDA

Founded in 1890, the British Deaf Association (BDA) is a national Deaf-led organisation that works directly with Deaf people that use British Sign Language (BSL). Our work concentrates on campaigning for equal rights on a national level and working at a local level empowering Deaf people to achieve access to their local public services. This is carried out through projects delivering individual and community advocacy. We also work to ensure BSL is included by public bodies by delivering a public commitment through signing the BSL Charter.

Our Board of Trustees are all Deaf (we use the capitalised 'D' to denote the fact that we have a separate language and culture and 80% of our staff are Deaf themselves).

Many Deaf people who use BSL lack access to education, health services, employment and other public services. Our work is designed to empower Deaf people and to improve access to general information and public services. We seek to achieve this by working with Deaf people at the local level through setting up forums to lobby public bodies and supporting Deaf people individually.

This is in line with the overall BDA objectives, which are: **D**eaf **E**quality, **A**ccess and **F**reedom of choice

For a list of signatories, FAQs, and other information, including what the BDA can do for your organisation, please look at our website: **www.bda.org.uk**

020 7697 4140 | www.bda.org.uk | bda@bda.org.uk

The BDA stands for **D**eaf **E**quality, **A**ccess and **F**reedom of Choice

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CARE QUALITY COMMISSION (CQC) UPDATE **18/132**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 2019**
SUBJECT:	**CARE QUALITY COMMISSION (CQC) UPDATE**
BOARD SPONSOR:	**CHIEF NURSE & DIRECTOR OF QUALITY AND MEDICAL DIRECTOR**
PAPER AUTHOR:	**QUALITY IMPROVEMENT PROGRAMME LEAD**
PURPOSE:	**INFORMATION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides an update on CQC inspection activity, the improvement plan and associated work streams.

October 2018 Paediatric inspection

The final inspection reports were published on 13 February 2019. Briefing sessions for staff were held on Tuesday, 12 February.

The Paediatric Taskforce continues to meet weekly and maintains an oversight of the improvement plan. The Quality Committee received the latest update on 26 February 2019. The plan addresses the verbal feedback following the inspection; the Section 31 requirements and the 'must do' actions in the inspection reports. Current status of the plan at time of writing is:

	Number of actions	%
Total on track	38	57%
Total complete	28	42%
Total in progress	1	1%
	67	100%

The East Kent Clinical Commissioning Groups undertook visits to WHH and QEQM on 7 and 8 February to review the improvements made and offer support to the Trust. They reported seeing significant improvement, with staff positive and keen to share their vision of on-going improvements. A summary of the improvements made to date are shown below:

Concern	Action Taken
Staffing Levels in ED – there was not a 24 hour RN Child on duty	A business case was approved and there is now an establishment that allows 24 hour cover of RN Child in both paediatric EDs
Resuscitation Trolleys found unchecked every single day	We have implemented a daily safety huddle in paediatric ED, Rainbow, Padua, SCBU and NICU. This includes confirmation that we are running safe services every day. The huddle checklist is emailed to the Care Group leads and up to the Chief Nurse and Medical Director daily. Required action and escalation is followed by the Care Group leads. Resuscitation checks' assurance is one of the criteria.
Fridge Temperatures	We have implemented a daily safety huddle in paediatric ED,

CARE QUALITY COMMISSION (CQC) UPDATE **18/132**

not always routinely recorded and acted upon	Rainbow, Padua, SCBU and NICU. This includes confirmation that we are running safe services every day. The huddle checklist is emailed to the Care Group leads and up to the Chief Nurse and Medical Director daily. Required action and escalation is followed by the Care Group leads. Fridge Temperature checks assurance is one of the criteria
Poor medicines management practices	As above – and controlled drugs and drug cupboard checks form part of the daily assurance. Monthly audits of medicines' practices are carried out and reported by the Pharmacy Team with action plans in place.
Accurate recording of the paediatric early warning scores when taking observations	Re-training of all staff is underway. Monthly audits of compliance with PEWS standards are carried out. Action plans are in place where required. VitalPac is being rolled out to address escalation and accurate recording and reporting.
Mental Health training	Training for mental health and learning disabilities is underway. We have sourced an e-learning package. Staff attended the Learning Disability development day last week. The Chief Nurse has a call scheduled with her equivalent in the mental health Trust to take this forward further.
Risk assessments for children using trolleys	The risk assessment is complete and has been shared with the CQC. 20 additional cots have been purchased for use by children under two years.
The initial assessment (streaming) of a child arriving in ED needed to be improved.	A standard operating procedure (SOP) has been written and implemented. This works well at WHH. The QE requires further embedding and this work is underway.
Child safeguarding training compliance	An action plan is in place and all Care Groups have mapped the staff group against the training needs analysis to ensure everyone is receiving the right level of training. Each Care Group is developing their trajectory on a name by name basis for compliance. Trust wide overall we are compliant. Compliance at each level is being completed.
Child Friendly environment on the journey to Theatres	Plans are being developed to decorate the walls and ceilings for children travelling to theatres.
Padua ward environment requires updating	Work is in progress to improve the environment for children in this ward, it is anticipated that this work will be completed by 31 March 2019.
Ward to Board reporting needs improvement	The governance processes have been reviewed. We have introduced smaller Care Groups and a clinically led model to facilitate oversight at all levels in the Trust. The Children's Board is in place. The C&YP strategy is being developed. Benchmarking against national guidance has been completed. The next step is the gap analysis and action plans to be in place. This will be brought to the Children's Board and strategy day.

The CQC has informed us of its intention to lift the Section 31 notice – written confirmation of this is awaited. In the meantime, as required by the Section 31 notice, weekly reporting to the CQC has continued.

The Chief Nurse & Director of Quality and Trust Secretary met to review the assurance and evidence requirements to demonstrate embedding of the actions as part of the monitoring of the plan. The plan now has a clear governance audit trail described and the Quality Committee has requested to see on a regular basis, compliance reports against the audits

and checks that the plan describes as assurance. This is to ensure when an action (a task) is completed, we continue to assure ourselves that the improvement is sustained and does not deteriorate.

CQC Improvement plan

The Improvement Plan Delivery Board (IPDB) next meets on 1 March 2019, chaired by the Chief Nurse & Director of Quality, and oversees the improvements from the May 2018 inspection. It continues to meet monthly to ensure pace.

Monthly meetings are also being held between the Quality Improvement Team and the Care Group Clinical Directors to ensure progress against the plan.

The Quality Committee received the latest plan at its meeting on the 26 February 19. The current status is:

	Complete actions	Actions on target	Actions not yet due, issues identified	Actions overdue	Total
Overall compliance	40	51	0	3	**94**
% complete	43%	54%	0	3%	**100%**

Recovery plans are in place to complete these outstanding actions.

Sustaining Improvement

It is imperative that the Board is sighted on all risks in relation to quality that impact on our fundamental standards and inspection ratings and systems and processes are in place that anticipate where and when we have quality risks so that we can take early action in order to consistently provide safe, effective, person-centred care. This will enable us to take early corrective action to prevent further poor inspection visits and reports. The way we are ensuring this is described in the remainder of the paper.

The CQC has changed the way it engages with Trusts. They have moved from meeting with the Medical Director, Chief Nurse monthly, and the Chief Executive quarterly to also undertaking deep dives into different services.

Previously we were required to complete an information proforma and that was the basis of our discussions. If they had concerns they would request that particular team to present at the meeting and provide assurance.

During last year the CQC became more proactive in engaging with Trusts. They now request to learn about different services, which may not be areas with which they are concerned necessarily, but areas they wish to gain a greater understanding of, in relation to their key lines of enquiry. However, concerns may also trigger a deep dive.

The Chief Nurse and Medical Director now meet with the CQC monthly using the proforma they complete (from the CQC Insight data) and further information provided by us. They have set a timetable of visits. In order to prepare we have in place:

- Routine Quality Reviews;
  - each core service on rotation,
  - or where we have concerns
  - and in preparation for the CQC relationship visits

- Annual Trust wide mock visits – these may move to 6 monthly

- Self-assessment against the key lines of enquiry (KLOEs)
  - Each Care Group
  - Trust wide – policies and processes.

Routine Quality Reviews

Routine Quality Reviews (RQRs) have been planned to those core services receiving an informal CQC visit (see below). This helps the service prepare for the CQC's visit as if it were a formal inspection, and ensures staff and areas are working to expected standards. The service also uses an inspection preparation checklist as a prompt to review documents, posters, leaflets, website etc.

RQRs will continue on a regular basis to become business as usual, so that each of our core services receives a RQR on rolling basis(approximately every 8 months), irrespective of CQC activity. Dates completed and planned are:

22 January – critical care at WHH, QEQM and K&CH
5 February – outpatients at K&CH
22 February – end of life care at WHH
24 April – awaiting confirmation of service from the CQC

Children and Young People's services undertook an assurance mock visit on 26 February. We await the report which is due in 2 weeks. Our Improvement Director is coordinating the report to enable us to celebrate areas of improvement and focus us on where we still need to embed our improvement work. Verbal feedback is that the visit was positive; however the amount of space the staff have to work in is a challenge. Essential checks were all found to be completed.

CQC Relationship visits

The CQC undertook an informal visit to the critical care service at WHH on 31 January 2019. The day commenced with a presentation delivered by Mark Snazelle, Consultant Anaesthetist, and Julia Cristall, Interim Head of Critical Care. This was followed by a tour of critical care services at WHH led by Jane Kirk-Smith, Matron ITU. Drop in sessions for critical care staff took place in the afternoon

There was no formal feedback provided by the CQC because it was an informal visit, but the inspectors advised that they considered the day very positive and had seen no issues of concern.

The next relationship visit is Tuesday 5 March. The two inspectors will be visiting the Outpatients Department and K&CH receiving a presentation before being shown round. They finish their visit by meeting staff. Plans are going well for this visit. Following that, the CQC will be meeting the End of Life teams. Again, preparations are on track and the teams are looking forward to showcasing their improvement work.

CQC Insight report

The CQC published the latest insight report in January 2019. Intelligence indicates that overall performance for the Trust is about the same; Caring, Effective, Responsive, Safe and Well led performance is stable. The report concludes that Urgent and emergency care performance is improving, critical care, maternity and gynaecology, medical care and surgery performance is stable. Outpatients and diagnostic imaging performance has reduced. This is in relation to the Trust's RTT and 62 day cancer performance that is reported in the Integrated Performance Report to the Board each month. There are plans within the Care Groups to address this.

CARE QUALITY COMMISSION (CQC) UPDATE **18/132**

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks to the successful delivery of the new plan are possible. Management actions include tight governance and effective systems in place to deliver with monthly monitoring and oversight at Director level.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR2 – Failure to maintain the quality and standards of patient care.
RESOURCE IMPLICATIONS:	Potential costs associated with harm arising from sub optimal patient experience.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is invited to discuss the report and the actions in place to support the CQC improvement programme.

MEDICAL DIRECTOR'S REPORT **18/133**

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

BACKGROUND AND EXECUTIVE SUMMARY

1. **Duty of Candour Compliance by Care Group**

   Duty of Candour has been a legal requirement since November 2014 and the CQC is able to take enforcement action when it finds breaches. Last month's report detailed that the Trust's initial compliance had risen from <15% to 80%. Following the report the Board requested a trajectory for complete compliance. Six of the eight Care Groups are 100% compliant with Duty of Candour (Cancer, Clinical Support, Corporate, Women and Children and the 2 surgical care groups).

2. **Child Safeguarding**

   The Trust has been criticised by the CQC for its compliance with child safeguarding. Last month's report detailed that 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). Following the report the Board requested a trajectory for medical staff compliance with child safeguarding training.

3. **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

   Following the report the Board requested a trajectory to bring us back in line with national data. This is detailed in the main body of the report.

4. **Mortality**

   This month's report details updated mortality indices (crude mortality, HSMR or hospital standardised mortality rate, RAMI or risk adjusted mortality index and SHMI

or summary hospital mortality index) together with peer comparison and analysis of disease codes underlying and contributing to the mortality metrics. In terms of numbers the diagnostic code 'septicaemia' is the biggest contributor to mortality both locally and nationally and since the identification of septicaemia as a mortality outlier in the Trust last year this diagnostic code continues to receive special attention. Additional information has been included here.

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.
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:	Support for the Structured Judgment Review of Deaths programme.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to note that:

- 6 of the 8 Care Groups are fully compliant with Duty of Candour
- Documented medical staff compliance with Child Safeguarding is now 76% (732/959) overall and that the Cancer and Corporate Care Groups are fully compliant
- systemic anti-cancer therapy for non-small cell lung cancer and chemotherapy for small cell lung cancer should achieve at least national average figures by the end of April 2019
- The Trust's mortality indices have not altered in the last 5 years and are all around the national average. Focussed work is required in targeted areas to now effect improvement in these indices. This work needs to be underpinned through the programme of structured judgment reviews of deaths to identify the changes required to effect improvement.

MEDICAL DIRECTOR'S REPORT **18/133**

1. Duty of Candour Compliance

6 Care Groups are 100% compliant for the last calendar year (Cancer, Corporate, Surgery & Anaesthetics, Surgery, Head & Neck and Dermatology and Women and Children). General & Specialist Medicine are now at 58% having improved from 33% but Urgent & Emergency are at 27%.

2. Child Safeguarding compliance for medical staff

For the doctors, 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.

Overall compliance currently is 76% (732/959).

<u>Individual Care Group Compliance</u>

2.1 Cancer
16 Medical & Dental, 100% compliance.

2.2 Clinical Support
76 Medical & Dental, 82% compliance (62/76). Trajectory for compliance not yet received.

2.3 Corporate
9 Medical & Dental, 100% compliance

2.4 General & Specialist Medicine
269 Medical & Dental, 64% compliance (171/269). Their trajectory for improvement is 80% by the end of March 2019, 90% by end of April and 100% by the end of May 2019.

2.5 Surgery & Anaesthetics
308 Medical & Dental, 81% compliance (249/308). All non-compliant staff have been identified and their training needs reviewed. An exact trajectory for compliance is awaiting course bookings.

2.6 Surgery, Head & Neck and Dermatology
86 Medical & Dental, 72% compliance (62/86). Trajectory for compliance not yet received.

2.7 Women and Childrens
149 Medical & Dental, 81% compliant (118/145)
27 registered as non-compliant are all Level 3, 7 have training booked between now and July 2019, the other 20 are junior doctors and are being actively followed up to determine training needs.

2.8 Urgent and Emergency
50 Medical & Dental, 90% compliance (45/50) in A&E.

Those Care Groups who have yet to submit a trajectory for compliance are reviewing their medical staff requirement for level 3 training commensurate with GMC advice and negotiating with Child Safeguarding training for additional level 3 training courses.

3. National Lung Cancer Audit

The actions required to bring the Trust outlier status back in line with National performance detailed in last month's report and progress against those actions are shown in the table below. The aim is to have achieved at least National levels of chemotherapy and systemic anti-cancer therapy by April 2019.

Action	Progress	Update
Liaison with primary care to ensure that patients are aware of the reasons for 2WW referral and don't cancel their appointments.	Completed January 2019	2WW cards are being given to patients explaining what this means and the importance of attending their appointments Working closely with the Macmillan GPs to support education and training to practices
Recruitment of 2 new Lung CNS (Macmillan Funded).	Completed February 2019	2 new Macmillan Lung Cancer Clinical Nurse Specialists have been recruited
Use of Navigators in Lung to triage and streamline patients at the front end and to ensure 2ww compliance	Recruitment underway	Will be in post by April 2019
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	Ongoing	Working with radiology weekly to ensure delays are reduced and introduction of pathology and radiology trackers to help with blockages.
Use of electronic patient tracking list (PTL) to pull patients through	In place	Cancer Services team review

Action	Progress	Update
the system, reviewed weekly		daily
Increased oncology support from the cancer centre (Maidstone & Tunbridge Wells Trust) to support treatment decision making and implementation and lung cancer multidisciplinary meetings	To be advised by Maidstone & Tunbridge Wells	Two new Oncologist posts have been agreed by Maidstone and Tunbridge Wells Trust
Appointment of a new Cancer manager	January 2019	A new Operations Director for Cancer Services has commenced in post

4. Mortality

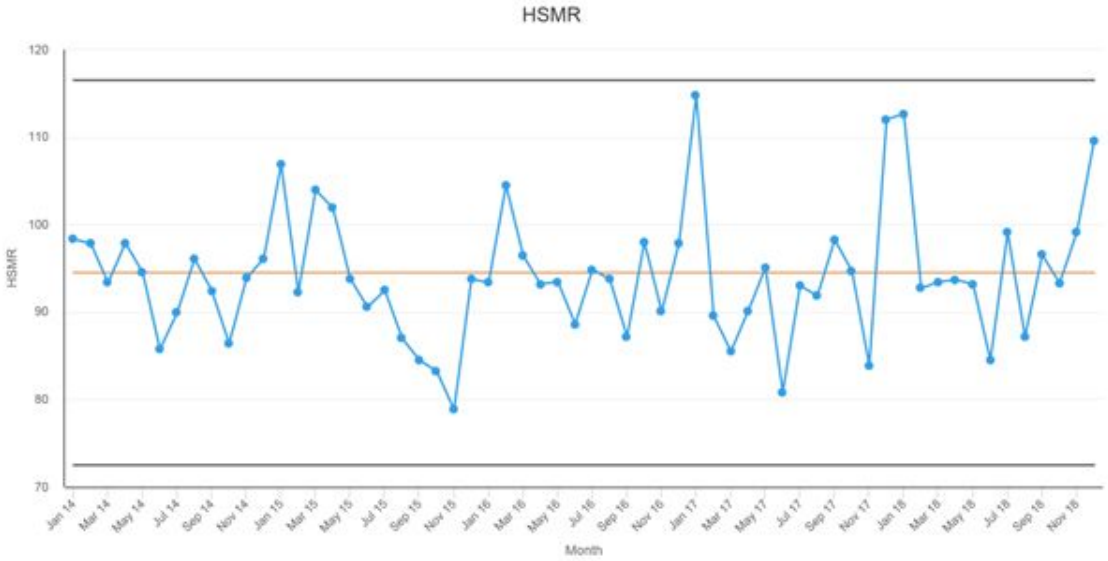
4.1 Crude Mortality

Crude mortality continues to have a seasonal variation, generally peaking in January each year which is an expected outcome. Of note those peaks in January 2017 and 2018 exceeded the upper control limits, January 2019 data is not yet available. Overall crude mortality for the last 5 years is 1.38% and for the last calendar year (January 2018 - December 2018) is 1.4%. Crude mortality is consistently 0.2% higher than peer, this is also an expected result based on the demography and comorbidity of our catchment population in comparison to peer.

4.2 HSMR

The HSMR is a method of comparing mortality levels in different years, or for different subpopulations in the same year, while taking account of differences in population structure. The ratio is of (observed) to (expected) deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be
greater than 100. HSMR adjusts crude mortality for a number of factors including age group, deprivation, comorbidity and number of previous admissions.

The HSMR overall for the last 5 years is 94.5, below the peer average of 98.9. Over the last calendar year HSMR covered 87.1% of hospital deaths with 38 deaths attributed following transfer and 23 still births and the value was 96.8 in comparison to the peer average of 95.7. In terms of national comparison our HSMR is in the 50th centile for the last calendar year, and in the 25th to 50th centile for the last 5 years overall. The SPC run chart of monthly HSMR again shows the seasonal variation but indicates little change in our overall Trust HSMR over the 5 year period. The change in our position in comparison to peers is driven by improvement in HSMR nationally.



4.3 RAMI

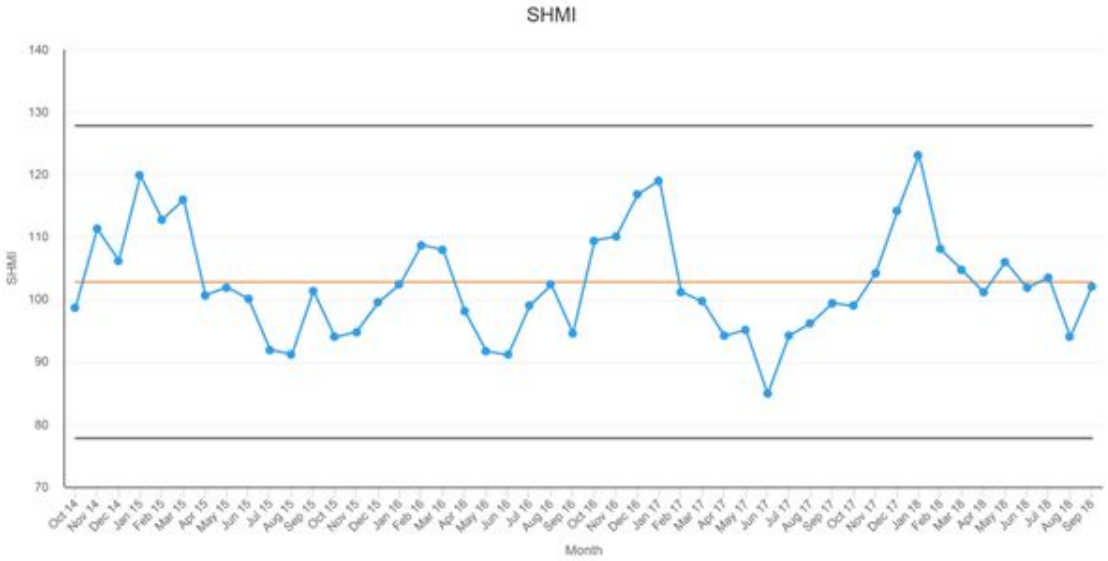
The risk adjusted mortality index is also a ratio of observed to expected deaths but includes all deaths (all activity including well babies and palliative care). The RAMI model is rebased periodically by recalculating the norms based on a more up to date data period. Our RAMI was last rebased in 2017.

The Trust RAMI overall for the last 5 years is 99.3 compared to a peer average of 92.9, in the last calendar year the Trust RAMI was 91.6 and the peer average RAMI

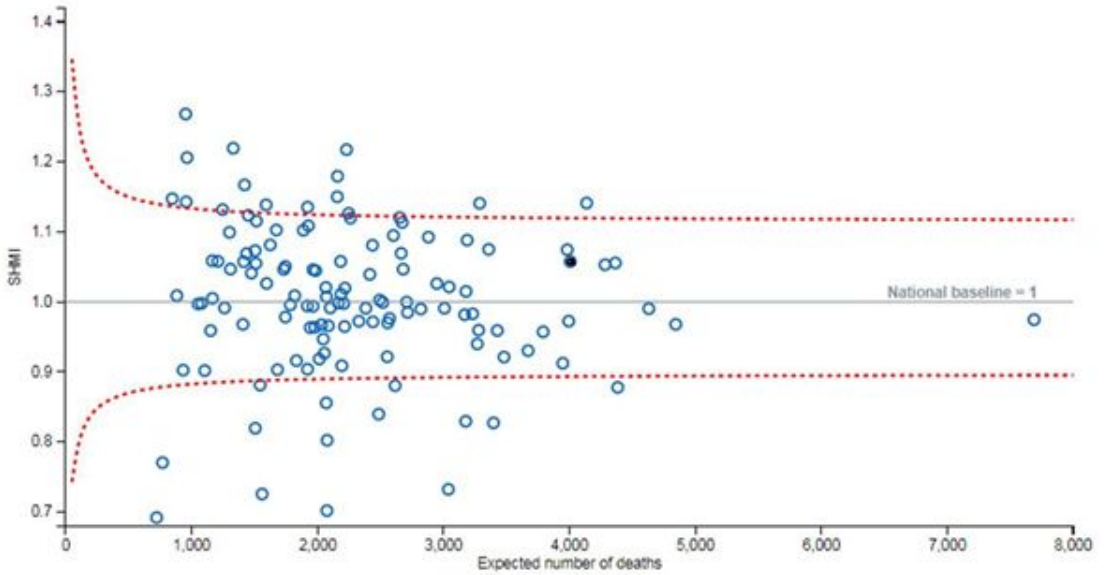
was 85.9. RAMI also shows seasonal variation but again the SPC run chart would suggest little change over the last 5 years.

4.4 SHMI

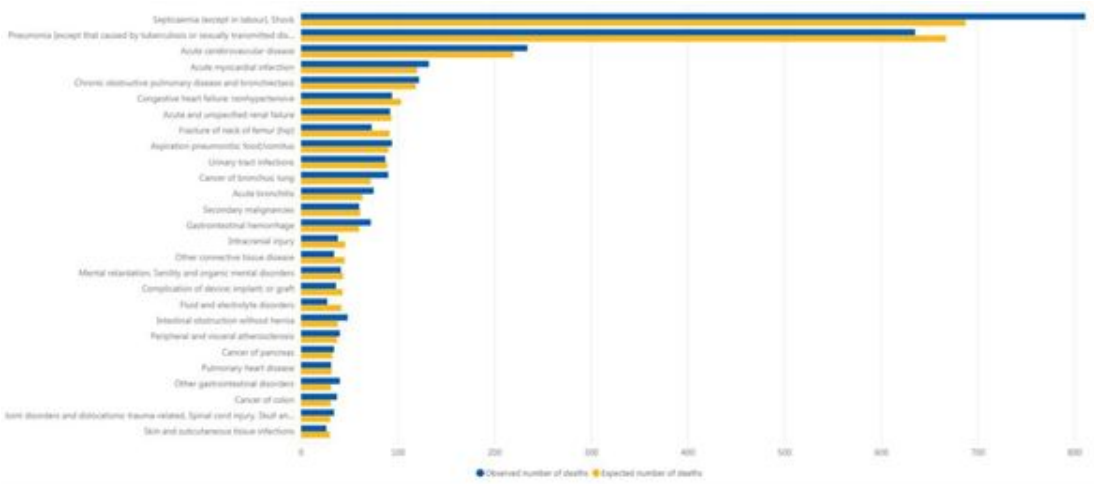
The summary hospital mortality index is similar to the RAMI but also includes deaths 30 days post discharge, which will add an average of around 35 per cent more deaths into the calculation. This will start to change the peer comparison because 35.2% of our Trust's deaths occur after discharge from hospital compared to a national average of 29.3%.



The run chart shows our SHMI values month by month for the last 5 years, again there is seasonal variation but the SHMI also remains between control limits. Nationally the SHMI is currently reported 6 months in arrears because it includes deaths after discharge from hospital. Peer comparison for the latest reporting period (October 2017 to September 2018) is in the funnel plot below.



4.5 Diagnostic Codes Contributing to Mortality Indices

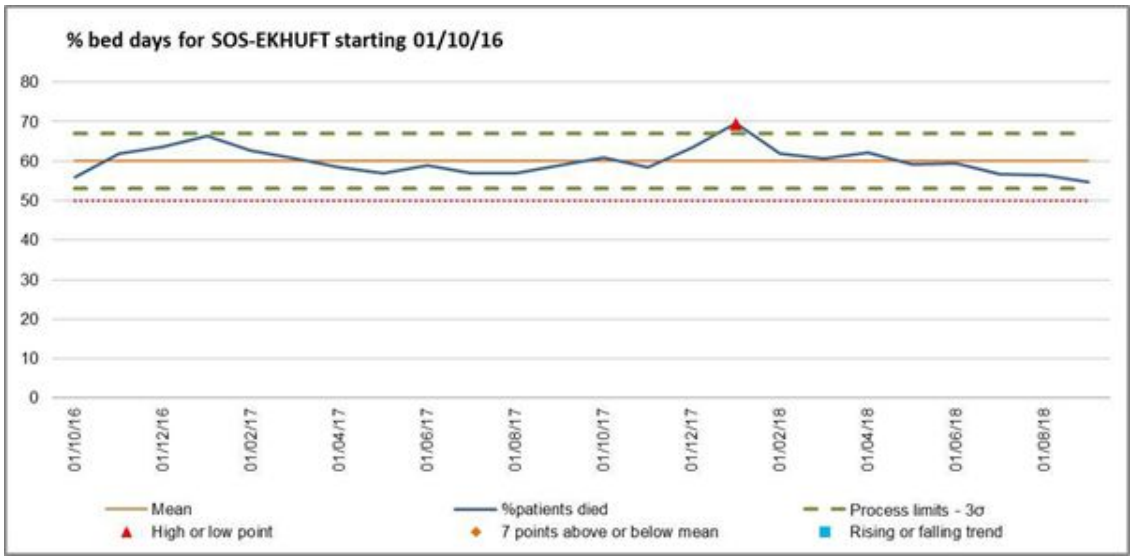


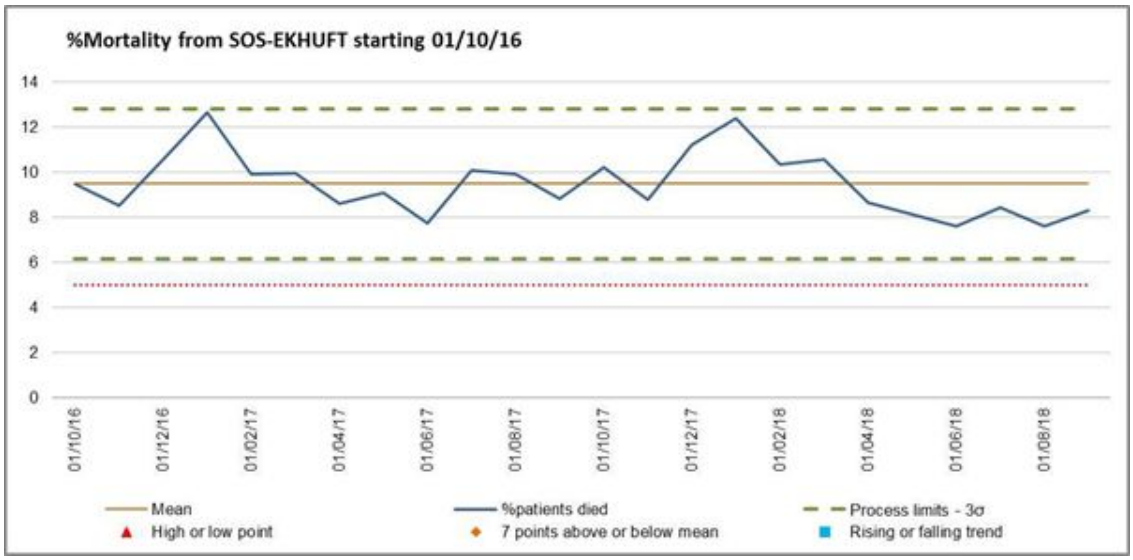
This is a selection of the 140 underlying diagnostic codes for the SHMI in which the number of expected deaths for the year are less than 30. Where the blue bar exceeds the orange bar our observed mortality exceeds expected, most notably in this example for deaths coded as sepsis. This data from the SHMI and is triangulated with data from the other mortality indices. Although septicaemia has the highest number of deaths per year there are another 3 underlying disease codes of particular interest 'other perinatal conditions', 'coma, stupor and brain damage' and 'other injuries and conditions due to external causes'. These will not be considered further in this report but the approach taken in terms of understanding drivers and identifying areas for improvement is the same.

Although all the mortality indicators can be affected by the quality of coding it should not be taken as the likely cause unless there are known clear data quality issues. Septicaemia is fortunate to have national and regional collaboratives driving improvement in sepsis identification, management and mortality. Suspicion of sepsis (SOS) describes emergency admissions with infection that can cause sepsis. It is based on a validated set of 200 ICD10 codes that can be used to create reports from NHS administrative data. In England, SOS is the admission code in 1.9 million emergency admissions per year and is responsible for 25-38% of emergency admissions. An SOS code confers three to six times the mortality of non-SOS codes and SOS is the cited reason for admission in 60% of patients who die. More recent analysis of HES admissions data in March 2018, that excludes emergency admissions with a length of stay of less than one day, reveals that the percentage of all emergency admissions that contains an SOS code is 38% and the percentage of emergency bed days that contains an SOS code rises to nearer 50%.

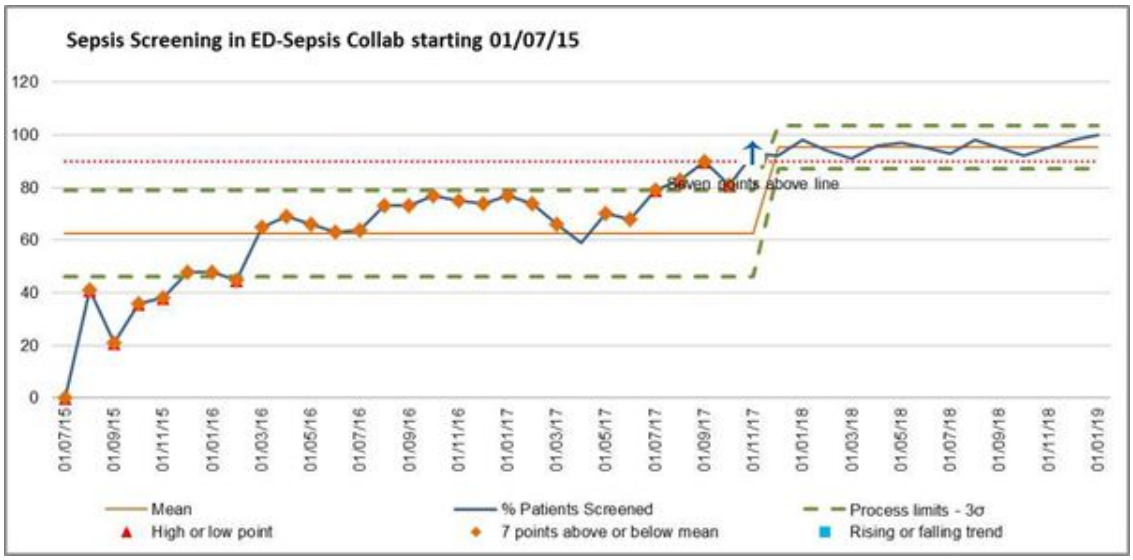
The percentage of bed days for suspicion of sepsis codes since 1/10/2016 is shown in the charts below. This too shows a seasonal variation with peaks in January. Notably the January 2018 peak exceeded the upper control limit and corresponds with the crude mortality breach of the upper control limit in January 2018, although mortality from suspicion of sepsis in January 2018 remained just within control limits. Overall, as can be seen in the run chart for mortality, sepsis mortality remains within control limits.

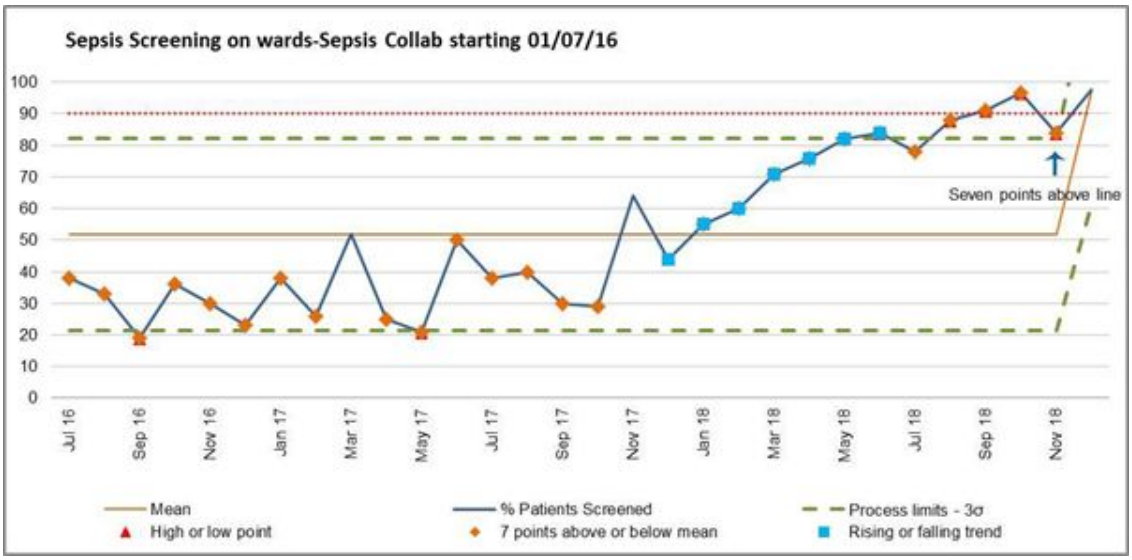
MEDICAL DIRECTOR'S REPORT **18/133**





Part of the work undertaken by our local sepsis collaborative is to drive earlier identification of sepsis in our patients, both at the front door and in our inpatient wards.





Although early identification has significantly improved it has been difficult to sustain the next step which is administration of intravenous antibiotic within an hour of arrival at the emergency department, which is impacted by the overcrowding and lack of flow through both emergency departments. December 2018 figures indicate just under 60% of those identified through screening received intravenous antibiotic within an hour of arriving at the WHH ED and 60% of those identified at QEQMH ED.

To establish whether this is the sole factor contributing to the elevated mortality structured judgement reviews are being undertaken in a random sample of 30 deaths coded as septicaemia. In future the structured judgment review process should enable a much more proactive approach to this through identification of trends form the Learning from Deaths dashboard as the process becomes embedded throughout the Care Groups.

4.6 Learning from Deaths Dashboard

As of end February 2019 the dashboard records the first 283 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 283 cases, in 5 the reviewers opinion was that death was more likely than not to have resulted from a problem in care, in 9 there were problems in care identified which may have contributed to death, and in 58 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. Although some cases will have had more than one problem with care identified throughout the inpatient episode, overall 138 of 283 cases reviewed had a problem with care identified. 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	26	2	9
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	35	4	2

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

4.7 Conclusions and next steps

Overall there has been little change in mortality indices for the Trust as a whole over the last 5 years. There has been a change in the Trust's position in comparison to other Trusts in the country driven by improvements in national mortality indices. There is also a difference between our depth of coding compared to the England average which may partially explain this (3.4 for elective admissions and 3.9 for non-elective admissions versus the England average of 4.5 and 4.7 respectively). Nevertheless identification of underlying disease codes where observed mortality is higher than expected and in depth review of individual cases to identify areas for improvement should drive the mortality indices in the right direction.

This report has not delved into site differences in mortality but this will shortly become possible through a change in NHS Digital reporting and will form part of the next report.

Next steps included analysis of mortality by site, in depth notes reviews in selected areas, and driving increased numbers of structured judgment reviews through apportioning time to mortality champions.

QUALITY COMMITTEE CHAIR REPORT **18/134**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 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 February 2019 Quality Committee meeting. The report seeks to answer the following questions in relation to the quality and safety performance:

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

MEETING HELD ON 26 FEBRUARY 2019

1. The following went well over the period:

1.1 The Committee revised its meeting format allocating sufficient time to have focussed discussions on each of the seven Care Group Quality, Risk and Governance reports. These were received at the beginning of the meeting and were presented by each of the Care Group Heads of Nursing. This revised format along with the new style reports was welcomed by Committee members, it was acknowledged that these reports were still work in progress and will be continuously improved. This resulted in positive challenging discussions and the Committee noted the key issues from each of the Care Groups as noted below:

1.1.1 Urgent and Emergency Care (UEC):

1.1.1.1 Staffing remains the main issue, there is on-going work around the recruitment of nursing and medical staff. The Committee requested a briefing to be presented to the next meeting regarding the steps being taken to mitigate any patient safety risks due to medical and nurse staffing.

1.1.1.2 Patient flow continues to be a major issue, which has a detrimental impact on the Emergency Departments (EDs). Particular in relation to the continued issue regarding appropriate provision in the community and support from the Community Trust to enable patients to be discharged.

1.1.2 General and Specialist Medicine (GSM):

1.1.2.1 Performance in relation to compliance regarding responses to complaints is improving.

1.1.2.2 Compliance against Venous Thromboembolism (VTE) assessments remains poor.

1.1.2.3 Staff turnover remains an area of concern.

1.1.3 Surgery – Head and Neck, Breast and Dermatology (SHNBD):

1.1.3.1 A reported Never Event, in relation to a wrong lens surgery.

1.1.3.2 Improved position regarding compliance against on line training.

1.1.4 Surgery and Anaesthetics

1.1.4.1 An overall compliance improvement against the VTE assessment of 94.20%.

1.1.4.2 Increase in the Hospital Standardised Mortality Ratio (HSMR) (rebased data source), which is not significant and this is being reviewed by the Mortality and Morbidity Steering Group around carrying out a more detailed analysis.

1.1.4.3 Actions are in place to address the risk regarding insufficient assurance relating to the corporate risk of inadequate Health and Safety (H&S) systems in the Care Group. To ensure the appropriate provision of evidence and assurance that this is being robustly managed, and that the annual H&S audit programme is being progressed.

1.1.5 Women's and Children's (W&C):

1.1.5.1 A mock Care Quality Commission (CQC) inspection taking place on 26 February, supported by NHS Improvement (NHSI).

1.1.5.2 There has been a decrease in compliance against the VTE risk assessments, which is being addressed and actions put in place to improve compliance.

1.1.5.3 The Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentive Scheme Year 2 is progressing well and is on target to be completed and submitted by the required deadline.

1.1.5.4 The frequency of hand hygiene audits requires improvement and compliance is being monitored weekly by the Ward Managers.

1.1.5.5 There has been a rise in HSMR due to the changes in coding.

1.1.6 Cancer:

1.1.6.1 Mock CQC inspection took place mid-February in preparation for the CQC visit in mid-March for End of Life (EoL) care.

1.1.6.2 CQC corrective actions have been agreed and are being progressed to be completed by the end of February.

1.1.7 Clinical Support Services (CSS):

1.1.7.1 Recruitment remains a challenge and focussed work continues to recruit to vacant posts.

1.1.7.2 Mock CQC inspection identified areas for improvement in Outpatients that have been addressed prior to the CQC visit.

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

1.2.1 The Friends and Family Test (FFT) inpatient satisfaction rate remains positive at 96.5%. In total, 90.5% of responders would recommend the Trust to their friends and family and 5.5% would not.

1.2.2 Overall Harm Free Care (HFC) related to harms patients are admitted with as well as those they acquired in the Trust's care. The Safety Thermometer continues to report green for January 2019 (94.36%) and shows a significant improvement since the previous month (91.87%), exceeding control limits.

1.2.3 Harm free care (new harms) is registering green 99.43%, showing an improvement from the previous month (98.81%), positively exceeding control limits.

1.2.4 Healthcare Associated Infection (HCAI); there have been no Methicillin Resistant Staphylococcus Aureus (MRSA) and the Trust is registering green (below Trust limit) in January. The number of Trust apportioned

MSSA bacteraemias year to date is 23 (as at 23 January 2019), exceeding upper control limit.

1.2.5 Pressure ulcer (PU) rate, the Trust's category 2 PU rate positively exceeded the Trust target in January registering green (0.12) compared with amber (0.19) in December 2018.

1.2.6 Overall Patient Experience, in month 2766 completed inpatient surveys were received, an improvement from 2196 the previous month and improvement across all the questions.

1.2.7 A further increase in incidence of mixed sex accommodation (MSA) breaches in January, with 7 non justifiable breaches affecting 34 patients.

1.2.8 Complaints performance, in relation to complaints responded to within timescales has decreased to 84% (85% is the standard) in January registering amber. Considerable work continues to improve the timeliness of all complaints and reduce the average time open.

1.2.9 Hand hygiene reported at 94% registering red, improvement actions are in place and being progressed to improve compliance.

1.2.10 VTE risk assessment performance remains red (91.8%) against a target of 95%. Improvement actions are being taken forward and the recovery actions are overseen by the PSC.

1.2.11 Serious Incidents (SIs): five breached SI cases were reported in January. The Executive SI meeting continues to support completion and the quality of the investigations. The Chief Nurse and Medical Director continue to receive weekly updates on all SI cases including the breached cases.

1.2.12 The Accident & Emergency (A&E) four hour wait standard remains a priority for the Trust Emergency Departments (EDs).

2. Concerns highlighted over the reporting period:

2.1 The Committee received and discussed a highlight report on the National Constitutional Standards, noting the following:

2.1.1 Emergency Care performance of 77.93% against trajectory of 88.4% including Minor Injury Unit (MIU).

2.1.2 Referral to Treatment (RTT) performance of 76.10% against trajectory of 81.16%.

2.1.3 Cancer performance of 67.92% against trajectory of 85.31%.

2.1.4 Diagnostics performance of 99.73% against of 99.11%.

2.1.5 The Committee received assurance that patient safety and risks are being mitigated as much as possible despite the operational pressures and busy conditions that staff are working under.

2.1.6 The main area of concern is around GP streaming and stranded and super stranded patients. Actions continue around daily focus on internal and external delays to reduce these and improve patient flow through the hospital.

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

2.2.1 Three Never Events declared, relating to wrong site block (outside of theatres), a wrong lens implant and a fall from a restricted window. Root Cause Analysis (RCAs) are in train to understand the underlying factors.

2.2.2 There have been improvements in month with regards to medicines safety.

2.2.3 The confirmed minutes.

QUALITY COMMITTEE CHAIR REPORT **18/134**

3. Other topics discussed:

3.1 The Committee received and discussed a Care Quality Commission (CQC) update report, noting positive progress against the October 2018 paediatric inspection improvement plan. The paediatric taskforce is maintaining weekly oversight in relation to the Section 31 requirements and the 'must do' actions. These actions are on track and overall compliance is above 90%.

3.2 The Committee received and discussed the following reports:

3.2.1 Principal Mitigated Quality Risks, the Committee took assurance from the updates provided in the report in relation to the actions being taken to mitigate the risks.

3.2.2 Board Assurance Framework (BAF) and Annual Priorities 2018/19: Quarter 3, noting these were within the Board's risk tolerance.

3.2.3 Patient Experience Committee (PEC), noting the confirmed minutes and approved the revised terms of reference (ToR).

3.2.4 Quality Strategy Quarter 3, an update report was requested to be presented to the next Committee meeting providing a briefing regarding the 'red' risks and the actions being taken to turn these to 'amber' by the end of Quarter 4.

3.2.5 Central Alert System (CAS) Incorporating Compliance with Patient Safety Alerts (PSA), noting the 95% compliance, an improved position from the 2017/2018 financial year of 80%. The Committee received assurance from the Care Groups that PSAs are appropriately acted upon. The Committee requested the designated lead attend to provide assurance of the actions being taken with regards to any outstanding and 'red' areas.

3.2.6 Infection Control Quarter 3, noting the total number of *C.difficile* cases is 1 below the Department of Health (DH) trajectory, Methicillin Resistant *Staphylococcus aureus* assigned blood stream infections increased to 5 above the DH limit of zero, Methicillin Sensitive *Staphylococcus aureus* remain largely community based infections.

3.2.7 National Institute of Clinical Excellence (NICE)/Clinical Audit and Effectiveness Committee (CAEC), noting the confirmed minutes and approved the revised ToR.

3.2.8 Clinical Audit Progress Report, noting the significant improvements in the Trust's clinical audit programme. Progress and performance on delivery of the programme is monitored monthly by the NICE/CAEC.

RECOMMENDATIONS AND ACTION REQUIRED:

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

REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE 18/135

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 2019**
SUBJECT:	**REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE (NRC)**
BOARD SPONSOR:	**WENDY COOKSON, CHAIR OF THE NRC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Nominations and Remuneration Committee is a Committee of the Board and fulfils the role of the Nominations and Remuneration Committee for Executive Directors described in the Trust's constitution and the NHS Foundation Trust Code of Governance.

The purpose of the committee will be to decide on the appropriate remuneration, allowances and terms of and conditions of service for the Chief Executive and other Executive Directors including:

(i) all aspects of salary (including performance related elements/ bonuses).
(ii) provisions for other benefits, including pensions and cars.
(iii) arrangements for termination of employment and other contractual terms.

To appoint and set the terms and conditions for subsidiary Board members and review any Key Performance Indicators/performance bonus. Receive a recommendation from the subsidiary Board and Nominations and Remuneration Committee on achievement against these.

To recommend the level of remuneration for Executive Directors and monitor the level and structure of remuneration for very senior management.

To agree and oversee, on behalf of the Board of Directors, performance management of the Executive Directors, including the Chief Executive.

The Trust Chairman and other Non-Executive Directors and Chief Executive (except in the case of the appointment of a Chief Executive) are responsible for deciding the appointment of Executive Directors.

The appointment of a Chief Executive requires the approval of the Council of Governors.

MEETING HELD ON 7 FEBRUARY 2019

The Committee received and discussed the following reports:

1.1 Recruitment of Chief Nurse and Director of Patient Experience and Quality. The Committee approved to commence the appointment process for this position as well as approval:
- 1.1.1 To formally convene an appointments panel including the Chief Executive. The panel will have the delegated responsibility for agreeing the job description, candidate pack and the appointments process.
- 1.1.2 The agreed salary range for this post.
- 1.1.3 That the Chief Executive seek the opinion from NHS Improvement on the

appointment to the post and the agreed salary range.

1.2 Acting Up for Director of Human Resources (HR). In relation to the provision of cover in the absence of the Director of HR, the Committee nominated and authorised that the Trust's Deputy Director of HR formally act as Director of HR until further notice.

1.3 Trust Secretary. The Committee discussed and approved the revised job description of the Trust Secretary in relation to the dimensions and responsibilities of this role.

1.4 Fit and Proper Persons Requirement (FPPR) Policy. The Committee received and approved the revised Fit and Proper Persons Requirement Policy, reflecting the changes within the appraisal process that discussions to confirm that the individuals' circumstances have not changed in relation to meeting the FPPR.

1.5 Executive Remuneration and Appointment of Managing Director for 2gether Support Solutions (2gether). The Committee approved:

1.5.1 The appointment of the permanent Managing Director role for 2gether along with the remuneration for this role.

1.5.2 The Remuneration Policy for Executive and Non-Executive Directors in 2gether.

1.6 Subsidiary Non-Executive Director (NED) Appointments. The Committee agreed the annual remuneration for NEDs in-common roles.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and accept the report for approval.

REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE 18/136

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 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:	**APPENDIX 1: EQUALITY INFORMATION REPORT PEOPLE**

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 February 2019 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 12 FEBRUARY 2019

1. SWC Effectiveness Survey

The Committee received and discussed a report following the annual effectiveness survey of the SWC. In relation to undertaking a self-assessment of the SWC objectives delegated by the Board against the Committee's terms of reference (ToR). It was agreed that the ToR would be further revised to include more specific remit regarding the Kent and Medway Medical School. The Committee discussed the frequency of SWC meetings and whether these should be reduced to enable focus on strategic elements of workforce, and that the operational elements be moved for discussion at the Finance and Performance Committee (FPC) and/or the Quality Committee (QC). The Committee would review the further revised ToR along with the SWC work programme at its next meeting in April 2019.

2. Integrated Performance Report (IPR) – HR Performance Metrics for December 2018

2.1 The Committee discussed and noted the following headlines:

2.1.1 Positive news in relation to improvements around the recruitment of staff, as well as staff retention.

2.1.2 The Trust's planned overseas recruitment of medical staff and nurses in March 2019.

2.1.3 Sickness absence increased during the reporting period to 4.5% and remains above Trust target. However, the rolling 12 month average shows this is a reduction on a rolling average with the same period last year.

2.1.4 Statutory training compliance remains within Trust target at 96% and shows an improved picture of 98% average compliance over the 12 month period.

2.1.5 Turnover rates remained at 14.4% during December but remain higher than the average reported for the proceeding rolling 12 month period. It is anticipated that January will show a decrease with 105 new starters attending the Trust

welcome day on the 7 January.

2.1.6 Appraisal rates continue to increase at 79.6% but have not yet reached the target. Completion rate is lower on a rolling 12 month average than this time last year. Appraisal rates are being discussed and monitored through the Executive Performance Review (EPR) process by the Chief Operating Officer on a monthly basis and the Director of HR quarterly.

2.1.7 Monthly agency taskforce meetings continue, aiming to increase the numbers of staff working additional shifts through the bank and reduce over time and agency spend along with reducing the reliance on agency. Managers' guidance on when to authorise over time is being produced to ensure this is applied consistently and to enable further reduction in spend.

3. Leadership Programme

The Committee noted that the Leadership Programme would be cascaded to senior teams throughout the Trust.

4. Clinical Support Services (CSS) Care Group Presentation

The Committee received and discussed a presentation from the CSS Care Group, covering the audiology, out-patients, pathology, pharmacy, therapies and radiology departments. This provided an overview of the Care Group's performance against the workforce key performance indicators (KPIs), along with progress against its recruitment plan, particularly in relation to the hard to recruit roles. The presentation was provided by the Care Group Clinical Director and Operational Director, providing details of the priorities and the planned changes to be implemented in the coming year. The Committee noted the very positive presentation and the hard work and progress already made by the Care Group.

5. Equality Information Report People

5.1 The Committee received, discussed and approved the Equality Information Report People for publication, which is attached (Appendix 1) for the Board's consideration and approval. The Equality Act 2010 (Specific Duties) Regulations 2011, requires each public authority to publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act (The Public Sector Equality Duty [PSED]). This report provides evidence of the Trust's Diversity and Inclusion performance. The Trust continues to work with the Black Asian or Minority Ethnic (BAME) Network to develop programmes to support minority progression in the Trust. The areas for development generally focus on Pay Bands, providing opportunities for activities to improve access to promotion and recruitment into higher band for minority groups, particularly in relation to:

5.1.1 Women continue to be over represented in grades from Apprentice to Band 8D and underrepresented above Band 8D.

5.1.2 There is a reduced proportion of BAME staff in all non-clinical bands.

5.1.3 In Bands 8C, 8D, 9 and Executive. There are no staff who have declared a disability.

6. Patient/Service User Engagement

The Committee noted that the Trust will be supporting the encouragement of patient/service user engagement throughout the organisation, and acknowledged the significant benefits of this around the Trust sustaining continued improvements.

7. Workforce Modelling

7.1 The Committee received and discussed a report regarding the Trust delivering a comprehensive workforce plan, around identifying future requirements in terms of workforce design including roles and responsibilities. The development of this plan will enable strategic planning of recruitment and development along with monitoring progress against trajectories. The Committee noted the following key points:

REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE 18/136

7.1.1 HR Business Partners are working closely with the Care Groups actively exploring working models in relation to introducing or expanding Associate Nurses, Physician Associates, Advanced Clinical Practitioner roles and the use of Mental Health Nurses in Emergency Departments.

7.1.2 The Trust has successfully appointed Trainees to the Advanced Clinical Practitioner (ACP) roles, all trainees are achieving their academic milestones with a retention rate of 100%, 6 trainees based at William Harvey Hospital (WHH) and 5 at Queen Elizabeth the Queen Mother Hospital (QEQMH).

7.1.3 The Trust is currently supporting 117 staff through Apprenticeships, including 19 Nursing Associates at level 5, 3 Healthcare Assistant Practitioners at level 5, 12 Senior Healthcare Support Worker apprenticeships at level 3, 11 Laboratory science level 3 apprenticeships, 4 Pharmacy apprenticeships and a range of leadership and administration apprenticeships.

7.1.4 The Trust is exploring with the Kent and Medway apprenticeship forum the procurement of apprenticeships for Mamographer Associates (level 5), Operating Department Practitioners, Midwives, Advanced Clinical Practitioners, Physiotherapy, Occupational Therapy, Nursing and Healthcare sciences apprenticeships at level 6, around establishing a joint procurement process and plan.

7.1.5 The Committee noted that the longer-term strategic view of the Trust's workforce requirements will be a standing agenda item at future Committee meetings, ensuring robust monitoring of progress against remodelling its workforce to support the Clinical Strategy.

8. Staff Turnover and Exit Interview – Quarter 2 and Quarter 3 Report

8.1 The Committee received and discussed a report regarding staff turnover and feedback from exit interviews. The Committee noted the key headlines below:

8.1.1 The Corporate Retention Group will review areas with the highest turnover.

8.1.2 The Committee commended the Recruitment team on their hard work and support, which resulted in the Trust successfully achieving a high volume of recruitment.

8.1.3 The total number of joiners has far outstripped the total number of leavers.

8.1.4 Nurse turnover (18.78%) has remained considerably lower than the previous year's average (25%).

9. Other Reports

9.1 The Committee received and discussed a report regarding diversity targets and approved the recommendations:

9.1.1 That the Head of Diversity & Inclusion (Head D&I) review the NHS Workforce Equality Strategy after publication and report on its implications.

9.1.2 That the Head of D&I prepare targets for black and minority ethnic representation in line with the NHS Strategy.

9.1.3 That the Head of D&I includes the targets and an action plan in the NHS Workforce Race Equality Standard (WRES) programme report to be presented to the SWC in June.

9.2 The Committee received and discussed the following reports:

9.2.1 Occupational Health Activity Report.

9.2.2 People Strategy 2018/19 Update.

9.2.3 Board Assurance Framework (BAF) and Annual Priorities 2018/19: Quarter 3.

9.2.4 HR, Workforce and Organisational Development Risks Review.

9.3 The Committee received and noted reports and confirmed minutes from the following:

9.3.1 Joint Chairs of Staff Committee.

9.3.2 Joint Chairs of the Local Negotiating Committee of the British Medical Association.

REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE **18/136**

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss the report from the Strategic Workforce Committee and:

1) Accept the report for approval.
2) Approve the Equality Information Report People for publication.

NHS
East Kent
Hospitals University
NHS Foundation Trust

Diversity & Inclusion Report for the period: 01 April 2017 – 31 March 2018

Part A: People

Bruce Campion-Smith

Head of Equality, Diversity and Inclusion

January 2019

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Summary

This report provides evidence of East Kent Hospitals University NHS Foundation Trust (EKHUFT) Diversity & Inclusion performance. Overall, the data paints an improving picture resulting from Diversity & Inclusion activities during the year.

There continue to be areas for development generally would appear to focus on Pay Bands, providing opportunities for activities to improve access to promotion and recruitment into higher bands for minority groups. The Trust is working with the Black Asian or Minority Ethnic (BAME) Network to develop programs to support minority progression in the Trust.

- Women continue to be over represented in grades from Apprentice to Band 8D and underrepresented above Band 8D.
- There is a reduced proportion of BAME staff in all nonclinical bands.
- In Bands 8c, 8d, 9 and Exec. There are no staff who have declared a disability.

1 Rationale

This document is the EKHUFT response to The Equality Act 2010 (Specific Duties) Regulations 2011, which require each public authority to publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act (The Public Sector Equality Duty [PSED])

The information must include, in particular, information relating to persons who share a relevant protected characteristic who are its employees (People - Part A) and other persons affected by its policies and practices (Patients – Part B).

2 Introduction

The public sector Equality Duty, in section 149 of the Equality Act 2010, requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to:

a. eliminate discrimination

b. advance equality of opportunity and

c. foster good relations between different people when carrying out their activities

2.1 Protected Characteristics

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

3 Data Collection

This report is based on data collected from the Electronic Staff Register (ESR).

4 Report Style

To dramatically reduce the length and complexity of this document only those issues, which have been identified as statistically significant, are covered.

5 Statistical Significance

Data has only been considered significant when numbers fall outside the range of plus (+) or minus (–) two standard deviations. The standard deviation is commonly used to measure confidence in statistical conclusions. The reported margin of error is typically about twice the standard deviation, the half-width of a 95 per cent confidence interval. In science, researchers commonly report the standard deviation of experimental data, and only effects that fall much farther than one standard deviation away from what would have been expected are considered statistically significant – normal random error or variation in the measurements is in this way distinguished from causal variation.

6 Demographics

The demographic data used to produce this report has been based on data obtained in the 2011 census and ONS Mid-Year Estimates 2015. Comparisons have been made between trust data and population where appropriate. A more detailed summary of the East Kent population is published on the Equality pages of the EKHUFT web site

7 Headcount

On 31 March 2017 the Trust employed 7904 people.

On 31 March 2018 the Trust employed 7928 people.

7.1 Sex

77.92% of employees are female in contrast to the local population where 51.1% are female (ONS Mid-Year Estimates 2015). This situation is reflected across the NHS at large.

	2017	2018	Population %
Female	77.98%	77.92%	51.40%
Male	22.02%	22.08%	48.60%

Table 1 Breakdown by Sex

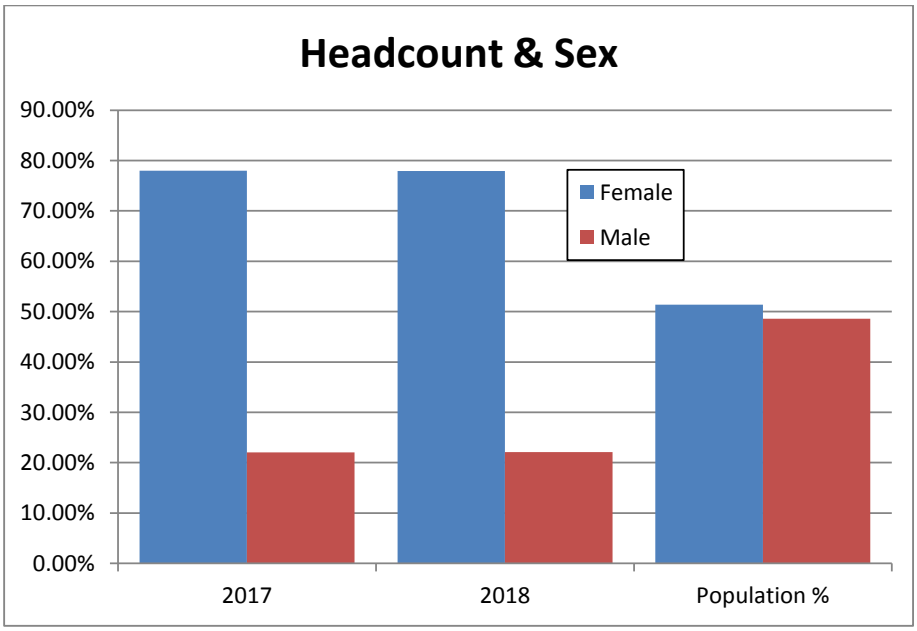


Chart 1 Breakdown by Sex

7.2 Race

The national census current population estimates suggest that 90.56% of the local population described themselves as White. The level of EKHUFT staff who describe themselves as White is noticeably less at 65.4% which is probably a consequence of high number of staff who have not declared their ethnicity..

	2017	2018	Pop.
A White - British	64.35%	66.50%	90.80%
B Irish	0.92%	0.80%	0.70%
C Any other White background	4.91%	5.24%	3.50%
D White & Black Caribbean	0.29%	0.27%	0.40%
E White & Black African	0.03%	0.03%	0.20%
F White & Asian	0.39%	0.42%	0.40%
G Any other mixed background	0.42%	0.40%	0.30%
H Indian	5.22%	5.19%	0.60%
J Pakistani	0.67%	0.63%	0.10%
K Bangladeshi	0.23%	0.19%	0.20%
L Any other Asian background	3.56%	3.13%	1.20%
M Caribbean	0.32%	0.28%	0.20%
N African	1.87%	1.77%	0.60%
P Any other Black background	0.23%	0.22%	0.10%
R Chinese	0.53%	0.76%	0.40%
S Any Other Ethnic Group	1.08%	1.04%	0.30%
Z Not Stated	15.00%	13.16%	

Table 2 Ethnicity and Headcount

16.3% of our staff describe themselves as from a BAME but only 5.0% of our local population describe themselves as BAME

1040 members of staff have chosen not to declare their ethnicity.

	2017	2018	Pop.
White	70.18%	72.53%	95.00%
BAME	29.82%	27.47%	5.00%
Z Not Stated	15.00%	13.16%	

Table 3 Ethnicity 2

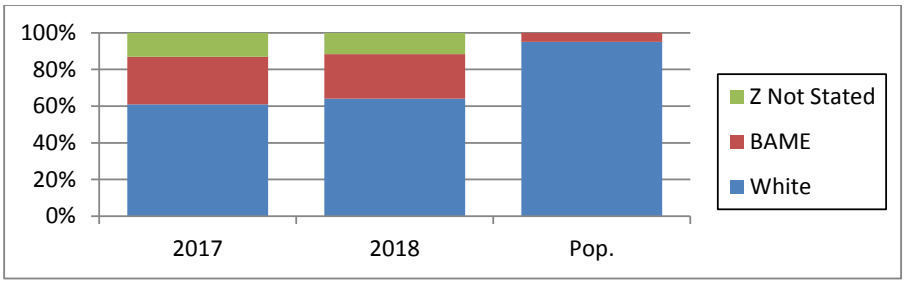


Chart 2 Ethnicity

7.3 Religion

46.51% of staff at EKHUFT did not wish to disclose their religion/belief compared to 7.47% of the East Kent Population.

	2017	2018	2017	2018	Pop.	Pop.%
No religion	670	654	8.45%	8.27%	209193	27.57%
Buddhism	44	45	0.55%	0.57%	3934	0.52%
Christianity	2890	2957	36.45%	37.41%	472194	62.23%
Hinduism	151	152	1.90%	1.92%	5577	0.74%
Not disclosed	3738	3676	47.15%	46.51%	56659	7.47%
Islam	86	81	1.08%	1.02%	6196	0.82%
Other	341	327	4.30%	4.14%	3412	0.45%
Judaism	2	2	0.03%	0.03%	924	0.12%
Sikhism	6	10	0.08%	0.13%	676	0.09%
Grand Total	7928	7904	100.00%	100.00%	758765	100.00%

Table 4 Religion

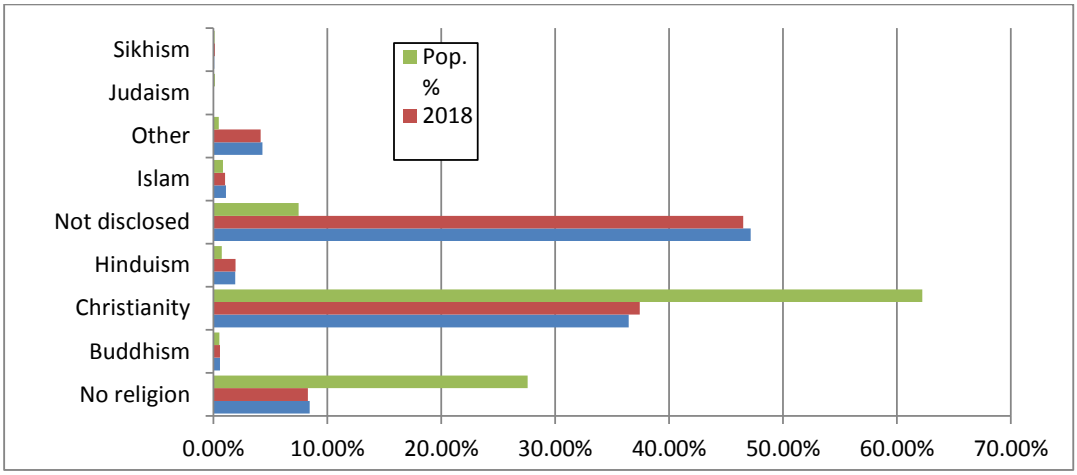


Chart 3 Religion

7.4 Sexual Orientation

55.23% of EKHUFT Staff identified as Heterosexual. 43.50% chose not to disclose their sexual orientation leaving 1.28% of staff identifying as lesbian, gay, bisexual or Transgender(LGBT+).

	2017	2018	2017	2018
Bisexual	46	44	0.58%	0.56%
Gay	39	31	0.49%	0.39%
Heterosexual	4348	4365	54.84%	55.23%
Not disclosed	3465	3438	43.71%	43.50%
Lesbian	30	26	0.38%	0.33%

Table 5 Sexual Orientation

8 Grade

8.1 Sex

Women continue to be over represented in grades from Apprentice to Band 8D and underrepresented above Band 8D. The levels for doctors in training are evenly balanced. It is reassuring to note that there have been significant increases in the number of women employed as apprentices, consultants, senior managers and managers employed at Band 8B and 8D. This may suggest that our Gender Pay Gap action plan is resulting in positive change. It must be rec recognised that these changes in numbers will probably take some years before they impact on the Gender Pay Gap calculations.

Band	2017		2018		% Change
	Female	Male	Female	Male	
Apprentice	6	16	28	12	366.67%
AfC Band 1	30	14	29	12	-3.33%
AfC Band 2	1431	304	1431	304	0.00%
AfC Band 3	684	83	684	89	0.00%
AfC Band 4	419	84	435	96	3.82%
AfC Band 5	1375	252	1293	227	-5.96%
AfC Band 6	1061	166	1049	169	-1.13%
AfC Band 7	573	146	609	151	6.28%
AfC Band 8a	128	49	129	62	0.78%
AfC Band 8b	67	35	75	33	11.94%
AfC Band 8c	19	9	19	9	0.00%
AfC Band 8d	5	2	7	2	40.00%
AfC Band 9	1	2		2	-100.00%
Consultant	102	285	119	298	16.67%
Doctor in Training	199	210	214	179	7.54%
Non Consultant Doctor	47	77	47	89	0.00%
Senior Manager	12	11	14	12	16.67%
Grand Total	6159	1745	6182	1746	0.37%

Table 6 Sex

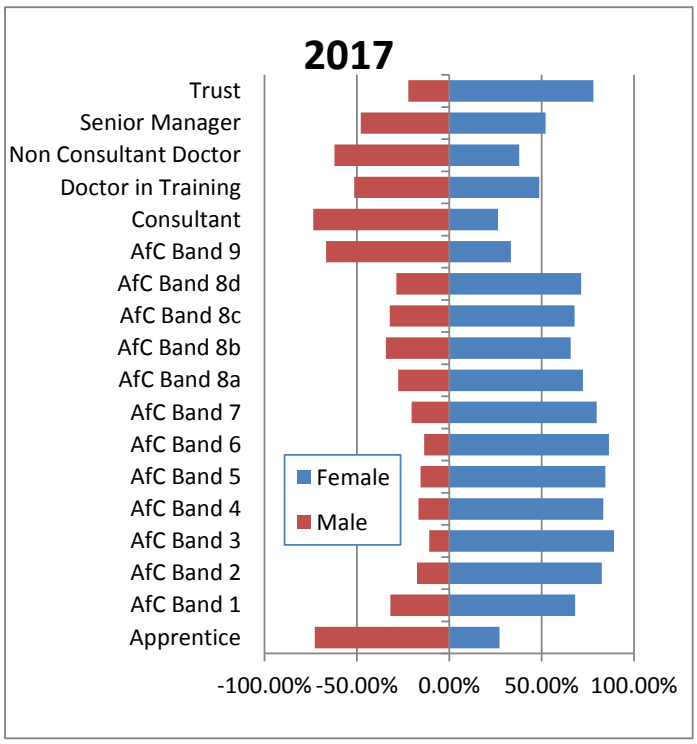


Chart 4 Band 2017

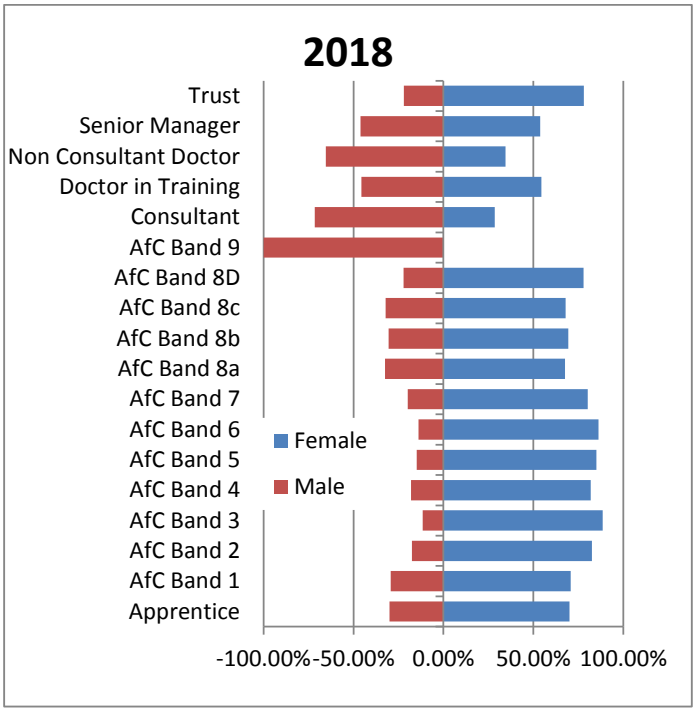


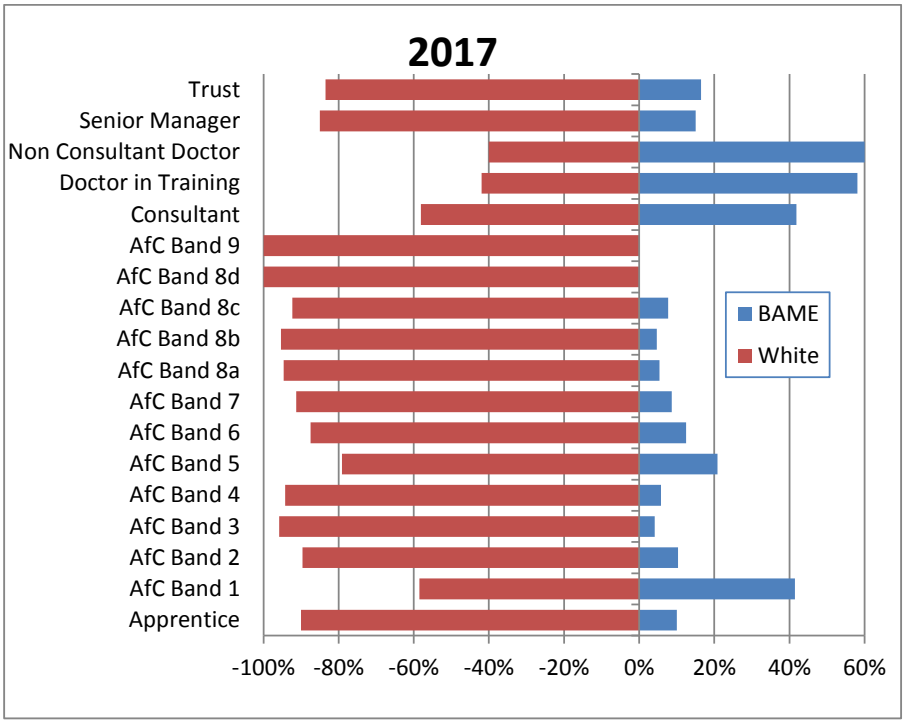
Chart 5 Band 2018

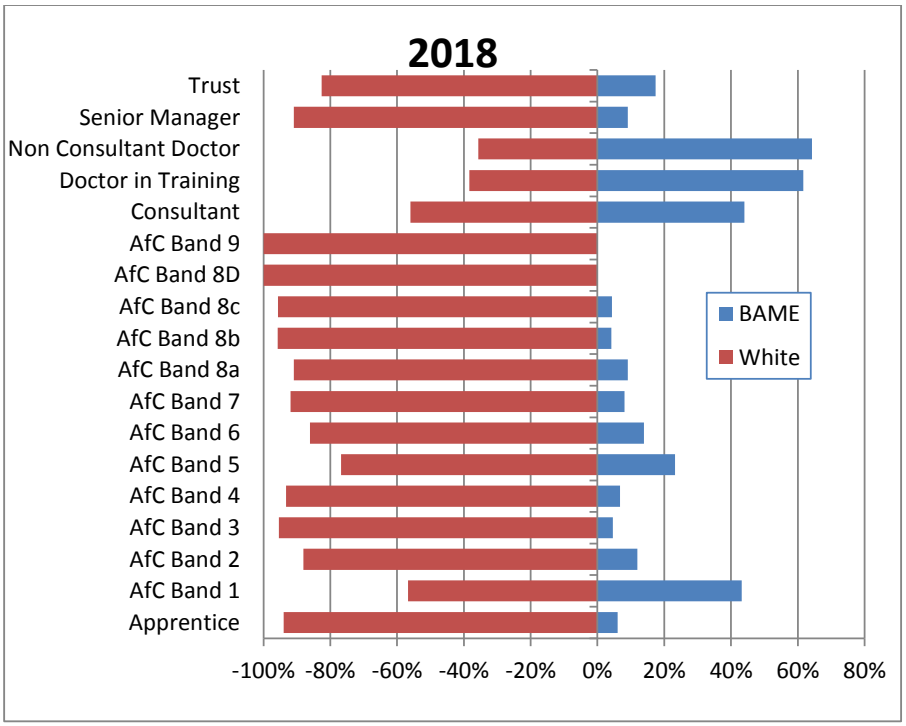
8.2 Race

In general, the Trust employs a higher proportion of Black Asian and Minority Ethnic (BAME) staff than found in the local population. Currently 15% of the Trusts employees are from BAME groups compared to 5% found in the East Kent population. There is a reduced proportion of BAME staff in all nonclinical bands. There is a much higher proportion of BAME Clinical grades

	BAME		White		Not Stated	
Grade/Band	2017	2018	2017	2018	2017	2018
Apprentice	1	2	9	31	12	7
AfC Band 1	17	16	24	21	3	4
AfC Band 2	154	176	1335	1298	246	261
AfC Band 3	28	31	647	640	92	102
AfC Band 4	26	32	424	440	53	59
AfC Band 5	281	288	1067	953	279	279
AfC Band 6	135	146	946	905	146	167
AfC Band 7	57	55	600	623	62	82
AfC Band 8a	9	16	158	160	10	15
AfC Band 8b	4	4	82	91	16	13
AfC Band 8c	2	1	24	22	2	5
AfC Band 8d			7	8		1
AfC Band 9			3	2		
Consultant	142	157	197	200	48	60
Doctor in Training	209	177	151	110	49	106
Non Consultant Doctor	63	72	42	40	19	24
Senior Manager	3	2	17	20	3	4
Grand Total	1131	1175	5733	5564	1040	1189

Table 7 Ethnicity


2017
Trust
Senior Manager
Non Consultant Doctor
Doctor in Training
Consultant
AfC Band 9
AfC Band 8d
AfC Band 8c
AfC Band 8b
AfC Band 8a
AfC Band 7
AfC Band 6
AfC Band 5
AfC Band 4
AfC Band 3
AfC Band 2
AfC Band 1
Apprentice
BAME
White
-100% -80% -60% -40% -20% 0% 20% 40% 60%


2018
Trust
Senior Manager
Non Consultant Doctor
Doctor in Training
Consultant
AfC Band 9
AfC Band 8D
AfC Band 8c
AfC Band 8b
AfC Band 8a
AfC Band 7
AfC Band 6
AfC Band 5
AfC Band 4
AfC Band 3
AfC Band 2
AfC Band 1
Apprentice
BAME
White
-100% -80% -60% -40% -20% 0% 20% 40% 60% 80%

8.3 Disability

2017				
Band/Grade	**Not Disabled**	**Not Declared**	**Disabled**	**Grand Total**
Apprentice	8	12	2	22
AfC Band 1	26	13	5	44
AfC Band 2	1110	560	65	1735
AfC Band 3	504	232	31	767
AfC Band 4	344	132	27	503
AfC Band 5	1049	524	54	1627
AfC Band 6	770	399	58	1227
AfC Band 7	478	219	22	719
AfC Band 8a	124	43	10	177
AfC Band 8b	63	35	4	102
AfC Band 8c	16	12		28
AfC Band 8d	6	1		7
AfC Band 9	3			3
Consultant	195	182	10	387
Doctor in Training	194	209	6	409
Non Consultant Doctor	49	70	5	124
Senior Manager	17	5	1	23
Grand Total	4956	2648	300	7904

Table 8 Disability 2017

2018				
Band/Grade	Not Disabled	Not Declared	Disabled	Grand Total
Apprentice	29	10	1	40
AfC Band 1	26	11	4	41
AfC Band 2	1114	559	62	1735
AfC Band 3	521	222	30	773
AfC Band 4	362	140	29	531
AfC Band 5	968	499	53	1520
AfC Band 6	760	403	55	1218
AfC Band 7	493	242	25	760
AfC Band 8a	137	45	9	191
AfC Band 8b	66	37	5	108
AfC Band 8c	15	13		28
AfC Band 8d	7	2		9
AfC Band 9	2			2
Consultant	213	196	8	417
Doctor in Training	67	325	1	393
Non Consultant Doctor	63	69	4	136
Senior Manager	20	5	1	26
Grand Total	4863	2778	287	7928

Table 9 Disability 2018

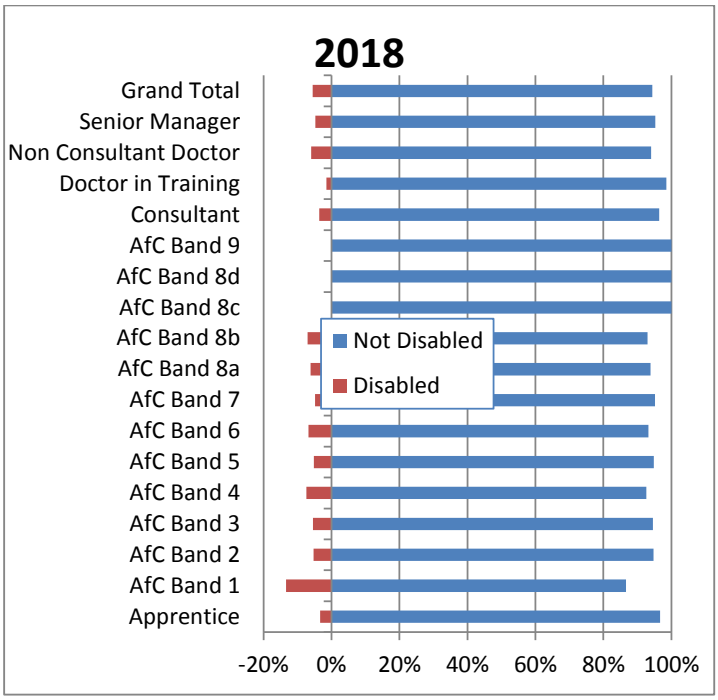


Chart 6 Band & Disability

The UK Government's Office for Disability Issues states that 16% of working age adults have a disability. 3.62% of staff employed by EKHUFT have declared a disability.

35.23% of EKHUFT staff chose not to declare whether or not they have a disability.

In Bands 8c, 8d, 9 and Exec. There are no staff who have declared a disability.

9 Promotion

This section compares headcount to promotion. Promotion is defined as, when a member of staff moves to a higher band.

9.1 Race

Ethnicity	2017 % Promoted	2018 % Promoted	% of workforce
BAME	7.29%	10.59%	14.82%
Not Stated	8.33%	16.47%	15.00%
White	84.38%	72.94%	70.18%

Table 10 Promotion & Ethnicity

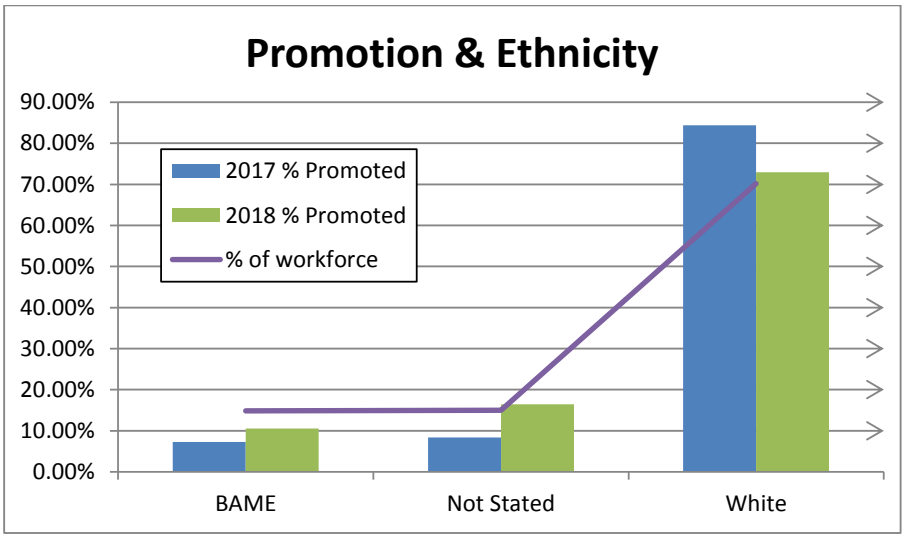


Chart 7 Promotion & Etnicity

In The Year ending 31 March 2017, 7.29% of those promoted identified themselves as BAME when BAME staff constituted 14.82%of our staff.

In The Year ending 31 March 2018 10.59% of those promoted identified themselves as BAME.

The proportion of BAME staff promoted increased by 3.3% 2018, which is significant improvement but which still needs to be a focus of activity.

9.2 Sex

Sex	% Promoted 2017	% Promoted 2018	% of Workforce
Female	90.63%	75.29%	77.92%
Male	9.38%	24.71%	22.08%

Table 11 Promotion & Sex

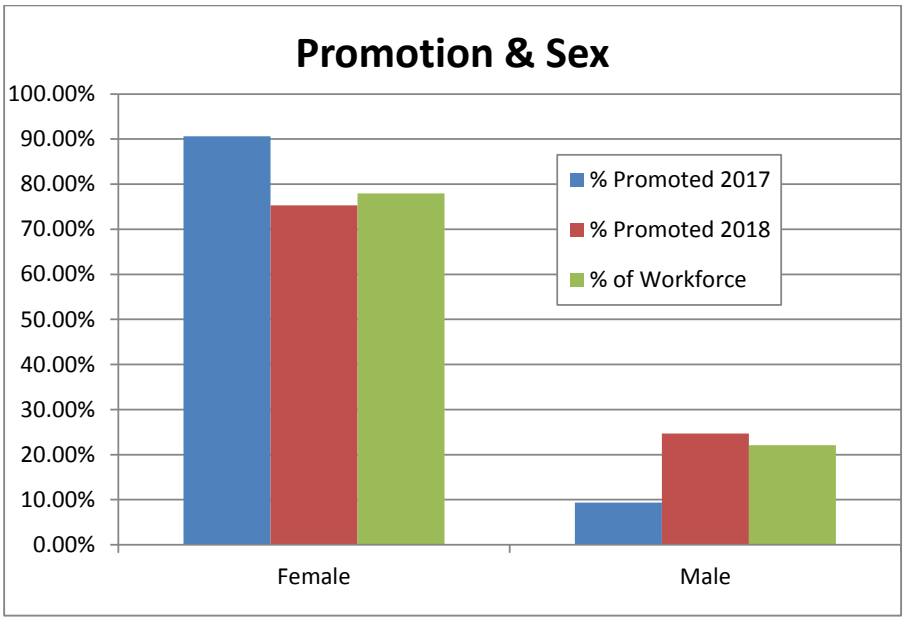


Chart 8 Promotion & Sex

Proportionately women were more likely to be promoted in 2017 and men more likely in 2018

9.3 Working Pattern

Working pattern	% Promoted 2017	% Promoted 2018	% of Workforce
Full Time	69.79%	76.47%	67.38%
Part Time	30.21%	23.53%	32.62%

Table 12 Promotion & Work Pattern

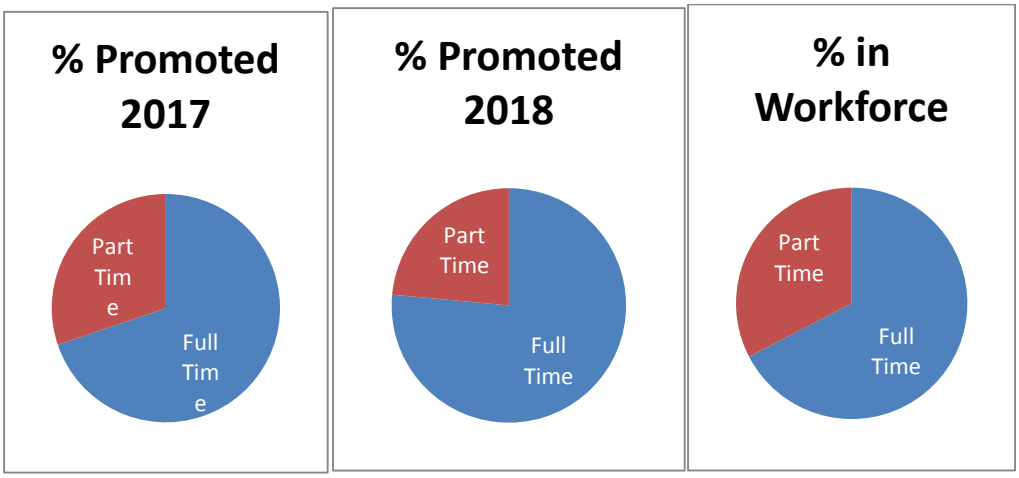


Chart 9 Promotion & Work Pattern

During 2018, full time workers were promoted proportionately more than part-time workers.

9.4 Disability

Disability	% Promoted 2017	% Promoted 2018	% in Workforce
Not Disabled	67.71%	67.65%	61.30%
Not Declared	29.17%	30.00%	35.08%
Disabled	3.13%	2.35%	3.62%

Table 13 Promotion & Disability

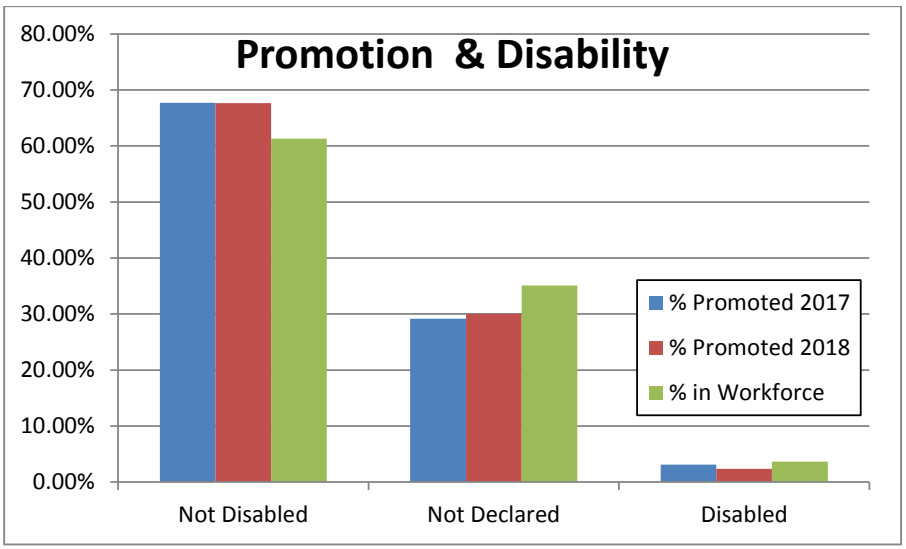


Chart 10 Disability & Promotion

10 Sickness

In the following section, Worktime refers to the total time that staff are normally available for work show as a percentage for each relevant group.

10.1 Sex

Sex	% Absence 2017	% Worktime 2017	% Absence 2018	% Worktime 2018
Female	86.31%	78.75%	86.41%	78.78%
Male	13.69%	21.25%	13.59%	21.22%

Table 14 Sickness & Sex

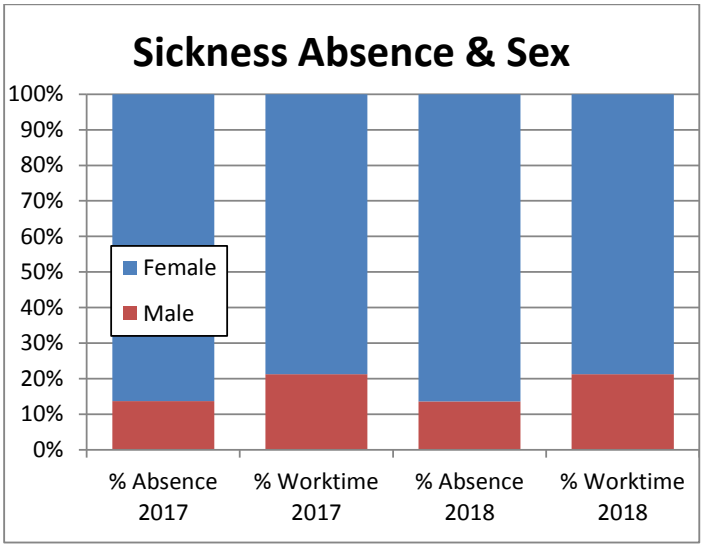


Chart 11 Sickness & Sex

Women who account for 78.7% of the workforce availability account for 86.41% of sickness absence. Men are contracted to work for 21.2% but are responsible for 13.5% of absence.

10.2 Disability

Disability	% Absence 2017	% Worktime 2017	% Absence 2018	% Worktime 2018
Not Disabled	57.27%	63.55%	60.15%	62.22%
Not Declared	36.71%	32.63%	33.00%	34.21%
Disabled	6.02%	3.82%	6.85%	3.58%

Table 15 Sickness & Disability

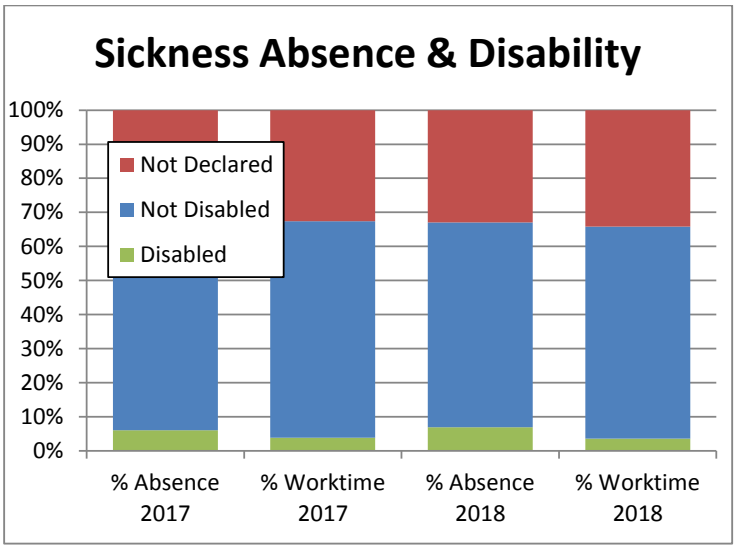


Chart 12 Sickness & Disability

People who classified themselves as disabled on average took higher levels of sickness absence than those who did not.A very high proportion of staff have chosen not to declare their status.

10.3 Age

Age Band	% Absence 2017	% Worktime 2017	% Absence 2018	% Worktime 2018
16 - 20	0.34%	0.57%	0.58%	0.56%
21 - 25	5.26%	7.01%	4.33%	6.16%
26 - 30	8.34%	12.30%	8.04%	12.00%
31 - 35	9.23%	11.20%	9.94%	11.43%
36 - 40	8.83%	11.89%	9.94%	12.10%
41 - 45	10.37%	12.86%	11.76%	13.04%
46 - 50	15.09%	13.67%	16.25%	13.55%
51 - 55	18.22%	14.63%	18.24%	14.46%
56 - 60	16.37%	10.29%	13.33%	10.92%
61 - 65	6.30%	4.38%	6.04%	4.47%
66 - 70	1.10%	0.80%	0.92%	0.90%
71 & above	0.54%	0.41%	0.62%	0.42%

Table 16 Sickness & Age

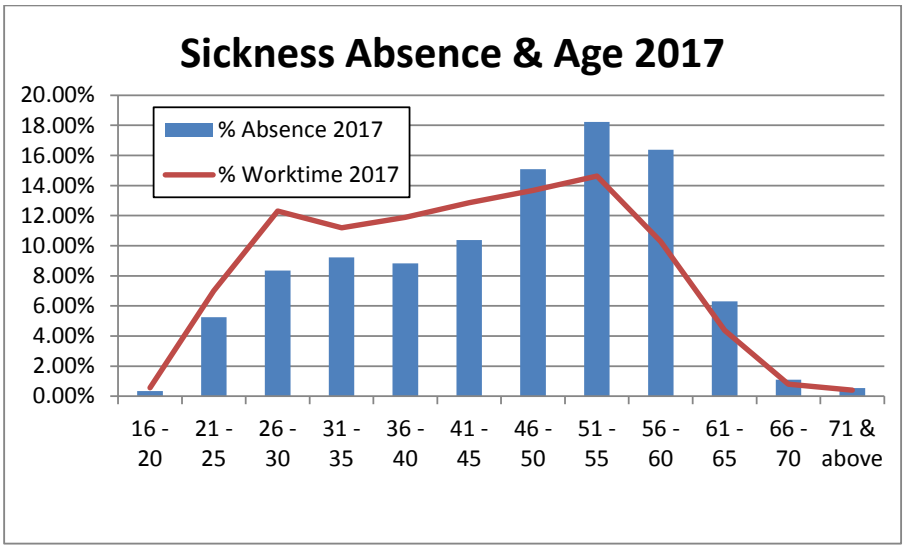


Chart 13 Sickness & Age 2017

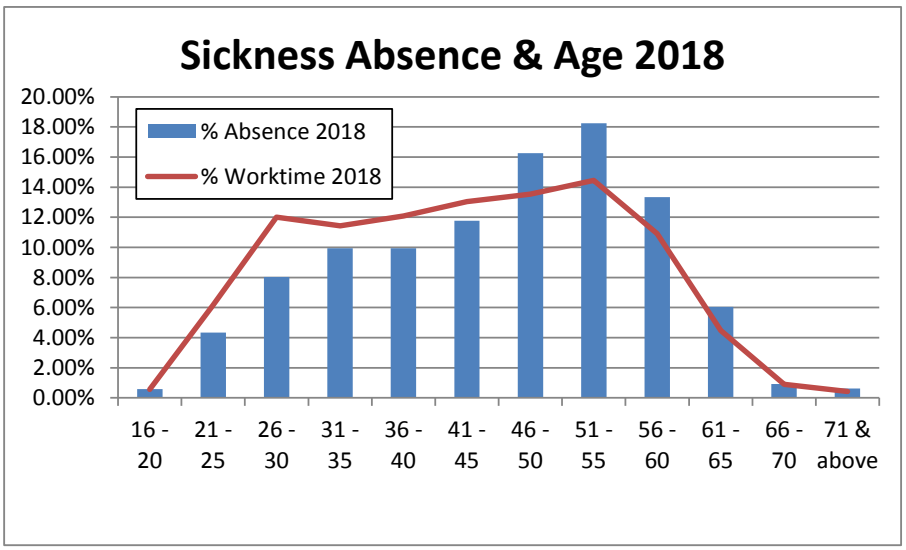


Chart 14 Sickness & Age 2018

Those staff members over the age of 46 tend to take higher levels of sickness absence than those 45 years and younger. The highest levels of sickness absence were taken by those aged 51 to 60 years old.

10.4 Ethnicity

Ethnicity	% Absence 2017	% Worktime 2017	% Absence 2018	% Worktime 2018
BAME	8.61%	14.75%	9.94%	15.29%
Not Stated	11.20%	11.78%	13.56%	13.88%
White	80.20%	73.47%	76.50%	70.83%

Table 17 Ethnicity & Sickness

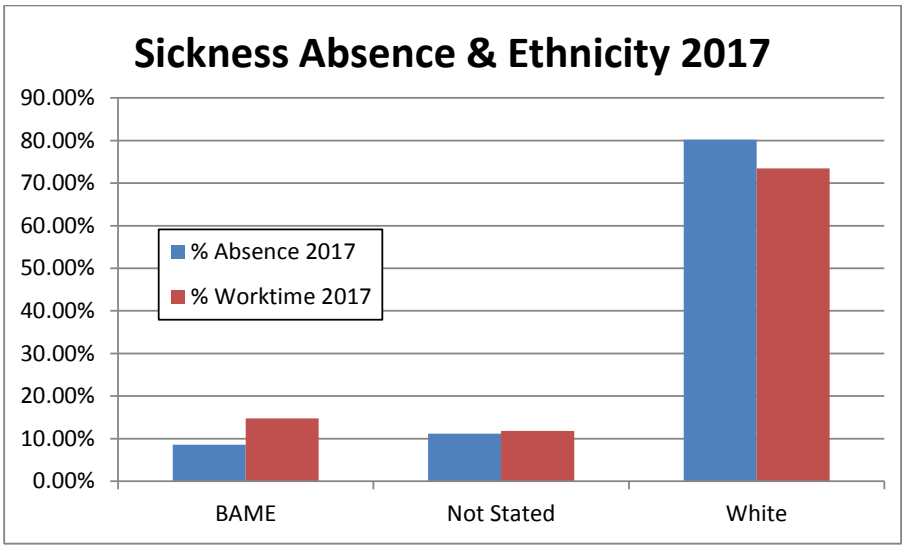


Chart 15 Sickness & Ethnicity 2017

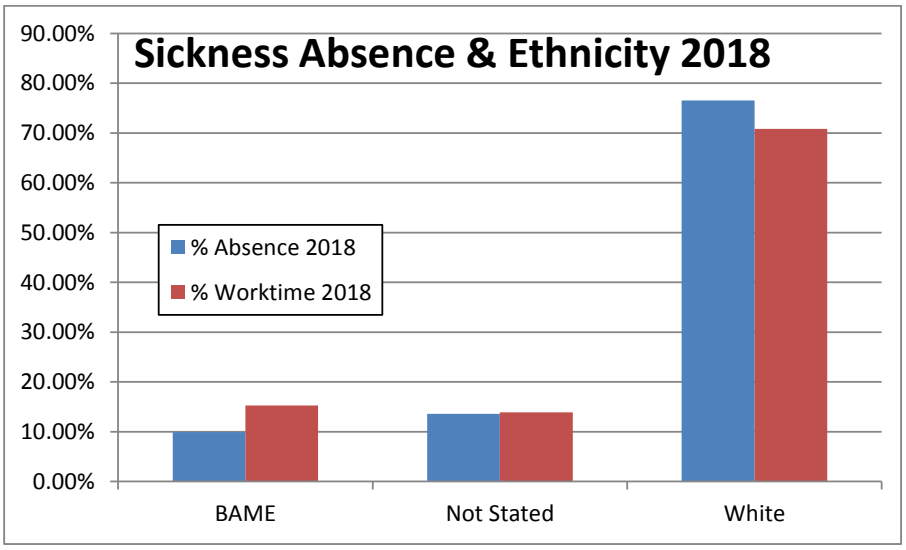


Chart 16 Sickness & Ethnicity 2018

Generally white staff take higher levels of sickness than black staff.

10.5 Work Pattern

Work Pattern	% Absence 2017	% Worktime 2017	% Absence 2018	% Worktime 2018
Full Time	67.62%	74.19%	68.71%	74.02%
Part Time	32.38%	25.81%	31.29%	25.98%
Grand Total	100.00%	100.00%	100.00%	100.00%

Table 18 Sickness & Work Pattern

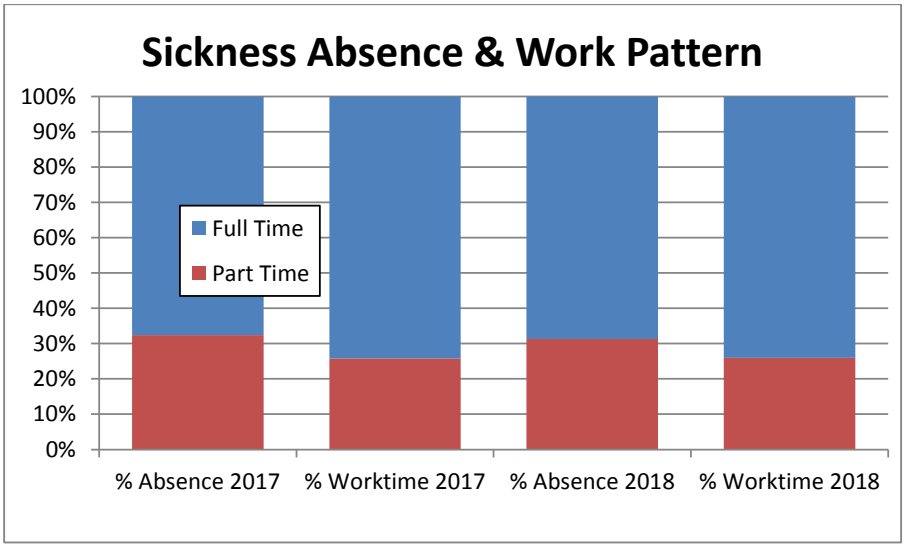


Chart 17 Sickness & Work Pattern

Part time staff tend to take proportionally more sickness absence than full time staff.

11 Workforce Race Equality Standard 2017

#		Ethnicity	2015	2016	2017	2018
2	Relative likelihood of White staff being appointed from shortlisting compared to BAME staff:		1.59	1.54	1.17	1.21
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff:		1.35	0.56	0.35	0.41
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff:		1.16	1.25	1.21	0.97
5	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	33.54%	32.19%	32.68%	33.73%
		BAME	31.21%	31.77%	30.89%	33.33%
6	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	41.82%	42.22	35.94%	34.42%
		BAME	38.35%	39.43%	34.59%	31.96%
7	% of staff believing that trust provides equal opportunities for career progression or promotion	White	77.44%	82.48%	83.69%	83.36%
		BAME	67.60%	67.38%	74.67%	74.15%
8	% of staff personally experienced discrimination at work from Manager/team leader or other colleague	White	10.49%	9.01%	8.13%	8.56%
		BAME	19.64%	20.58%	16.62%	17.31%
9A	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By voting membership of the Board	White	23.07%	-3.9%	6.06%	8.41%
		BAME	14.27%	5.84%	7.12%	-0.55%
9B	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: By executive membership of the Board	White	23.07%	0.6%	13.18%	1.30%
		BAME	14.27%	2.5%	-0.00%	13.7%
Improvement over last year						
Worse than last year						

Table 19 WRES

12 Other Diversity and Inclusion Activity

12.1 NHS Employers Diversity and Inclusion Alumni

The Trust is an NHS Employers Diversity and Inclusion Alumni Member.

The diversity and inclusion alumni programme supports participating trusts to progress and develop their equality performance and to build capacity in this area. At the same time the programme provides an opportunity for partners to offer advice, guidance and demonstrations of good practice in equality and diversity management to the wider NHS. Partners are supported to achieve this via:

- Continuous improvement around equality and diversity within their own organisation.
- Raising awareness of what constitutes sustainable, outcome-focused improvement in managing equality and diversity across their region.
- Acting as a thermometer by which NHS Employers can determine the key issues facing the wider NHS, so that advice and guidance is relevant and up to date.
- Contributing to the development of emerging good practice and providing a channel for collecting case studies from which others can learn, within the wider context of NHS initiatives.
- Contributing to a broader understanding of equality and diversity, across both the NHS and the wider public sector, in the context of quality, innovation, productivity and disease prevention.

12.2 Kent Surrey & Sussex (KSS) Diversity Leads Group

The KSS Diversity Leads Group is attended by our Head of Diversity and Inclusion. The KSS Leadership Academy is supporting the KSS Inclusion Network

1. A leadership development programme on leading, influencing and facilitating change - specifically for ED&I leads, or people leading on ED&I
2. A programme of mentoring for ED&I leads
3. Coaching for ED&I leads and focused Coaching for people from groups underrepresented at senior levels
4. Support for ED&I leads attending leadership development programmes

12.3 enei

The Employers Network for Equality & Inclusion (enei) is the UK's leading employer network covering all aspects of equality and inclusion issues in the workplace. The enei e-quality standard is a pioneering benchmarking tool that helps organisations audit their diversity and inclusion performance across the 9 “Protected Characteristics” in the Equality Act 2010 as well other groups such as carers and ex-offenders.

East Kent Hospitals has recently rejoined the network and look forward to meeting with our account manager to discuss how enei can support the trust.

12.4 Two Ticks and Age Positive

The trust displays the ‘two ticks’ positive about disabled people and ‘Age Positive’ logos on all job adverts.

12.5 Diversity and Inclusion (D&I) Steering Group

The D&I steering group chaired the Director of Human resources. Steering Group standing members include Chief Nurse and Director of Quality, Director of Communications and Engagement. The Chairs of our BAME Network, Disabled staff council LGBT+ Network and Staff Side Committees and a representative from Healthwatch Kent are also members.

The steering group provides leadership to the achievement of Equality Diversity and Inclusion in employment and service provision within EKHUFT

12.6 Unconscious bias training

Susan Abbott Diversity and Inclusion Officer has developed a three hour Unconscious Bias Training Course that is being offered to all members of the Trust and has been very well received by everyone who has attended. All courses are fully booked with more being made available. Managers have noticed significant improvement in working relationships of their teams who have attended.

12.7 Managing Workplace Relationships Course

Susan Abbott, D&I officer has developed a Managing Workplace Relationships Course’

Rationale

East Kent Hospitals University NHS Foundation Trust is committed to transforming the Trust and making it a better place for both patients and employees. The Managing Workplace Relationships course will be offered by April 2018 and will play an integral part in this.

Aim of Managing Workplace Relationships

To provide managers with the opportunity to explore the skills and knowledge needed to manage diverse teams well.

Objectives: by the end of the half-day programme participants will:

- Appreciate some of the challenges of managing teams/individuals from a different culture or background
- Have an opportunity to have an open and honest discussion about workplace relationships in a safe environment
- Explore strategies for addressing the performance of individuals and teams

FINANCE AND PERFORMANCE COMMITTEE CHAIR REPORT 18/137

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 2019**
SUBJECT:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR FPC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: MONTH 10 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.

26 February 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 financial plan in 2018/19, as well as 2019/20 and beyond.
   1.1 The Trust continues to focus on improving its financial position, ensuring a robust financial plan is in place to deliver the 2018/19 plan, as well as developing a deliverable plan for 2019/20.
   1.2 There have been no material changes in relation to the Trust exiting FSM. NHS Improvement's (NHSI) FSM team recently visited the Trust to discuss the East Kent Planning for 2019/20.
   1.3 The Trust's Chief Executive and Director of Finance and Performance will be meeting with NHSI's Executive Regional Managing Director (South East) mid-March to discuss the Trust's financial position and performance as well as the development of its business plan for 2019/20.

Care Group Presentations

2 The Committee received a presentation from the Women's and Children's (W&C) Care Group, delivered by its Clinical Director, Interim Operational Director and Finance Lead. Key issues discussed for M10 are noted below:

2.1 The Care Group's under performance against a number of the key performance metrics acknowledging there had been a slight improvement in January. A recovery improvement plan is in place and being progressed.
2.2 Overspends on pay, as well as agency and bank staff. Additional consultant resources have been requested within the Care Group's business plan to ensure it meets demand, achieves its plan and reduce agency usage.
2.3 A number of issues are being addressed and require robust management to ensure improvements are achieved, particularly in relation to gynaecology services. This is around ensuring that job plans align with the availability of outpatient and theatre sessions. Annual leave and study leave guidance and processes has been reviewed and strengthened, this has been disseminated for all staff to adhere to, and will ensure activity performance and the provision of services are maintained. .
2.4 The Care Group is forecasting a deficit of £6.2m.
2.5 A review of the operational processes are being carried out to ensure any inefficiencies are addressed and rectified, as well as ensuring there is sufficient resilience within the Care Group.
2.6 A 12-month improvement plan in paediatrics is being implemented and monitored following CQC report.
2.7 Key risks highlighted are noted below:
2.7.1 The main area of concern is income under-performance, elective activity is £716k below the plan mainly within gynaecology, non-elective activity £757k below plan, and outpatients £563k below plan. One of the reasons for these under-performances might be due to ambitious FY 2018/19 activity plans. All Care Groups will need to ensure realistic plans are developed for FY 2019/20.
2.7.2 CIP underperformed by £542k against target.
2.7.3 Actions were noted to address the gynaecology electives shortfall and paediatric outpatient waiting times backlog.
2.8 The Committee agreed that the Care Group would provide an update in two months regarding progress against its improvement plan, activity and income performance.

3 The Committee received a presentation from the Cancer, Clinical Haematology and Haemophilia (CCHH) Care Group, delivered by its Operational Director and Finance Lead. Key takeaways included:
3.1 CCHH are performing well against performance metrics and making good progress against its priorities around improving cancer performance, maximising efficient use of chemotherapy chairs to deliver demand, 7 day acute oncology service and 52 week medical oncology cover, End of Life (EoL) care and review of options for 7 day cover.
3.2 Additional achievements included:
3.2.1 Income above plan.
3.2.2 No agency expenditure.
3.2.3 Exceeding CIP target Year to Date (YTD) of £0.64m (143%) against plan of £0.44m, of which is 90% recurrent and a forecast of £0.8m. Positive progress has been made around identifying CIP schemes for 2019/20, with a target of £800k, of which £638k proposed schemes identified to date.
3.3 The main area of concern is workforce and the recruitment of substantive staff. Work continues around promoting the Trust to attract high calibre candidates, as well as exploring different methods to recruit staff.
3.4 The Committee congratulated and thanked the Care Group staff for all their hard work and achieving improvements in performance.

Cost Improvement Programmes (CIPs) Update

4 The Committee received and discussed an update against CIPs:
4.1 The 2018/19 programme of £30m, in M10 £2.3m was achieved against a plan of £3.2m, mainly due to under-delivery in the Surgical Care Groups (including £0.3m for the Elective Orthopaedic Centre (EOC)) and agency

spend reductions). Non-recurrent CIPs in the month equated to £0.7m (30%).

4.2 The YTD delivery of CIPs is £24m against the planned £23.3m, £0.7m ahead of the plan. Additional schemes are being scoped to ensure the £30m target for the year is delivered, which may require Care Groups initially taking savings non-recurrently. All Care Groups have agreed monthly goals. The Committee received assurance that the £30m forecast will be achieved by year-end.

4.3 Confirm and challenge sessions continue to be held with the Care Groups to ensure sustained focus and robust monitoring against progress in achieving the forecast outturn for year-end.

4.4 The identified pipeline for 2019/20 is currently circa £27m. The Trust has set a target of identifying and working up schemes of at least £15m to 'green' status by the end of March. £3.5m have currently been identified as 'green'.

4.5 The Committee received an additional report in relation to reducing agency costs presented by the Acting Director of Human Resources (HR). Assurance was received regarding the processes now in place to manage agency spend, which include robust measures in relation to requests for agency expenditure. Agency costs and spend is actively monitored at an Executive Director level. A focus on recruitment has resulted in a substantial increase of the appointment of substantive staff. A further report was requested for the April FPC meeting from the Acting Director of HR, Medical Director and Chief Nurse & Director of Quality. This report will identify top three clinical areas where we need to focus on to further reduce agency costs.

Month 10 Finance Report:

5 The Committee received and discussed the Month 10 (M10) finance report (attached Appendix 1), the following points were noted in relation to the Trust's financial position:

5.1 The generated consolidated deficit in month of £2.5m, of which is £0.6m behind plan, with a YTD deficit of £67m, £41.2m behind plan. The main drivers of this deficit in month continue to be around the themes in relation to operational pressures leading to significant agency spend on Medical and Nursing staff. Elective activity and income remain behind plan. .

5.2 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 10 (January) is £32.4m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £24.9m, which is £7.4m worse than the plan. A revised full year forecast of £42.2m deficit has been approved by the Board and submitted to NHS Improvement (NHSI). An estimated £4.4m of risk remain in regard to the revised year end forecast, the main risks relate to CIP delivery and the delivery of elective activity.

5.3 The Trust is mitigating these risks by having in place weekly meetings between the Chief Operating Officer (COO), Director of Finance and Performance and the Care Groups to maintain focus and monitor improvements in the elective trajectory

5.4 The Trust's cash balance as at the end of September was £8.7m, the Trust's total cash borrowing is now £72.8m, and is forecasted to be £81.6m by the year end.

Forecast Update on EKHUFT Position and Assessment of Financial Risks

5 The Committee received and discussed an update report on the forecast for EKHUFT in relation to its financial outturn for 2018/19. The key elements and risks were noted:

5.1 The main drivers of the changed forecast, the inability of the Trust to meet its planed elective activity levels, the approval of some unplanned schemes

to aid winter performance (e.g. opening wards and observation bays) along with operational temporary staffing costs running ahead of additional emergency and Accident & Emergency (A&E) income.

5.2 The Trust continues to work hard to control spend and increase the level of outpatient, day case and inpatient elective activity as planned, to ensure that the revised forecast position is achieved by year-end. This includes putting in place a number of operational mitigations to ensure delivery.

5.3 Risks remain, along with a new emerging risk in relation to advice the Trust has received with regards to the revaluation of assets in year and the potential impact of this of an estimated £2.4m.

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 All the risks have been reviewed and updated. There have been no changes to the residual risk scores, no financial risks for closure, and no new financial risks to be added to the register.

6.2 A change to one target score, in relation to SRR 8 – Inability to attract, recruit and retain high calibre staff (substantive) to the Trust. This has decreased from 12 (moderate) to 8 (low) due to the additional actions being undertaken to mitigate the risk, which are considered sufficiently robust once implemented to reduce the likelihood of the risk occurring to unlikely.

Highlight Report: on the National Constitutional Standards for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostic

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 Emergency Care performance continues to be challenging, compliance against the 4 hour standard of 77.93% against the trajectory of 88.4%, including the Minor Injury Unit (MIU). Representing a decrease in performance compared to the previous month (79.4%), an improvement on the Trust wide compliance on the previous January (69.3% in 2018). There were no 12 hour trolley waits in January. An analysis of Accident & Emergency (A&E) attendances to the EKHUFT sites over 2018/19 shows that activity over M1-M9 this year has risen by 6% compared to the previous year. Actions continue to implement the Emergency Department (ED) improvement plan and winter capacity plan, including the provision of observation bays at Queen Elizabeth the Queen Mother Hospital (QEQMH) and William Harvey Hospital (WHH) to elevate operational pressures. An internal review as well as external oversight has been undertaken in relation to congestion and identifying areas for improvement.

7.2 There has been significant challenges around patient flow due to low discharges. The Trust will need to continue efforts to ensure health economy focus on patient flow is maintained in order to increase safe discharges.

7.3 Performance against RTT standard of 76.10% against a trajectory of 81.16%. The total waiting list reported 50,134, which is over 3,000 less than the previous month. 38 patients are waiting over 52 weeks against a trajectory of 125. Actions to progress RTT recovery plan continues. These include Director led review of all 52 week wait patients as well as daily reviews of theatre list bookings.

7.4 Cancer 62 day performance at 67.92% against a trajectory of 85.31%. The Trust continues to actively progress the Cancer recovery plan to ensure sustained performance is achieved against standards across all tumour sites. The total number of patients on an active cancer pathway at the end of the month of 2,371, of which 10 patients waiting 104 days or more for treatment or potential diagnosis.

7.5 Diagnostics performance has been met with a compliance of 99.73% against a trajectory of 99.11%, the highest performance since November 2017. As at the end of the month 35 patients had waited over 6 weeks for their diagnostic procedure.

Board Assurance Framework (BAF) and Annual Priorities 2018/19: Quarter 3

8 The FPC received and discussed a report regarding Q3 and the Trust's current performance, risks and assurance level. The key elements are noted below:
- 8.1 Performance against the partnership priority improved on Q2 showing an 'amber' position, the strategic risk remained 'extreme' due to continued delays in terms of delivery of the Sustainability and Transformation Partnership (STP), assurance remains adequate.
- 8.2 Performance against the provision priority overall remains 'red', with the strategic risk 'high' reflecting the risks in delivery of the Trust's Operational Plan, assurance remains adequate.
- 8.3 The Committee noted that some of the risks were outside of the Board's risk appetite.

9 The Committee also received and discussed the following reports:
- 9.1 Capital Report.
- 9.2 Service Line Reporting Q3 2018/19.
- 9.3 National Cost Collection (Reference Costs and Patient Level Costs (PLICs) 2017/18 update.
- 9.4 Strategic Investment Group minutes.

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

January 2019

Director of Finance and Performance Management
Philip Cave

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Month 10 (January) 2018/19

Executive Summary

Month 10 (January) 2018/19

Executive Summary

The Trust has generated a consolidated deficit in month of £2.5m (£0.6m behind plan) and a year to date (YTD) deficit of £67m which is £41.2m 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. In addition there was a slowing down of outpatient work following the PAS implementation. The main specialties showing performance behind plan are Trauma & Orthopaedic (T&O), Urology, Pain Management 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 two months which, if not delivered, will lead to a failure to deliver the revised financial forecast. Care groups are meeting weekly with the COO and FD to improve the elective trajectory.

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 10 (January) was £32.4m (consolidated position including subsidiaries and after technical adjustments) against a planned deficit of £24.9m, £7.4m worse than plan. A revised full year forecast of £42.2m deficit has been approved by the Board and submitted to NHSi. A reconciliation of the various adjustments is presented below. The year to date position now includes a £360k impact on consolidation relating to intercompany trading between 2gether and the Trust which was highlighted when the full Q3 accounts were completed for NHS I. The M10 YTD position is slightly better than expected however due to outstanding risks the forecast is held at £42.2m.

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income (inc PSF)	49,996	51,390	1,394	487,370	497,872	10,502
EKHUFT Pay	(30,941)	(32,355)	(1,414)	(305,078)	(318,121)	(13,043)
EKHUFT Non-Pay	(21,118)	(22,213)	(1,096)	(208,191)	(248,047)	(39,856)
EKHUFT Financial Position (inc PSF)	**(2,063)**	**(3,178)**	**(1,115)**	**(25,899)**	**(68,295)**	**(42,396)**
Subsidiaries Financial Position	12	577	566	107	1,291	1,184
Consolidated I&E Position (inc PSF)	**(2,051)**	**(2,601)**	**(550)**	**(25,792)**	**(67,004)**	**(41,212)**
Impairments/ Donated Assets Adjustment	86	73	(14)	853	34,654	33,801
PSF Funding	0	0	0	0	0	0
Consolidated I&E Position (excl PSF)	**(1,965)**	**(2,528)**	**(563)**	**(24,939)**	**(32,350)**	**(7,411)**

Trust unconsolidated pay costs in month of £32.4m are £0.9m more than December. Substantive costs have increased £0.1m due to the payment of Bank holiday pay and agency staffing costs have increased £0.8m in month due to a higher levels of Agency cover being available to fill open shifts. During the Christmas period it is normal for these staffing groups to reduce as workers are less willing to cover the holiday period. When measured against Budget, pay is over spent by £1.4m in month and £13m YTD. 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 £4m year to date and £0.4m in month of pay awards relating to Agenda for change not previously budgeted. Agency costs are now £14.6m 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 on plan in month. Once the impact of pay awards income funding (£0.6m, not included in the plan) is adjusted the net position in £0.6m less than plan for the month. The YTD position is now £3.2m ahead of plan but once pay awards income funding (YTD £4.2m) and prior year reserve releases (£3m) are removed the net position is £4m 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 however this underperformance has significantly reduced in month. Month on month income has increased £4.8m due to more activity in almost all areas, other than A&E, driven by additional available working days and a care group focus on increasing elective activity. Other income is £1.4m ahead of plan in month (driven by increased education income and the release of deferred income to match PAs costs) and above plan £7.3m YTD, driven by the month 10 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, £24m of CIPS have been delivered YTD against a target of £23.3m, £0.7m ahead of plan. CIPs achieved in Month 10 were £2.3m, £0.9m behind plan due to Agency and Patient flow schemes slightly under delivering in month and phasing differences. CIPs in January amounted to £1.7m recurrent and £0.6m on a non-recurrent basis. The YTD position is recurrent £14.9m and non-recurrent £9.1m.

The Trusts cash balance as at the end of September was £8.7m, which is £5.8m above plan. The Trust's total cash borrowing is now £72.8m 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

Income and Expenditure A

Overall Income has exceeded plan in Month 10 by £1.4m, due to Other Income benefiting from over performance of education income, service charges to 2gether Solutions and release of deferred income to cover PAS rollout costs. All of these are offset by increased costs. In Clinical income non elective and A&E demand has continued to be high. Although this is offset by underperformance of elective inpatient and outpatient work delivery in these areas has increased in month due to a higher number of working days and a focus by care groups to increase performance. Weekly meetings are held with the COO and FD to continually monitor performance. Further improvement in monthly elective and outpatient activity will be required to deliver the forecast at year end. Elective under activity is being supported by outsourcing to the independent sector.

Pay performance is adverse to plan in January by £1.4m and by £13.0m ytd (4.28%). The main driver for the pay overspend in month continues to be above plan usage of agency staff for medical and Nursing cover. Pay CIPs are adverse to plan in month by £0.6m and by £4.2m ytd. Total expenditure on pay in January was £32.4m, £0.9m higher than December due to more agency staffing being available to fill shifts.

Non Pay expenditure is adverse to plan in January by £1.6m and by £7.8m 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 £5.8m above plan. The main drivers for the YTD position are as follows:-

- CCG payments are net £8.2m below plan due to the lowering of the contract value .
- HMRC VAT returns are £5.9m below plan
- Other NHS receipts are £8.6m above plan, including AfC pay award funding of £4.2m.
- Other Income is £11.2m above plan (e.g. Serco settlement income)
- Loans from DHSC are £7.8m above plan
- Unplanned receipts from 2Geather are £19.9m (off set by creditor payments)
- Payroll is £4.5m below plan and
- Creditor payments including non pay, agency and capital are £32m above plan net.

The Trust borrowed £2m cash in month increasing total borrowings to £72.8m. The total expected borrowing by the end of the year remains at £81.6m.

Capital Programme A

The Trust has spent £11.5m on capital to January which is £2.1m behind plan. In year the Trust received £6.4m additional capital funding which was 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 some spend has now slipped. In addition IT spend is running behind plan. The whole capital plan has been reviewed and weekly meetings held to ensure full delivery of the revised capital programme for 2018/19.

Cost Improvement Programme G

Net CIPs in month were £0.9m behind plan bringing the YTD position to £0.7m ahead of plan at £24m of savings YTD. The main variances in month relate to slow delivery of agency and LOS reductions and procurement efficiencies. The forecast is circa £28.6m for the full year driven mainly by the shortfalls in Agency reductions and Patient Flow Schemes. Care groups are reviewing plans with a view to mitigate the shortfall.

Income and Expenditure Summary

Month 10 (January) 2018/19

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	8,733	7,887	(845)	86,057	76,945	(9,111)	103,209
Non-Electives	14,158	15,217	1,059	135,575	140,777	5,203	161,862
Accident and Emergency	2,072	2,477	405	21,764	24,316	2,552	26,226
Outpatients	7,041	6,767	(274)	67,697	63,546	(4,151)	81,011
High Cost Drugs	4,728	4,440	(288)	46,663	44,811	(1,852)	55,662
Private Patients	21	41	20	210	261	51	248
Other NHS Clinical Income	9,403	9,446	44	91,239	101,855	10,616	109,496
Other Clinical Income	154	13	(141)	1,535	1,415	(120)	1,845
Total Clinical Income	**46,308**	**46,287**	**(21)**	**450,739**	**453,928**	**3,188**	**539,558**
Non Clinical Income	3,688	5,103	1,415	36,631	43,944	7,313	44,059
Total Income	**49,996**	**51,390**	**1,394**	**487,370**	**497,872**	**10,502**	**583,617**
Expenditure							
Substantive Staff	(27,907)	(27,702)	205	(277,605)	(274,378)	3,226	(326,479)
Bank	(1,111)	(1,414)	(303)	(11,188)	(12,855)	(1,667)	(19,900)
Agency	(1,923)	(3,239)	(1,316)	(16,285)	(30,887)	(14,602)	(19,431)
Total Pay	**(30,941)**	**(32,355)**	**(1,414)**	**(305,078)**	**(318,121)**	**(13,043)**	**(365,810)**
Non Pay	(18,884)	(20,440)	(1,556)	(186,039)	(193,870)	(7,831)	(222,146)
Total Expenditure	**(49,825)**	**(52,795)**	**(2,970)**	**(491,117)**	**(511,991)**	**(20,873)**	**(587,956)**
Non-Operating Expenses	(2,234)	(1,773)	461	(22,152)	(54,177)	(32,025)	(26,648)
Income and Expenditure Surplus/(Deficit)	**(2,063)**	**(3,178)**	**(1,115)**	**(25,899)**	**(68,295)**	**(42,396)**	**(30,987)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	47,000	47,085	85	457,651	462,439	4,788	547,857
Non Clinical Income	3,574	6,120	2,546	35,484	43,150	7,666	42,682
Total Income	**50,574**	**53,205**	**2,631**	**493,135**	**505,589**	**12,454**	**590,539**
Expenditure						-	
Pay	(31,294)	(34,743)	(3,449)	(308,616)	(332,294)	(23,678)	(370,054)
Non Pay	(19,074)	(19,289)	(215)	(187,927)	(186,198)	1,729	(224,416)
Total Expenditure	**(50,368)**	**(54,032)**	**(3,664)**	**(496,543)**	**(518,492)**	**(21,949)**	**(594,470)**
Non-Operating Expenses	(2,257)	(1,774)	483	(22,384)	(54,101)	(31,717)	(26,924)
Income and Expenditure Surplus/(Deficit)	**(2,051)**	**(2,601)**	**(550)**	**(25,792)**	**(67,004)**	**(41,212)**	**(30,855)**

Clinical Income

Income from Clinical Income in month is close to break even, showing only a small underperformance. Non elective income continues to remain higher than planned YTD. Elective income is showing a large adverse variance due to the phasing of CIP schemes which were expected to start in the second half of the year although the January income was higher than the previous run rate.
The majority of the adverse variances are contained within Electives, Outpatients and Non-PbR. The reduction in outpatient attendances following the implementation of the new PAS system and has continued into Quarter 4 with activity still below plan in month 10.
month 10.

The CCGs have agreed the 2017-18 outturn following the Expert Determination hearing. Final invoices have been raised and are understood to be pending payment. There remain some small issues regarding 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 above plan in month by £132k. Rechargeable expenditure such as high cost drugs, devices over performed by £252k. However haemophilia blood products under performed by £122k 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 £1.4m in January and by £7.3m ytd. Income CIPs are favourable to plan in January by £0.2m and by £2.4m ytd. Deferred income relating to the PAS project of £0.8m was released in January to offset project expenditure and this accounts for £0.7m of the favourable variance in month. Over performance on education and training income and services to subsidiaries account for a further £0.6m of the variance.

Total expenditure is adverse to plan by £3.0m in January and £20.9m ytd. In month, pay is overspent by £1.4m, mainly driven by expenditure on medical and nursing agency staff. Non pay is overspent by £1.6m in January, predominantly accounted for by PAS project expenditure (offset by income) totalling £0.7m, phase 2 staffing transfers to the subsidiary of £0.6m and slippage on non pay CIP schemes of £0.4m.

The expenditure run rate increased by £1.7m in January when compared to December, with the increase split equally between pay and non pay expenditure. The majority of the increase in pay relates to medical and nursing agency spend which grew by £0.8m, following low spend in December. Expenditure on drugs and PAS software grew by a total of £1.3m, offset by reductions in clinical supplies and secondary commissioning totalling £0.4m.

Key Highlights

Month 10 (January) 2018/19

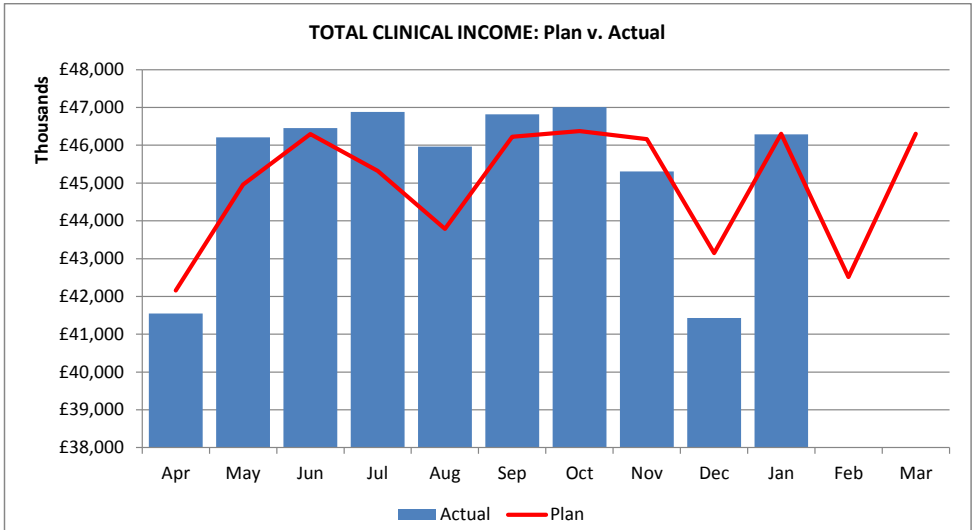
CLINICAL INCOME

Clinical income is under plan in January by £23k. Non-Elective income is over plan 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 19% (£395k) driven by activity increases.

Elective income is under planned levels by £855k due to increased activity plans in the second half of the year in which there was an expectation that CIP targets would be achieved. Outpatients are under performing by £528k. Much of the Elective CIPs are held centrally and services are finding it difficult to meet these income targets each month. The trend of having higher than planned levels of regular day attenders continue in M10 and is currently 26% over plan YTD, this is generating a lower case mix variance resulting in lower average tariffs within Electives.

ACTIVITY

A&E demand is ahead of plan by 11% this month, and 5% YTD. 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 over performed against plan in month by only 1% however the mix between short and long stay patients has favoured longer stays. The commissioners QIPP schemes in which they have invested in preventing patients with Pneumonia from coming to the hospital where they can be treated at home appear to have some impact as although January has seen the normal peak in activity, it is significantly lower than seen in the previous two years, circa 20% lower. Outpatient activity is behind plan in month and YTD. Elective activity is 6% behind plan in month.



COMMISSIONER ANALYSIS

Activity plans reflected commissioner QIPP schemes to the value of £3.4m 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. 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 10 (January) 2018/19

NON CLINICAL INCOME

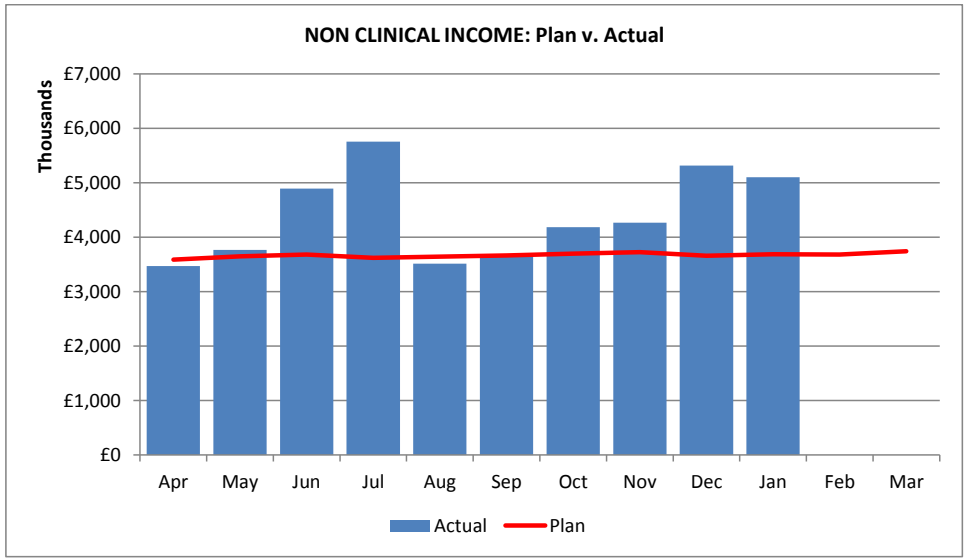
Non clinical income is favourable to plan by £1.4m in January and by £7.3m ytd. Income CIPs are favourable to plan in January by £0.2m and by £2.4m ytd. Deferred income relating to the PAS project of £0.8m was released in January to offset project expenditure and this accounts for £0.7m of the variance in month. Over performance on education and training income, and services to subsidiary companies account for a further £0.6m of the in month variance.

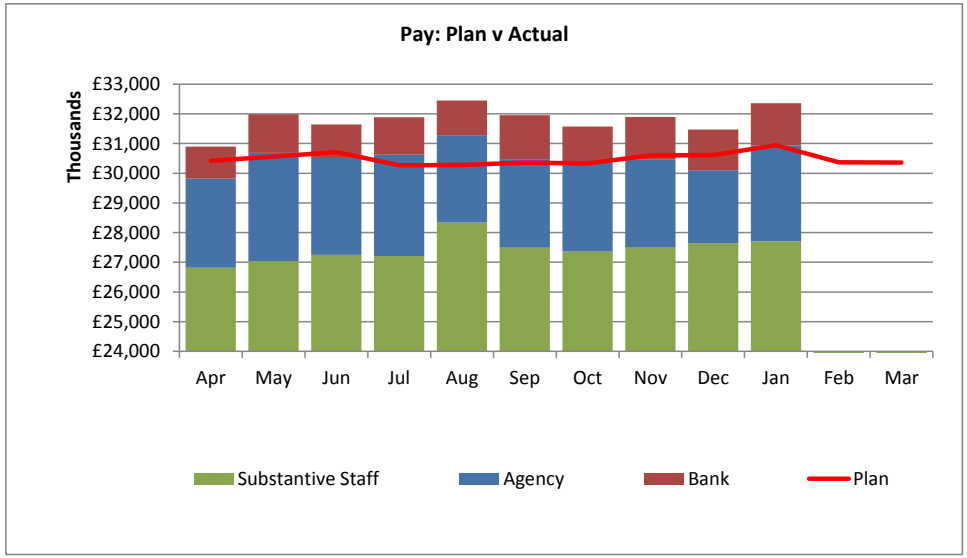
Other main headlines for the favourable performance ytd are income received from Serco following early exit from the contract of £2.1m, goods and services provided to 2gether Support Solutions of £1.7m, income relating to the PAS project of £1.2m, KCC property overage benefit of £0.6m and education and training income £0.4m.

PAY

Pay performance is adverse to plan in January by £1.4m and by £13.0m ytd (4.28%). Pay CIPs are adverse to plan in month by £0.6m and by £4.2m 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£0.5m in month and £4.2m ytd. The main driver for the pay overspend in month and ytd continues to relate to above plan usage of agency staff totalling £1.3m in month and £14.6m ytd.

Total expenditure on pay in January was £32.4m, £0.9m higher than in December, with the majority of the increase relating to expenditure on agency staff following reduced expenditure in December. Medical and nursing agency staff account for all of the increase in spend.





Key Highlights

Month 10 (January) 2018/19

NON-PAY

Non Pay expenditure is adverse to plan in January by £1.6m and by £7.8m (4.21%) ytd. Non pay CIP schemes are adverse to plan in total by £0.4m in month and by £6.3m ytd.

Expenditure on supplies and services - non clinical continues to drive the in month overspend and is adverse to plan by £1.5m in January, excluding the effect of all pass through costs from the subsidiary. Phase two staffing transfers to 2gether and unachieved CIP targets account for £1.0m of the adverse variance and PAS software and other project costs are adverse to plan in January by a total of £0.7m, offset by a favourable performance on income.

Non pay actual expenditure in January increased by £0.9m when compared to December. Expenditure on drugs and PAS software grew by £1.3m, offset by reductions in clinical supplies and secondary commissioning totalling £0.4m.

DEBT

Total invoiced debtors have decreased from the opening position of £28.5m by £12.4m to £16.1m. The largest debtors at 31st January were East Kent CCGs £5.1m and East Kent Medical Services £2.2m. Agreement has now been reached with CCGs in respect of 1718 overperformance, £3.5m is expected to be paid in February.

CREDITORS

The management of creditors continues to be an issue and in January the Trust commenced paying invoices at 20 days behind creditor terms on average (from 17 days).

CAPITAL

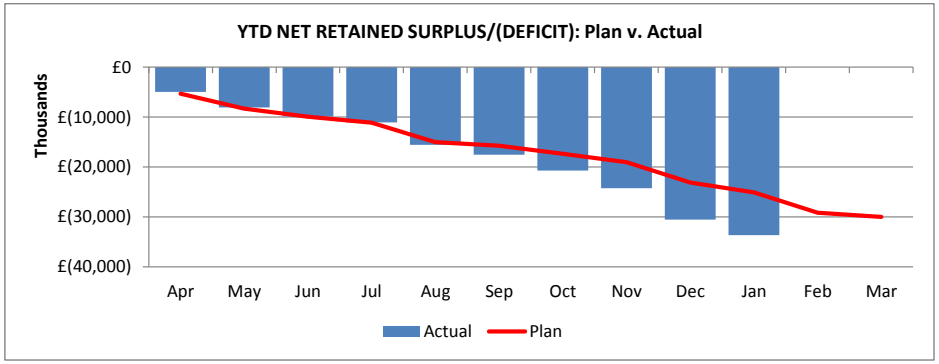
Total YTD expenditure for Mth 10 2018/19 is £2m below plan mainly driven by slower than planned delivery of the observation bays.

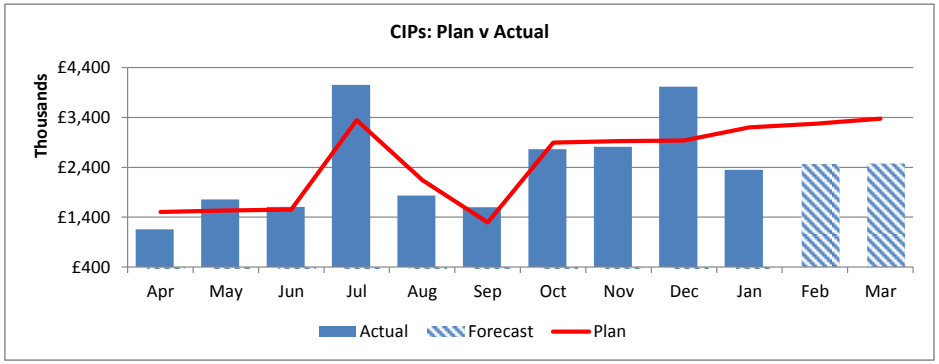
EBITDA

The Trust is reporting a year to date deficit EBITDA of £14.1m

CASH

The closing cash balance for the Trust as at 31st January was £8.7m





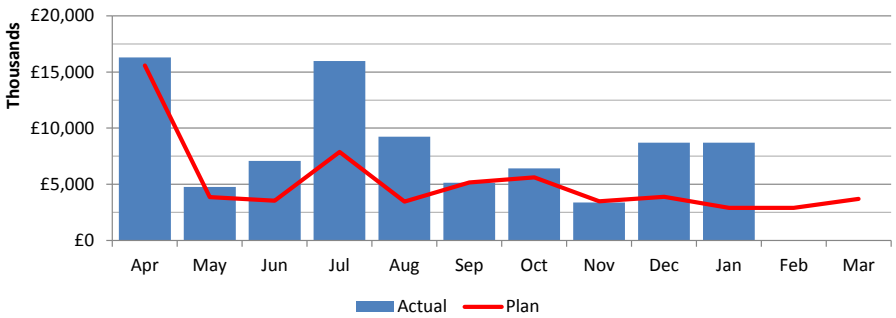
FINANCING

£1.7m of interest was incurred in respect of the drawings against working capital facilities to 31st January 2019.

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 10 (January) 2018/19



Unconsolidated Cash balance was £8.7m at the end of January 2019, £5.8m above plan.

Total receipts in January 2019 were £5.0m above plan
- Receipts from East Kent CCGs were £0.9m below plan for Main Contract
- Receipt of £2.8m from 2gether for Sale of Assets and Stocks.
- Vat reclaim was £0.9m above plan in the month
- Loan received in January of £2.0m, £0.6m below plan
- Receipt from HEE was £1.0m above plan
- Other receipts are £1.8m over plan

Total Payments in January 2019 were £4.0m above plan
- Monthly payroll was £0.3m below plan
- Creditor payments inc Capital were £1.8m below plan
- Payments to 2gether(prev Serco) were £6.1m above plan

YTD cash receipts are £33.3m above plan
- East Kent CCGs are net £8.2m below plan. Payments against contract are £10.5m below plan due to the reduction of their contract value. Payments for overperformance are £2.3m above plan
- Other NHS receipts are £8.6m above plan, which includes £4.3m AfC funding from DoH
- HMRC VAT returns are £5.9m below plan
- STF receipt was £1.4m above plan
- Loans from DHSC £7.8m above plan
- Receipts from 2gether £19.9m above plan
- Other receipts are £9.8m above plan; which includes £2.5m received from Serco and £6.5m capital PDC

YTD cash payments are £27.5m above plan
- Payroll is £4.5m below plan
- Creditor Payments including Capital are £32.0m 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

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. This has been exceeded with YTD borrowings to January totalling £26.5m (£7.8m over plan YTD) Borrowings of £2.2m in February have been approved by DHSC. A further £13.4m has been requested in March and is waiting authorisation by DHSC and NHSi.

Creditor Management
- Creditor management continued to be applied throughout January 19. 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 January 2019 the Trust was recording 50 creditor days (Calculated as invoiced creditors at 31st January/ 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 and currently pays suppliers 20 days behind due date on average.

- 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 10 (January) 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 £42.2m, 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

The unconsolidated forecast for impairments is higher than planned due to the revaluation of assets prior to transfer to 2gether. However, as this forms part of NHSi technical adjustments, the impact is removed and reflected in the adjusted deficit forecast.

Expenditure includes revised part year effect estimates for business cases approved to support the Winter plan, reflecting expected start dates and likely spend

Risks and Opportunities
Month 10 (January) 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 10 (January) 2018/19

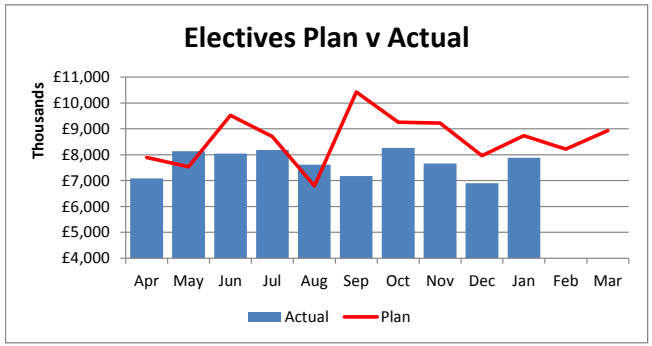
	This Month				Year to Date				Annual
£000	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	8,733	7,880	(853)	(9.8%)	86,057	76,945	(9,111)	(10.6%)	103,209
Non-Electives	14,158	15,124	966	6.8%	135,574	140,777	5,203	3.8%	161,862
Accident and Emergency	2,072	2,467	395	19.1%	21,764	24,316	2,552	11.7%	26,226
Outpatients	7,040	6,452	(588)	(8.4%)	67,697	63,546	(4,151)	(6.1%)	81,011
High Cost Drugs	4,728	4,442	(286)	(6.0%)	46,663	44,812	(1,851)	(4.0%)	55,662
Private Patients	21	41	20	93.0%	210	261	51	24.1%	248
Other NHS Clinical	9,403	9,694	291	3.1%	91,239	101,857	10,618	11.6%	109,496
Other Clinical	154	13	(141)	(91.8%)	1,535	1,415	(120)	(7.8%)	1,845
Prior Month Adjustment		175	175	0.0%				0.0%	
Total	**46,308**	**46,287**	**(21)**	(0.0%)	**450,739**	**453,929**	**3,190**	0.7%	**539,558**
				Adverse				Favourable	

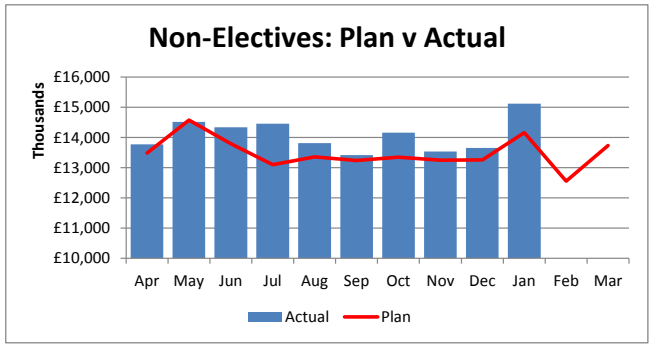
Income has performed only slightly under plan in January, with the over performance within Non Electives and A&E being balanced off by the under performance within Electives, Outpatients and Non-PbR.

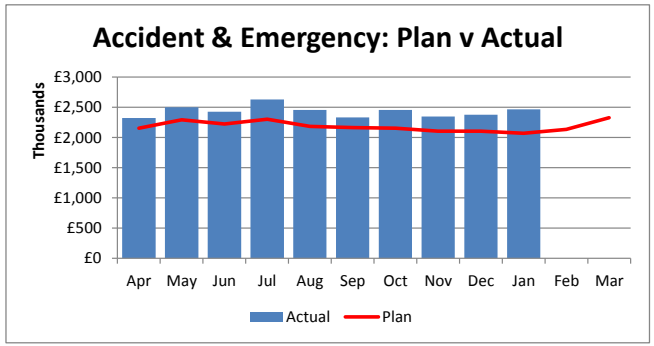
Elective inpatients and Day cases under performed in month by £1.0m as the Elective plan phasing was increased above run-rate incorporating the planned CIP schemes for the second half of the year, this has had a slight offset by regular day attenders which has over performed by £150k. The main areas behind plan continue to be the CIP schemes, but there are also underperformances in T&O, Pain Management, Urology 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 above plan in January.

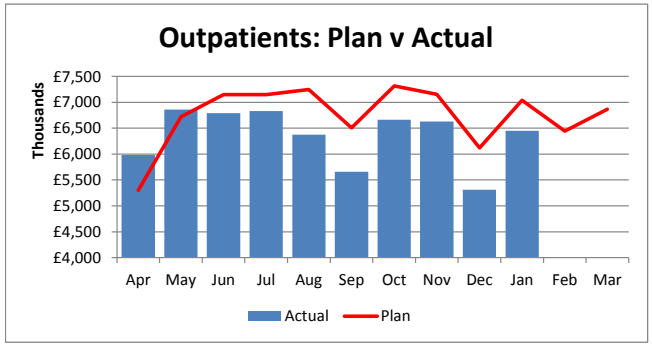
Other NHS Clinical activity is also ahead of plan due to an amount received to cover the increased pay award costs of £0.4m in the month.

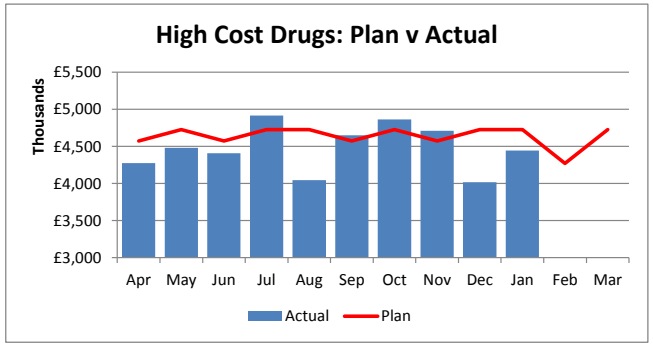
Rechargeable income is behind plan in month with Drugs and Devices £330k below plan. This does not impact the bottom line as there is a corresponding decrease in expenditure.

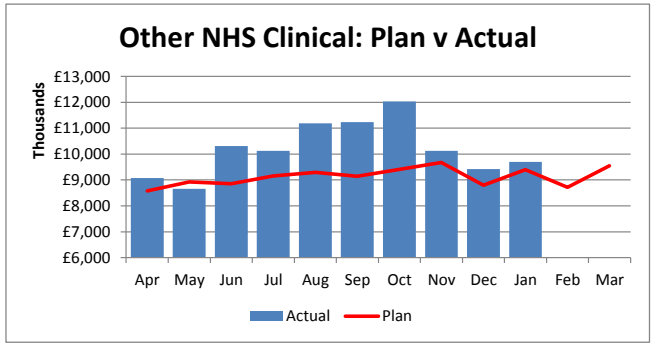












Clinical Activity

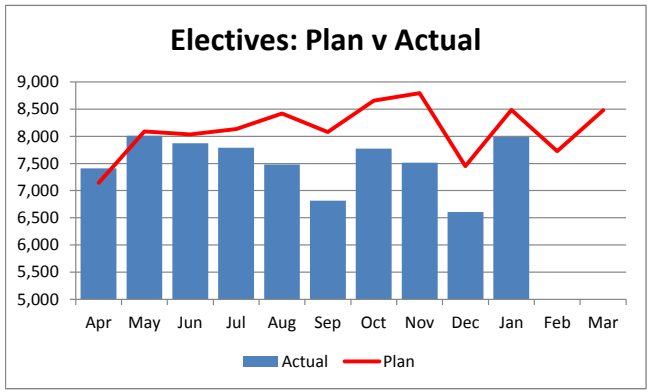
Month 10 (January) 2018/19

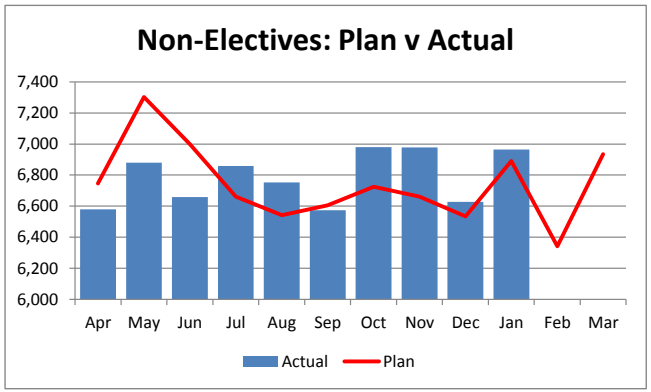
	This Month				Year to Date				Annual
Activity Units	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	8,484	7,990	(494)	(5.8%)	81,273	75,263	(6,010)	(7.4%)	97,477
Non-Electives	6,890	6,965	75	1.1%	67,667	67,855	188	0.3%	80,942
Accident & Emergency	16,673	18,462	1,789	10.7%	175,152	184,535	9,383	5.4%	211,076
Outpatients	69,444	64,533	(4,911)	(7.1%)	669,621	633,231	(36,390)	(5.4%)	802,917
Other NHS Clinical	459,071	489,969	30,898	6.7%	4,502,124	4,729,008	226,884	5.0%	5,397,116
Total	**101,491**	**97,950**	**(3,541)**	(3.5%)	**993,713**	**960,884**	**(32,829)**	(3.3%)	**1,192,412**
				Adverse				Adverse	

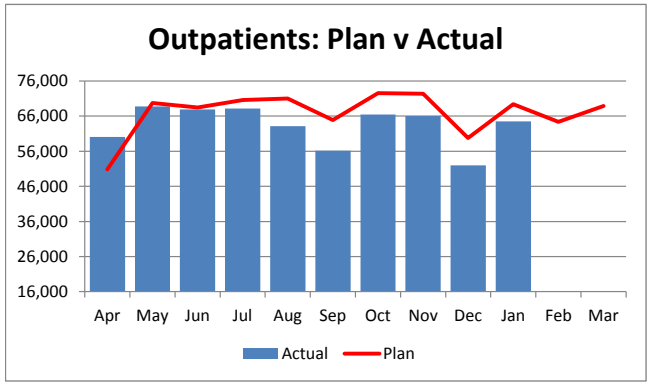
Within Elective activity (6% under plan in total in month), Inpatient activity was 2% under plan largely due to Urology (by 90) General Medicine continues to under perform (by 62). Day case activity was 14% under plan (T&O 507, Pain Management 146, Dermatology 100, General Surgery 162, ENT 63, Neurology 82 and Rheumatology 80). This is partially offset by continued activity over performance in Regular day attenders of 53%.

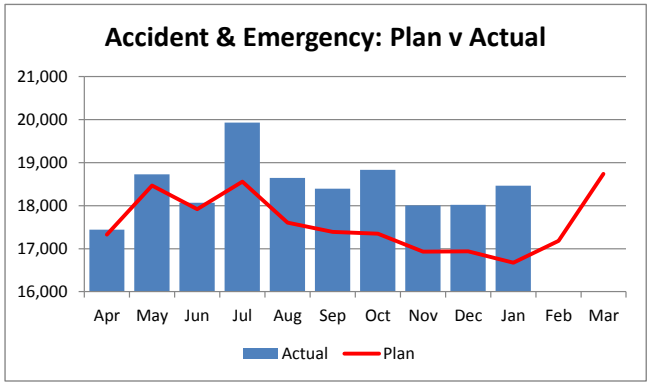
Outpatient activity under performed in month by 6% in new and 7% in follow up attendances. Many areas are behind plan such as: T&O, Urology, General Surgery, T&O, ENT, Ophthalmology, Pain Management, General Medicine, Gastroenterology, Gynaecology, Respiratory Medicine, Diabetic Medicine, Neurology, Rheumatology, Paediatrics, Clinical Oncology, Orthoptics, Occupational Therapy and Physiotherapy, while the only notable over performing specialties were Cardiology and Oral Surgery.

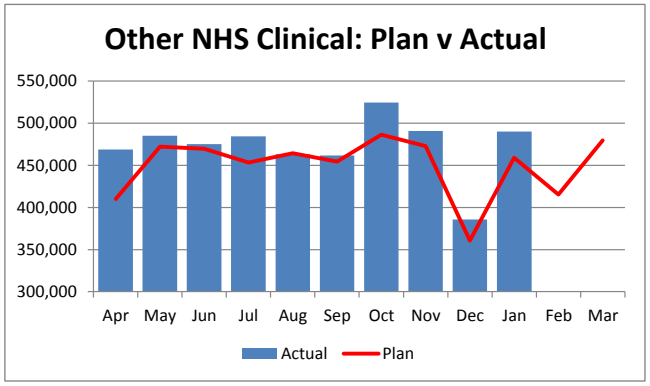
Most specialties reduced activity in September in order to ensure the smooth implementation of the new PAS system, however the run rates since then are lower than the previous M1-5 run rate. This is being investigated by the Care groups, one issue though is the cashing up of Outpatient clinics with 331 not being cashed up in November, in time to charge Commissioners.







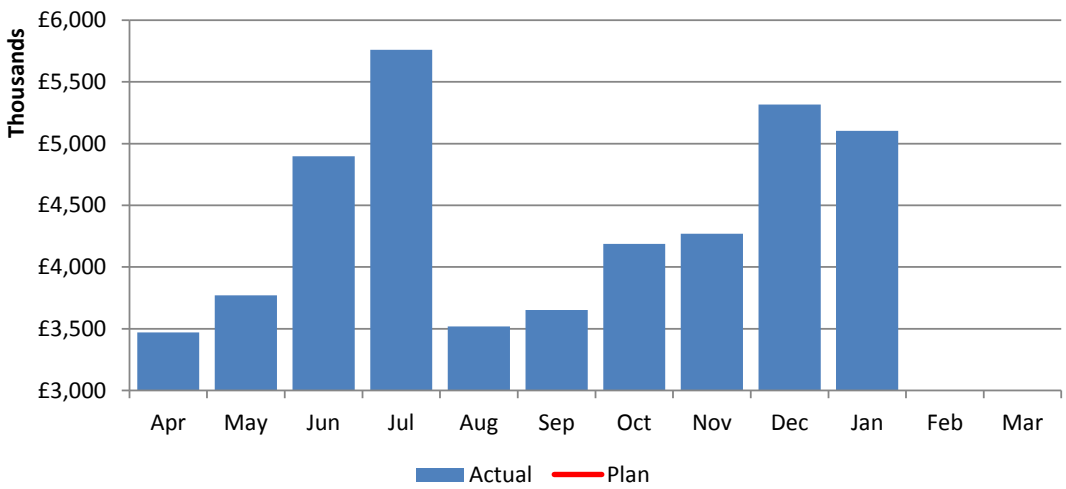




Non Clinical Income

Month 10 (January) 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	2,597	1,167	14,293	16,803	2,510	17,150
Research and development	222	225	3	2,229	2,249	20	2,673
Education and Training	1,269	1,552	283	12,690	13,065	375	15,233
Car Parking income	399	424	25	3,912	4,096	184	4,766
Staff accommodation rental	224	176	(48)	2,052	1,912	(140)	2,494
Property rental (not lease income)	1	1	()	11	10	(1)	13
Cash donations / grants for the purchase of capital assets	41		(41)	418	369	(49)	500
Charitable and other contributions to expenditure	12	12	()	120	120	()	145
Other	91	117	27	905	5,320	4,415	1,085
Total	**3,688**	**5,103**	**1,415**	**36,631**	**43,944**	**7,313**	**44,059**
			38.37% Favourable			19.97% Favourable	



Non clinical income is favourable to plan by £1.4m in January and by £7.3m ytd. Income CIPs are favourable to plan in January by £0.2m, mainly relating to above plan performance on the South East London AAA Screening contract, and by £2.4m ytd.

Deferred income relating to the PAS project of £0.8m was released in January to offset project expenditure and this accounts for £0.7m of the variance in month. Over performance on education and training income and services to subsidiary companies (Spencer Private Hospitals and 2gether) account for a further £0.6m of the in month variance.

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 £1.7m, income relating to the PAS project of £1.2m (offset by above plan expenditure) and benefits relating to KCC property sales overage, capital goods scheme benefits and profits on the disposal of assets reported in December totalling £1.4m. A favourable performance on car parking and education and training income totalling £0.6m is offset by an underperformance on staff accommodation income of £0.1m.

Pay

Month 10 (January) 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	1,143	1,047	96	(8,175)	(8,432)	(257)	(81,314)	(81,372)	(58)	(97,531)
Nurses and Midwives	2,427	2,069	359	(7,732)	(7,832)	(100)	(76,909)	(76,361)	548	(92,248)
Scientific, Therapeutic and Technical	1,401	1,351	51	(4,557)	(4,360)	196	(45,327)	(43,408)	1,919	(54,367)
Admin and Clerical	1,443	1,278	165	(2,889)	(2,700)	190	(28,742)	(27,232)	1,509	(34,474)
Other Pay	1,453	1,350	104	(4,011)	(3,996)	14	(39,903)	(41,080)	(1,177)	(47,859)
Permanent Staff Total	**7,868**	**7,094**	**775**	**(27,363)**	**(27,321)**	**43**	**(272,195)**	**(269,454)**	**2,741**	**(326,479)**
Waiting List Payments										
Medical and Dental	0	0	0	(228)	(165)	63	(2,270)	(2,267)	3	(2,723)
Waiting List Payments Total	**0**	**0**	**0**	**(228)**	**(165)**	**63**	**(2,270)**	**(2,267)**	**3**	**(2,723)**
Medical Locums/Short Sessions										
Medical and Dental	1	21	(21)	(316)	(217)	99	(3,140)	(2,658)	482	(3,766)
Medical Locums/Short Sessions Total	**1**	**21**	**(21)**	**(316)**	**(217)**	**99**	**(3,140)**	**(2,658)**	**482**	**(3,766)**
Substantive	**7,869**	**7,115**	**754**	**(27,907)**	**(27,702)**	**205**	**(277,605)**	**(274,378)**	**3,226**	**(332,968)**
Bank										
Medical and Dental	0	15	(15)	(468)	(236)	232	(4,717)	(3,149)	1,568	(5,654)
Nurses and Midwives	0	108	(108)	(248)	(461)	(214)	(2,494)	(3,485)	(991)	(2,990)
Scientific, Therapeutic and Technical	1	4	(3)	(12)	(20)	(8)	(123)	(202)	(79)	(147)
Admin and Clerical	0	66	(66)	(94)	(207)	(113)	(945)	(1,697)	(752)	(1,133)
Other Pay	0	166	(166)	(289)	(488)	(200)	(2,909)	(4,323)	(1,414)	(3,487)
Bank Total	**1**	**359**	**(358)**	**(1,111)**	**(1,414)**	**(303)**	**(11,188)**	**(12,855)**	**(1,667)**	**(13,411)**
Agency										
Medical and Dental	38	147	(109)	(881)	(1,998)	(1,116)	(7,464)	(17,332)	(9,868)	(8,906)
Nurses and Midwives	0	192	(192)	(565)	(1,019)	(455)	(4,780)	(9,482)	(4,701)	(5,704)
Scientific, Therapeutic and Technical	0	23	(23)	(64)	(146)	(82)	(545)	(2,203)	(1,658)	(650)
Admin and Clerical	0	2	(2)	(7)	(16)	(9)	(61)	(179)	(117)	(73)
Other Pay	0	5	(5)	(54)	(8)	46	(461)	(1,016)	(555)	(550)
Agency Total	**38**	**369**	**(331)**	**(1,572)**	**(3,187)**	**(1,615)**	**(13,311)**	**(30,212)**	**(16,900)**	**(15,883)**
Direct Engagement - Agency										
Medical and Dental	0	3	(3)	(351)	(52)	299	(2,974)	(675)	2,299	(3,548)
Direct Engagement - Agency Total	**0**	**3**	**(3)**	**(351)**	**(52)**	**299**	**(2,974)**	**(675)**	**2,299**	**(3,548)**
Agency	**38**	**372**	**(334)**	**(1,923)**	**(3,239)**	**(1,316)**	**(16,285)**	**(30,887)**	**(14,602)**	**(19,431)**
Total	**7,908**	**7,846**	**62**	**(30,941)**	**(32,355)**	**(1,414)**	**(305,078)**	**(318,121)**	**(13,043)**	**(365,810)**
						-4.57%			-4.28%	
						Adverse			Adverse	

Pay performance is adverse to plan in January by £1.4m and by £13.0m ytd (4.28%). Pay CIPs are adverse to plan in month by £0.6m and by £4.2m 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£0.5m in month and £4.2m ytd.

Total expenditure on pay in January was £32.4m, £0.9m higher than in December, with the majority of the increase relating to expenditure on agency staff.

Substantive staff expenditure is marginally favourable to plan in January and favourable to plan by £2.7m ytd. Expenditure increased by £0.2m when compared to December with bank holiday enhancement costs incurred in January of £0.2m. Expenditure on substantive medical and dental staff is again overspent in month by £0.3m and is now adverse to plan ytd by £0.1m. Expenditure on permanent nursing staff is adverse to plan in January by £0.1m. The overspends on medical and nursing staff are offset by underspends on all other staffing groups. All substantive staffing groups remain underspent ytd except medical and other staff which are £1.2m overspent ytd, predominantly relating to expenditure on HCAs as previously reported.

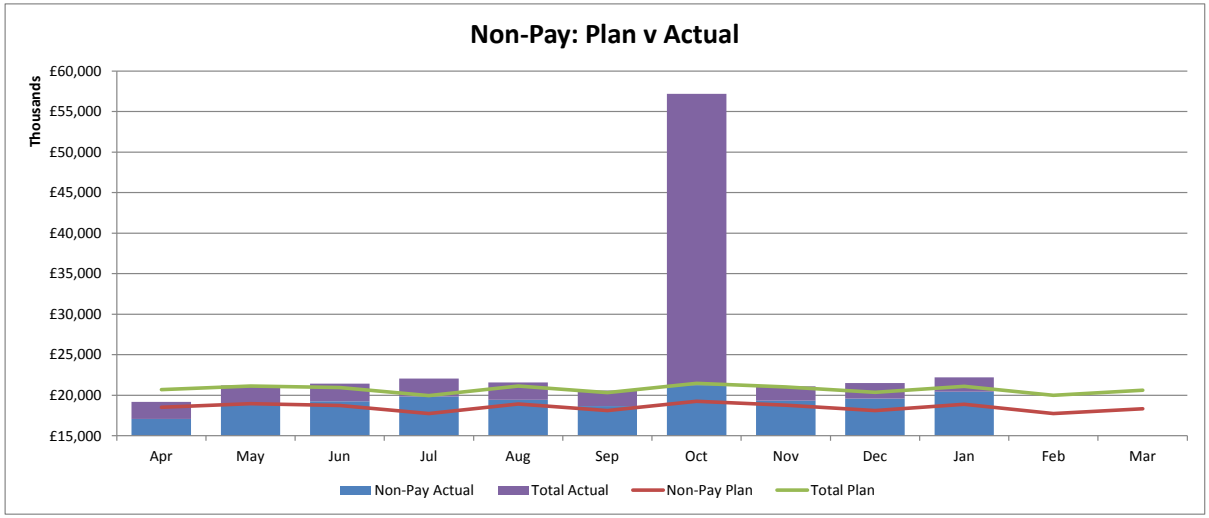
Expenditure on bank staff is adverse to plan by £0.3m in month and by £1.7m ytd. Previously reported trends continue in January with all staffing groups showing an overspend against plan in month and ytd except medical staffing, which is favourable to plan by £0.2m in January and by £1.6m ytd. Actual expenditure on bank staff in January increased marginally when compared to spend in December.

Expenditure on agency staff is adverse to plan in January by £1.6m, offset by a favourable performance on directly engaged agency medical staff of £0.3m. Ytd the overall agency variance stands at £14.6m adverse to plan with overspends in all staffing groups. All Care Groups contribute to the overspend but particular pressure can be seen in Urgent and Emergency Care, which is overspent on medical and nursing agency staff by £1.0m in month and by £7.4m ytd. Overall, agency CIP schemes are behind plan by £0.4m in January and by £2.9m ytd. Expenditure on agency staff increased by £0.8m in January, following low expenditure in December, with growth of £0.5m in medical staff and £0.3m in nursing. The increase in medical staffing is evenly split between General and Specialist Medicine, Urgent and Emergency Care and Surgery and Anaesthetics Care Groups and the increase in nursing agency cost relates predominantly to Urgent and

Non-Pay

Month 10 (January) 2018/19

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(5,749)	(5,640)	109	(56,870)	(53,934)	2,936	(67,802)
Clinical Supplies and Services - Clinical	(5,675)	(2,231)	3,444	(55,703)	(45,297)	10,406	(66,208)
Supplies and Services - Non-Clinical	(2,080)	(7,485)	(5,405)	(18,187)	(40,215)	(22,028)	(22,245)
Purchase of Healthcare	(761)	(673)	88	(7,616)	(8,485)	(869)	(9,138)
Education & Training	(246)	(180)	66	(2,460)	(1,530)	930	(2,951)
Consultancy	(71)	(51)	20	(719)	(737)	(18)	(861)
Premises	(1,718)	(1,590)	128	(17,260)	(16,732)	528	(20,552)
Clinical Negligence	(1,697)	(1,730)	(33)	(17,942)	(17,296)	646	(21,336)
Transport	(324)	(184)	140	(3,231)	(2,869)	362	(3,877)
Establishment	(273)	(322)	(49)	(2,752)	(3,071)	(319)	(3,296)
Other	(290)	(355)	(65)	(3,299)	(3,703)	(404)	(3,880)
Total Non-Pay Expenditure	**(18,884)**	**(20,440)**	**(1,556)**	**(186,039)**	**(193,870)**	**(7,831)**	**(222,146)**
Depreciation & Amortisation-Owned Assets	(1,517)	(1,169)	348	(15,168)	(13,955)	1,213	(18,201)
Impairment Losses	(42)		42	(417)	(34,205)	(33,788)	(500)
Profit/Loss on Asset Disposals	(10)		10	(100)	1	101	(120)
PDC Dividend	(501)	(357)	144	(5,011)	(4,219)	792	(6,013)
Interest Receivable	9	222	213	92	981	889	110
Interest Payable	(173)	(469)	(296)	(1,543)	(2,776)	(1,233)	(1,917)
Other Non-Operating Expenses	(1)		1	(6)	(3)	2	(7)
Total Non-Operating Expenditure	**(2,234)**	**(1,773)**	**461**	**(22,152)**	**(54,177)**	**(32,025)**	**(26,648)**
Total Expenditure	**(21,118)**	**(22,213)**	**(1,096)**	**(208,191)**	**(248,047)**	**(39,856)**	**(248,794)**



Non Pay expenditure is adverse to plan in January by £1.6m and by £7.8m (4.21%) ytd. Non pay CIP schemes are adverse to plan in total by £0.4m in month and by £6.3m ytd.

Drug expenditure is favourable to plan by £0.1m in month and favourable to plan by £2.9m ytd. Pass through drugs are favourable to plan in month by £0.2m and by £1.9m 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 £1.0m ytd. CIP schemes remain at £0.2m favourable to plan ytd.

Clinical supplies are favourable to plan in month by £3.4m and by £10.4m ytd. This favourable variance is offset by an overspend in supplies and services - non clinical relating to pass through expenditure on consumable items purchased via the Operated Healthcare Facility (OHF). Including the £2.9m in month and £11.4m ytd of actual OHF pass through expenditure relating to clinical supplies, purchases are favourable to the Trust's original plan by £0.5m in month and adverse to plan by £1.0m ytd. CIP schemes are adverse to plan by £1.6m ytd and account for all of the overspend on clinical supplies.

Expenditure on supplies and services - non clinical is adverse to plan in January by £5.4m and by £22.0m ytd. £3.9m of the total overspend in month (£15.1m 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 £1.5m in month and by £6.9m 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. In addition, there is an overspend of £0.3m in month relating to a catch up of 2gether set-up costs . Underperformance ytd on CIPs of £4.4m, including £2.1m from Serco planned as non clinical supplies but realised as non clinical income, and the effect of phase 2 staffing transfers to the subsidiary of £1.4m account for the majority of the overspend.

The underspend shown on Premises costs is offset by pass through costs of £0.5m leaving an adverse position in month of £0.4m all relating to PAS project costs which are offset by income.

Non pay actual expenditure in January increased by £0.9m when compared to December. Expenditure on drugs and PAS software grew by £1.3m, offset by reductions in clinical supplies and secondary commissioning totalling £0.4m.

Non Operating Expenditure YTD is £39.9m above plan. The Trust has incurred £1.7m interest charges in respect of the £72.8m cumulative facility utilised to date and £1.1m in respect of the leaseback from 2gether that is eliminated on consolidation. Impairment losses of £34.2m in respect of the 5 year cyclical valuation have been recognised.

Cost Improvement Summary

Month 10 (January) 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)	667	-	(667)	-	(1,000)
Agency	530	322	(208)	4,289	3,079	(1,211)	3,650	(1,767)
Workforce *	20	70	50	131	508	377	587	416
Procurement	207	176	(31)	1,567	873	(694)	1,029	(953)
Medicines Value	98	130	32	648	1,301	654	1,527	656
Division Schemes **	1,863	1,862	(1)	12,811	14,377	1,566	18,324	1,740
Sub-total	**2,885**	**2,561**	**(324)**	**20,112**	**20,138**	**26**	**25,117**	**(908)**
Central	320	(212)	(532)	3,232	3,815	583	3,782	(193)
Grand Total	**3,205**	**2,349**	**(856)**	**23,345**	**23,954**	**609**	**28,899**	**(1,101)**

*** 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	4,019
January	3,205	2,349
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 M10 were £2.3m were ahead of forecast by £0.2m and below plan of £3.2m. 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 January amounted to £1.7m recurrent and £0.6m on a non-recurrent basis. The YTD position is recurrent £14.9m and non-recurrent £9.1m.

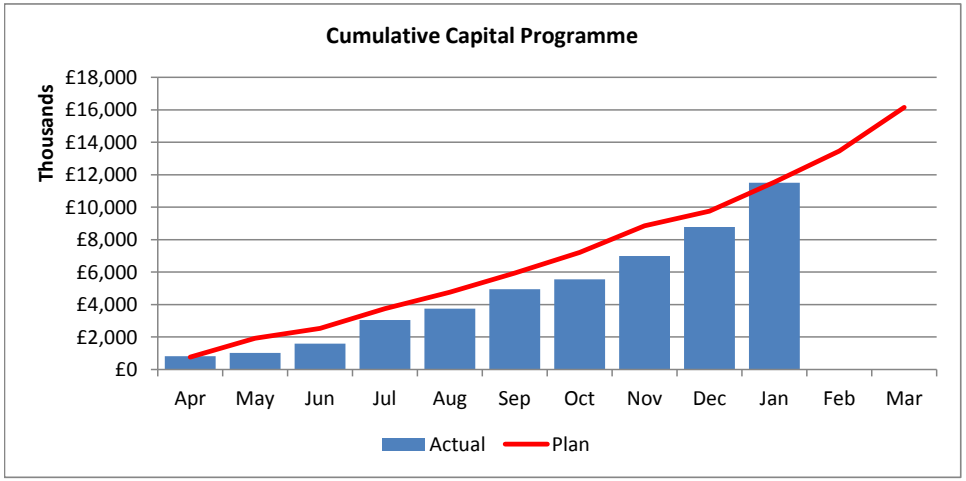
Capital Expenditure

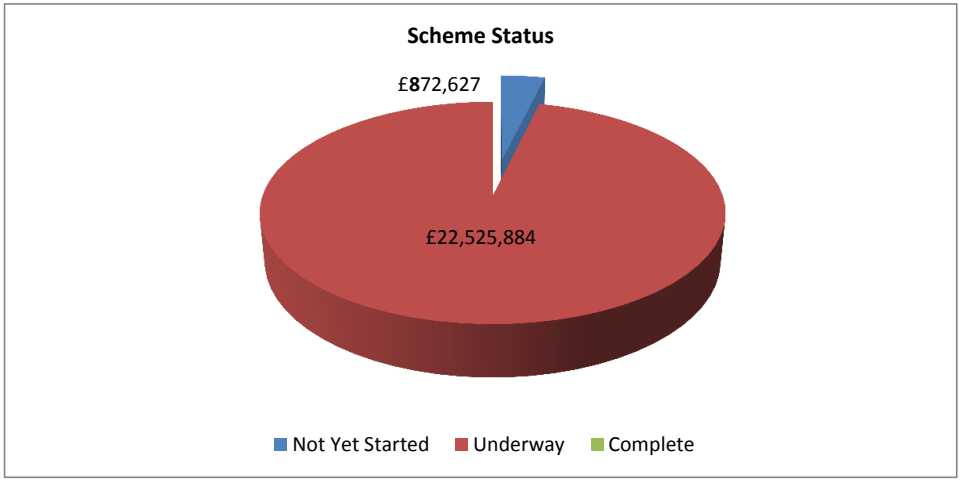
Month 10 (January) 2018/19

Capital Programme	Annual	To Date		
£000	Plan	Plan	Actual	Variance
Dementia Village	974	448	504	(56)
A&E Observation Area	6,400	1,464	2,182	(718)
Clinical Strategy Plans	200	182	143	39
Orthopaedic Modular Theatres	2,066	2,066	1,045	1,022
CT/CT SPECT Replacement	212	31	43	(12)
Invest To Save Schemes	39			
Medical Devices Group	3,693	2,050	1,866	184
Patent Environment Investment Committ	2,177	2,500	1,477	1,023
Information Development Group	2,000	1,950	2,084	(134)
Other Equipment Schemes	402	402	101	301
Other Building Schemes	70	70	8	62
Other IT Schemes	2,593	2,227	2,339	(113)
All Other Schemes	2,573	240	130	110
VAT Reclaim			(419)	419
Total	23,399	13,631	11,502	2,128

- Total expenditure at Mth 10 YTD is 15.6% 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 at QEQM are open with the WHH bays opening in early February.

- The current capital forecast outturn position for 2018/19 is £23.3m. However 2 new IT bids to NHSi are likely to raise this to £25.2m if agreed. 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.





Statement of Financial Position

Month 10 (January) 2018/19

£000	Opening	To Date	Movement	
Non-Current Assets	**270,767**	**328,402**	**57,636**	▲
Current Assets				
Inventories	8,949	3,901	(5,047)	▼
Trade and Other Receivables	39,034	46,362	7,328	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	7,157	8,703	1,546	▲
Total Current Assets	**55,139**	**58,966**	**3,827**	▲
Current Liabilities				
Payables	(39,536)	(44,441)	(4,905)	▲
Accruals and Deferred Income	(26,013)	(32,599)	(6,586)	▲
Provisions	(884)	(871)	12	▼
Net Current Assets	**(11,294)**	**(18,946)**	**(7,652)**	▼
Non Current Liabilities				
Provisions	(3,203)	(3,057)	146	▼
Long Term Debt	(46,228)	(163,760)	(117,532)	▲
Total Assets Employed	**210,042**	**142,639**	**(67,403)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	191,687	198,169	6,482	▲
Retained Earnings	(41,167)	(108,797)	(67,630)	▼
Revaluation Reserve	59,523	53,267	(6,256)	▼
Total Taxpayers' Equity	**210,042**	**142,639**	**(67,403)**	▼

Non Current asset values reflect in year additions of £11.9m (including donated assets) less depreciation charges of £13.9m 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 January was £5.8m above revised plan at £8.7m. See cash report for further details.

Trade and other receivables have increased from the 2018/19 opening position by £7.3m. Invoiced debtors have decreased from the opening position of £28.5m by £12.4m to £16.1m at the end of January

Accruals and Deferred Income have increased by 6.6m since the opening position. Of the £32.6m balance, £21.3m relates to Accruals and £11.3m is Deferred Income of which £2.5m relates to a notional profit on sale of assets to 2gether that has been eliminated on consolidation and a further £2.8m reflects cash received from Health Education England in January that will be released over the remaining months of the financial year.

The long term debt entry reflects drawings against working capital facilities. Total drawing to date £72.8m see cash report for details. The balance 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 10 (January) 2018/19

Creditors

Invoiced creditors have decreased by £4m from the opening position to £29.6m. 45% relates to current invoices with 16% or £4.8m over 90 days.

Over 90 days NHS creditors have increased by £100k in Month.

- Kings College Hospital NHS Foundation Trust - £25k
- Maidstone & Tunbridge Wells NHS Trust - £34k
- Medway NHS Foundation Trust - £117k
- NHS Blood & Transplant - £(80)k

YTD the Trust has paid 66.5% of NHS and 50.1% of non NHS invoices by value to 30 days. The average payment terms are 50 days.

Debtors

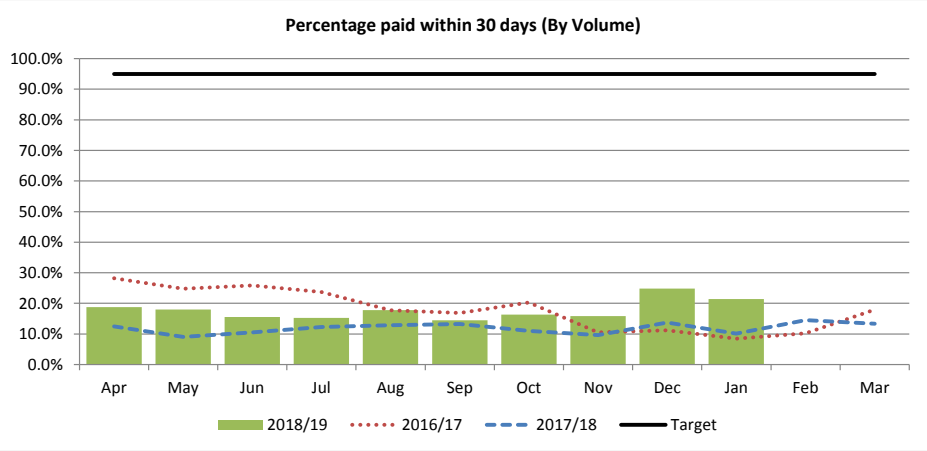
Total invoiced debtors have decreased from the opening position of £28.5m by £12.4m to £16.1m.
At 31st January there were 4 debtors owing over £1m.

- East Kent CCGs owing: South Kent Coast CCG £0.98m, Canterbury & Coastal CCG £1.6m, Ashford CCG £1.1m and Thanet CCG £1.4m. (outstanding invoices for 1718 and 1819 overperformance). Agreement has now been reached with CCGs in respect of 1718 overperformance, £3.5m is expected to be paid in February.
- East Kent Medical Services £2.2m

The debtors team are focussing on collection of all other debt to support the Trust cash position.

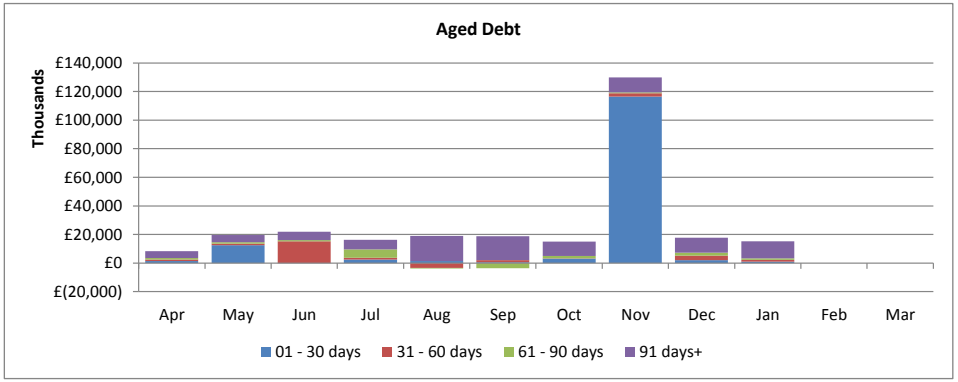
Better Payment Practice Code

	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	(161,428)	(24,002)	(19,693)	(2,548)
30+ days	(161,017)	(12,065)	(16,248)	(1,123)
By Volume				
0 - 30 days	14,500	270	1,430	41
30+ days	66,952	2,283	5,131	256
% by Value £	50.1%	66.5%	54.8%	69.4%
% by Volume	17.8%	10.6%	21.8%	13.8%
Target	95.0%	95.0%	95.0%	95.0%



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	809	1,021	1,229	1,064	11,990	15,305
Feb	0	0	0	0	0	0
Mar	0	0	0	0	0	0
		7%	8%	7%	78%	



Care Group Performance

Month 10 (January) 2018/19

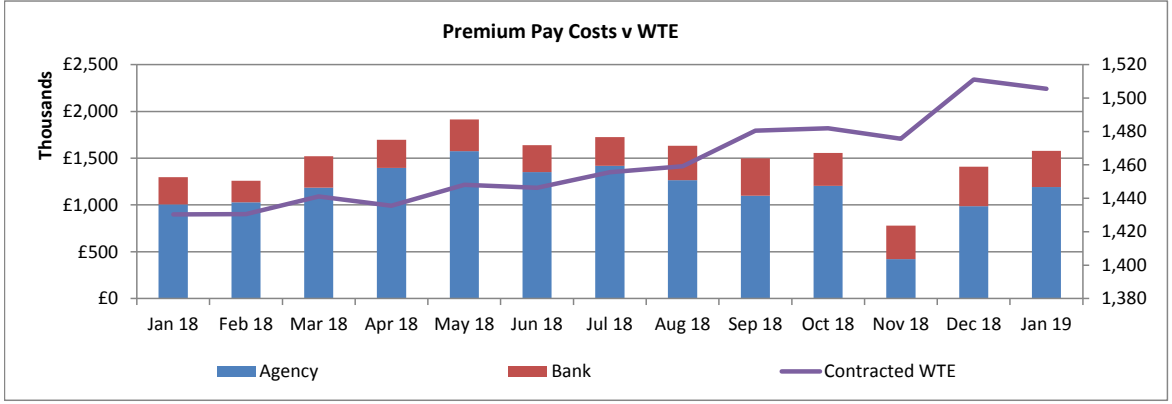
Year to Date Actual £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
General and Specialist Medicine	18,122	76,311	0	19,339	7,756	79	19,079	712	(71,052)	(26,148)	44,197
Urgent and Emergency Care	64	5,032	24,316		57	0	1,050	32	(31,061)	(3,746)	(4,256)
Surgery and Anaesthetics	37,091	32,022	0	12,352	250	68	12,048	1,833	(71,514)	(25,490)	(1,341)
Surgery - Head and neck, Breast Surgery and Dermatology	12,479	1,561	0	17,155	5,370	52	596	110	(12,702)	(8,954)	15,668
Clinical Support	535	30	0	3,412	13,156	57	29,417	5,054	(51,943)	(39,298)	(39,580)
Cancer Services	3,741	185	0	4,916	17,697		7,157	744	(6,353)	(20,858)	7,228
Women's and Children's Services	4,914	25,567	0	6,372	260	2	24,906	875	(41,031)	(3,791)	18,074
Clinical Total	**76,945**	**140,707**	**24,316**	**63,546**	**44,547**	**258**	**94,252**	**9,359**	**(285,655)**	**(128,285)**	**39,992**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	10,762	(8,975)	(40,213)	(38,426)
Corporate	0	0	0	0	0	0	0	14,996	(20,877)	(25,474)	(31,355)
Care Group Total	**76,945**	**140,707**	**24,316**	**63,546**	**44,547**	**258**	**94,252**	**35,117**	**(315,506)**	**(193,972)**	**(29,789)**
Central		70	0	0	264	3	9,020	8,826	(2,614)	102	15,671
							EBITDA				**(14,118)**
							Capital Charges and Interest			(54,177)	(54,177)
							Income and Expenditure Surplus/(Deficit)				(68,295)

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	(1,257)	3,421	0	(1,486)	(310)	6	(1,519)	170	(1,274)	(1,320)	(3,568)
Urgent and Emergency Care	63	473	2,501		33	0	(9)	(18)	(4,947)	(485)	(2,388)
Surgery and Anaesthetics	(7,293)	1,778	0	(1,631)	(97)	57	2,370	194	(5,331)	40	(9,913)
Surgery - Head and neck, Breast Surgery and Dermatology	(2,608)	294	0	(374)	(751)	7	605	(1)	(149)	109	(2,869)
Clinical Support	5	21	0	(155)	256	(19)	422	335	(1,756)	(2,048)	(2,939)
Cancer Services	527	(151)	0	162	(626)		94	(70)	(83)	630	484
Women's and Children's Services	(716)	(757)	0	(563)	(70)	()	(1,156)	(22)	(2,181)	472	(4,993)
Clinical Total	**(11,279)**	**5,079**	**2,501**	**(4,047)**	**(1,565)**	**51**	**807**	**589**	**(15,720)**	**(2,602)**	**(26,187)**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	1,427	130	(1,740)	(184)
Corporate	0	0	0	0	0	0	0	(13)	344	(53)	278
Care Group Total	**(11,279)**	**5,079**	**2,501**	**(4,047)**	**(1,565)**	**51**	**807**	**2,003**	**(15,247)**	**(4,395)**	**(26,093)**
Central	2,168	124	51	(104)	(286)	()	9,691	5,309	2,204	(3,435)	15,722
							EBITDA				**(10,371)**
							Capital Charges and Interest			(32,025)	(32,025)
							Income and Expenditure Surplus/(Deficit)				(42,396)

General and Specialist Medicine

Month 10 (January) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,911	1,932	21	19,379	18,122	(1,257)
Non-Electives	8,138	8,362	224	72,890	76,311	3,421
Accident & Emergency	0	0	0	0	0	0
Outpatients	2,184	2,015	(169)	20,825	19,339	(1,486)
High Cost Drugs	807	786	(21)	8,066	7,756	(310)
Private Patients	7	13	6	73	79	6
Other NHS Clinical	2,095	1,728	(367)	20,397	18,941	(1,456)
Other Clinical	20	12	(8)	201	138	(63)
Prior Month Adjustment	0	79	79	0		
Total Clinical Income	**15,162**	**14,926**	**(235)**	**141,831**	**140,685**	**(1,145)**
Non Clinical Income	53	123	70	542	712	170
Total Income	**15,215**	**15,049**	**(166)**	**142,372**	**141,397**	**(975)**
Expenditure						
Substantive Staff	(5,569)	(5,560)	10	(57,459)	(55,620)	1,839
Bank	(328)	(387)	(59)	(3,254)	(3,516)	(261)
Agency	(974)	(1,192)	(218)	(9,065)	(11,916)	(2,851)
Total Pay	**(6,871)**	**(7,140)**	**(268)**	**(69,778)**	**(71,052)**	**(1,274)**
Non Pay	(2,238)	(2,644)	(406)	(24,828)	(26,148)	(1,320)
Total Expenditure	**(9,110)**	**(9,784)**	**(674)**	**(94,607)**	**(97,200)**	**(2,593)**
Contribution	**6,105**	**5,266**	**(839)**	**47,766**	**44,197**	**(3,568)**



The Care Group is £0.8m adverse in January and £3.6m adverse YTD.

Income was £0.2m adverse to plan in January and is £1.0m adverse YTD. Outpatients were behind plan whilst the impact of activity recording for the new PAS is still under investigation in this area, however activity in this area was significantly higher than December. 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. Pockets of activity have been identified as not being recorded, the Care Group is putting steps in place to ensure this is rectified and also to reduce the number of "no outcome" patients.

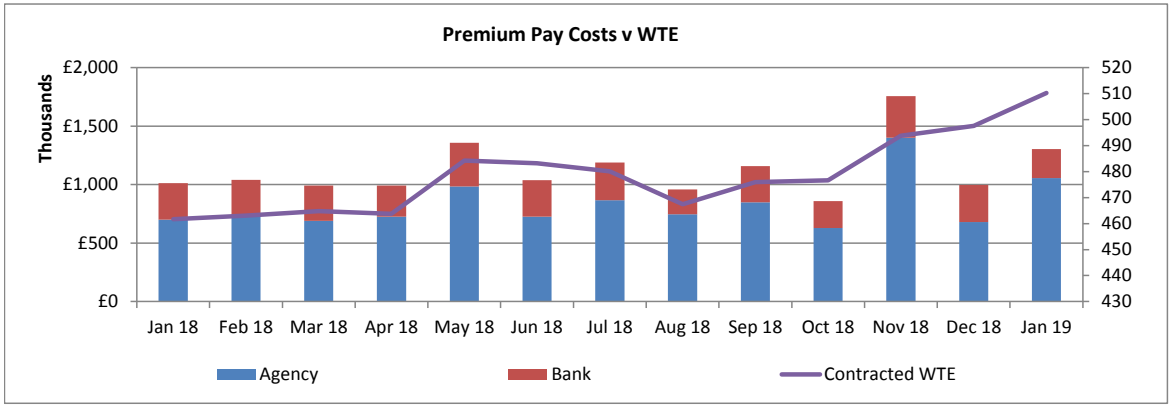
Pay overspent by £0.3m in January which is predominantly Nursing, reflective of premium costs and non-delivery of Agency CIPs; Nursing wte is under budget. Agency spend increased by £0.2m this month to £1.2m, the increase attributable to Medical staff. The Care Group is implementing a weekly Agency scrutiny panel to control and challenge spend. Junior Doctors will be subject to a detailed review of posts by ward and speciality to ensure resources are utilised most effectively.

The non-pay run rate is £0.1m lower than January, however overspent by £0.4m, mainly outliers recharge, rechargeable drugs and devices, disputed Renal Pathology tests and high levels of security recharges.

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

Urgent and Emergency Care
Month 10 (January) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	(1)	2	3	1	64	63
Non-Electives	426	705	278	4,559	5,032	473
Accident & Emergency	2,078	2,467	389	21,815	24,316	2,501
Outpatients	()	0				
High Cost Drugs	2	(4)	(6)	24	57	33
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	106	(26)	(132)	1,058	1,050	(9)
Prior Month Adjustment	0	(46)	(46)	0	0	0
Total Clinical Income	**2,611**	**3,098**	**488**	**27,458**	**30,520**	**3,062**
Non Clinical Income	5	9	4	50	32	(18)
Total Income	**2,616**	**3,107**	**491**	**27,508**	**30,551**	**3,044**
Expenditure						
Substantive Staff	(2,315)	(2,117)	198	(22,147)	(19,451)	2,696
Bank	(285)	(248)	37	(2,796)	(2,946)	(150)
Agency	(104)	(1,056)	(952)	(1,170)	(8,663)	(7,493)
Total Pay	**(2,704)**	**(3,420)**	**(716)**	**(26,114)**	**(31,061)**	**(4,947)**
Non Pay	(309)	(440)	(131)	(3,261)	(3,746)	(485)
Total Expenditure	**(3,013)**	**(3,860)**	**(847)**	**(29,375)**	**(34,807)**	**(5,432)**
Contribution	**(397)**	**(753)**	**(356)**	**(1,867)**	**(4,256)**	**(2,388)**



Income is significantly above plan, reflecting the higher than expected attendances which have been in evidence throughout the year. Non elective income is also considerably above plan in month. Other Clinical Income is under performing due to fewer CRU (Compensation Recovery Unit) receipts-Income fluctuates significantly in this area.

Pay was overspent by £0.7m in month and reflects savings shortfalls and an increase in temporary staffing expenditure compared to last year, combined with higher substantive costs. Medical agency increased by £0.2m from December. Nursing agency also increased by £0.2m. The increase in nursing agency was unexpected and is due to retrospective costs associated with a new managed service contract. Administrative processes are being improved by all parties involved and it is expected that accurate usage and accrual information will be available from February.

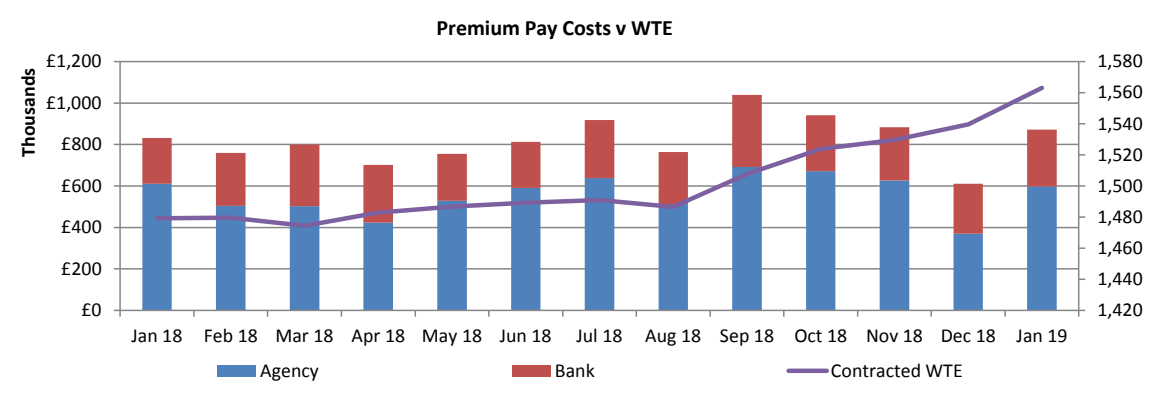
Non-pay was overspent by £0.1m. This is due to a mixture of overspends on clinical supplies, drugs, security services, cleaning services and computer equipment. The majority of these issues reflect the higher number of attendances going through A&E. However the reason for the escalating security and cleaning costs are being investigated.

The annual CIP target for the Care Group is £2.5m and is mainly focused on agency reduction plans. Currently performance is £1.1m adverse to plan and is forecast to be £1.5m adverse at year end. The Care Group is investigating what measures can be taken to help address the gap. However, without significant reductions to agency usage it is unlikely that major improvements will be made.

Surgery and Anaesthetics

Month 10 (January) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	4,951	3,679	(1,271)	44,384	37,091	(7,293)
Non-Electives	2,854	3,234	380	30,244	32,022	1,778
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,464	1,233	(230)	13,983	12,352	(1,631)
High Cost Drugs	35	30	(5)	347	250	(97)
Private Patients	1	9	8	12	68	57
Other NHS Clinical	966	1,294	328	9,595	11,952	2,356
Other Clinical	8	2	(6)	82	96	14
Prior Month Adjustment	0	5	5	0		
Total Clinical Income	**10,279**	**9,488**	**(791)**	**98,647**	**93,831**	**(4,816)**
Non Clinical Income	175	483	309	1,639	1,833	194
Total Income	**10,453**	**9,971**	**(482)**	**100,285**	**95,663**	**(4,622)**
Expenditure						
Substantive Staff	(6,104)	(6,497)	(393)	(60,203)	(63,217)	(3,013)
Bank	(217)	(274)	(57)	(2,102)	(2,645)	(543)
Agency	(390)	(598)	(208)	(3,878)	(5,652)	(1,775)
Total Pay	**(6,710)**	**(7,369)**	**(659)**	**(66,183)**	**(71,514)**	**(5,331)**
Non Pay	(2,621)	(2,281)	339	(25,530)	(25,490)	40
Total Expenditure	**(9,331)**	**(9,650)**	**(319)**	**(91,713)**	**(97,004)**	**(5,291)**
Contribution	**1,123**	**321**	**(802)**	**8,572**	**(1,341)**	**(9,913)**



The Care Group is £0.8m adverse to plan in month and £9.9m adverse YTD.

Below plan elective income (£7.2m) is mostly due to underperformance in Orthopaedics (£2.4m), and unachieved CIPs (£3.7m). 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 be achieved 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 (£1.8m) with high levels of General Surgery activity.

Outpatient performance is adverse (£1.6m), with Orthopaedics (£0.8m) the largest YTD which is mostly due to the greater than anticipated impact of the Virtual Fracture Clinics. Urology (£0.4m), General Surgery (£0.2m) and Pain services (£0.2m) are also under performing.

Other NHS Clinical Income is favourable mostly due to ITU (£2.4m).

Pay is adverse (£5.3m) 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, although start dates are mostly in the new financial year. 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 (£1.4m), which has instead been partially met through Income.

Non Pay is favourable (£40k) YTD with underspend on Independent Sector usage (£497k) offset by CIP underachievement (£779k).

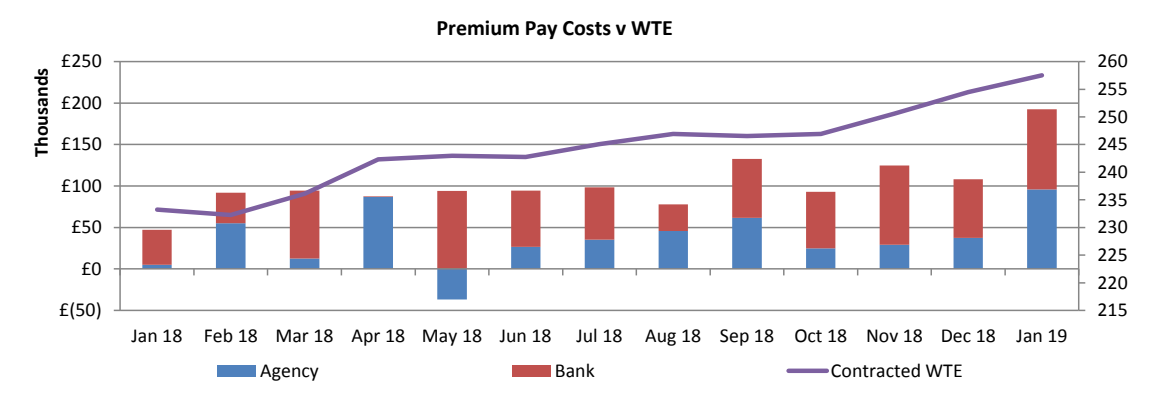
Included in the above expenditure is approximately £730k for medical patient outliers in the first six months, with no additional income. This has equated to the loss on average of 24 Surgical beds per day. Also incurred is £959k supporting the Winter/ED plan.

CIPs YTD target of £4.6m is underachieved by £1.1m.

Surgery - Head and neck, Breast Surgery and Dermatology

Month 10 (January) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,500	1,320	(180)	15,087	12,479	(2,608)
Non-Electives	118	162	44	1,267	1,561	294
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,802	1,739	(63)	17,529	17,155	(374)
High Cost Drugs	612	631	19	6,122	5,370	(751)
Private Patients	5	15	11	46	52	7
Other NHS Clinical	(25)	76	101	(49)	583	633
Other Clinical	4		(4)	40	13	(27)
Prior Month Adjustment	0	238	238	0	0	0
Total Clinical Income	**4,017**	**4,182**	**165**	**40,041**	**37,214**	**(2,827)**
Non Clinical Income	11	11	()	111	110	(1)
Total Income	**4,028**	**4,192**	**165**	**40,152**	**37,324**	**(2,828)**
Expenditure						
Substantive Staff	(1,194)	(1,160)	34	(11,688)	(11,635)	53
Bank	(56)	(96)	(41)	(553)	(659)	(106)
Agency	(25)	(96)	(71)	(311)	(407)	(96)
Total Pay	**(1,274)**	**(1,353)**	**(78)**	**(12,553)**	**(12,702)**	**(149)**
Non Pay	(875)	(1,043)	(168)	(9,062)	(8,954)	109
Total Expenditure	**(2,150)**	**(2,396)**	**(246)**	**(21,615)**	**(21,655)**	**(41)**
Contribution	**1,878**	**1,796**	**(82)**	**18,537**	**15,668**	**(2,869)**



The Care Group is £0.1m adverse to plan in month and £2.9m adverse YTD.

Below plan elective income (£2.6m) is mostly due to underperformances in Dermatology (£0.8m), Ophthalmology (£0.6m) & ENT (£0.4m), together with unachieved CIPs (£0.6m). 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 (£0.3m) with high levels of Maxillo Facial activity.

Outpatient performance is adverse (£374k), with underperformances in ENT (£285k) & Ophthalmology (£133k) partly offset with an overperformance in Dermatology (£141k).

High Cost Drugs under performance (£751k) is solely in relation to Ophthalmology AMD patients, and is offset with an underspend in expenditure.

Other NHS Clinical Income is favourable (£633k) mostly due to the Dermatology risk provision.

Pay is adverse YTD (£149k). Medical agency costs have reduced significantly with ENT & Breast Surgery the only specialties requiring agency cover. However prior months high usage of Medical agency has contributed to an unmet CIP Pay target (£76k).

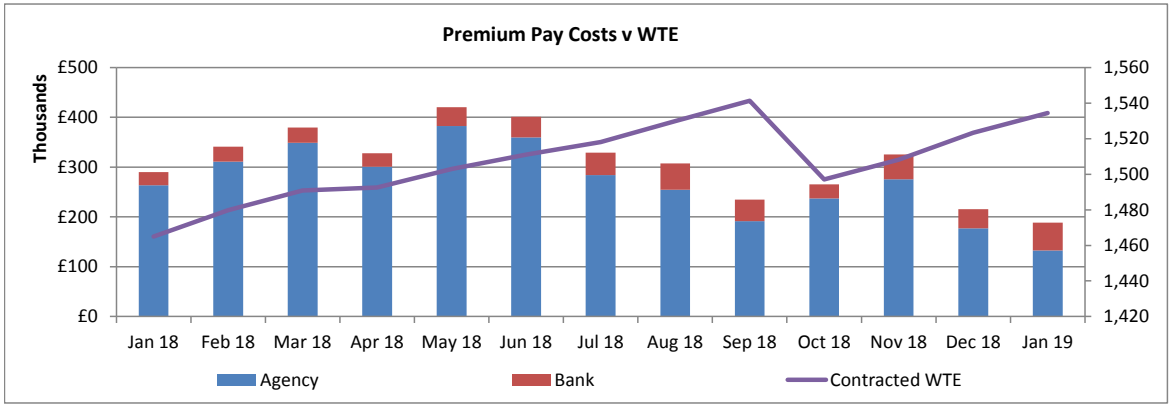
Non Pay is favourable (£109k) YTD, however the underspend on Drugs (£767k) is offset by the High cost drugs income under recovery and above planned usage (£726k) of Ophthalmology insourcing services. This was originally only planned to be utilised for the first five months, but is now required until the end of the financial year.

CIPs YTD target of £0.9m is underachieved by £0.2m.

Clinical Support

Month 10 (January) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	48	52	4	529	535	5
Non-Electives		0	()	9	30	21
Accident & Emergency	0	0	0	0	0	0
Outpatients	362	305	(57)	3,567	3,412	(155)
High Cost Drugs	1,290	1,129	(161)	12,900	13,156	256
Private Patients	8	3	(4)	75	57	(19)
Other NHS Clinical	3,055	3,022	(32)	28,995	29,416	422
Other Clinical	0	0	0	0		
Prior Month Adjustment	0	(294)	(294)	0	0	0
Total Clinical Income	**4,762**	**4,217**	**(545)**	**46,076**	**46,606**	**530**
Non Clinical Income	526	428	(98)	4,719	5,054	335
Total Income	**5,288**	**4,645**	**(642)**	**50,795**	**51,660**	**865**
Expenditure						
Substantive Staff	(4,814)	(4,973)	(159)	(48,318)	(48,927)	(608)
Bank	(23)	(56)	(33)	(237)	(420)	(183)
Agency	(151)	(133)	18	(1,632)	(2,596)	(964)
Total Pay	**(4,988)**	**(5,162)**	**(174)**	**(50,187)**	**(51,943)**	**(1,756)**
Non Pay	(3,838)	(3,606)	232	(37,249)	(39,298)	(2,048)
Total Expenditure	**(8,826)**	**(8,768)**	**58**	**(87,437)**	**(91,241)**	**(3,804)**
Contribution	**(3,538)**	**(4,122)**	**(584)**	**(36,642)**	**(39,580)**	**(2,939)**



The overall financial position deteriorated this month due to Income not meeting the increased plan as well as pay overspend. The main drivers of underperformance of income against plan is the Homecare passthrough drugs volume being lower than plan also impacted by price (£0.16m) and Therapies income is also below plan this month, which is a continuation of the booking system template issue. The Care Group is working to resolve this. Both Pathology and Interventional Radiology exceeded patient care income plans for direct access and electives.

Pay cost is lower than last month again however there is a CIP target within the budget this month of £0.2m which impacts heavily on the position. Radiology, Pharmacy, Pathology and Outpatients are all overspent on Pay in January. Agency cost was reduced in all areas expect Pharmacy. Overall the Care Group is spending c£0.2m per month more on Pay than in the last quarter of 2017/18, including the pay award. The driver behind this increase is increased staff recruitment in Pharmacy, Therapies, Pathology and Outpatients. However, on a positive note Radiology is spending c£0.07m less per month due to fewer agency staff and also a reduction in Medical premium pay costs.

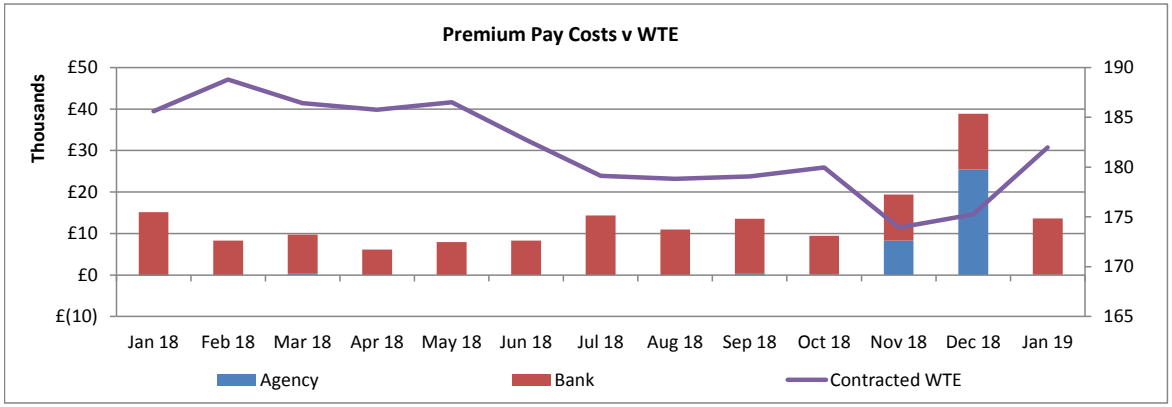
There was an overall reduction in Non-pay costs in January, unusual to trend this caused an underspend against plan. One of the drivers for this was a correction of maintenance contract and MRI outsourcing accruals, impact £0.1m. These both fall within Radiology which is significantly overspent on non-pay year to date predominantly due to outsourcing costs which is now £0.4m adverse to plan. The main drivers being increases in year on CT and MRI demand, however the department have now significantly reduced the outsourced reporting due to an increase in consultant reporting capacity. Aseptic suite drugs written off increased this month (£0.05m). Within the non-pay position is £0.1m undelivered savings target (£1m YTD). The Care Group overall income and expenditure forecast is £3.5m deficit.

The overall CIP target is being met and the forecast remains at £5.2m.

Cancer Services

Month 10 (January) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	380	420	40	3,214	3,741	527
Non-Electives	33	36	3	335	185	(151)
Accident & Emergency	0	0	0	0	0	0
Outpatients	505	524	19	4,755	4,916	162
High Cost Drugs	1,832	1,816	(17)	18,323	17,697	(626)
Private Patients		0	()			
Other NHS Clinical	715	727	11	7,063	7,155	92
Other Clinical		0	()		3	2
Prior Month Adjustment	0	34	34	0	0	0
Total Clinical Income	**3,466**	**3,557**	**91**	**33,690**	**33,696**	**6**
Non Clinical Income	79	109	29	814	744	(70)
Total Income	**3,545**	**3,665**	**120**	**34,504**	**34,439**	**(64)**
Expenditure						
Substantive Staff	(620)	(629)	(9)	(6,150)	(6,210)	(60)
Bank	(12)	(14)	(2)	(120)	(108)	11
Agency	0	()	()	0	(34)	(34)
Total Pay	**(632)**	**(643)**	**(10)**	**(6,270)**	**(6,353)**	**(83)**
Non Pay	(2,175)	(2,123)	52	(21,489)	(20,858)	630
Total Expenditure	**(2,807)**	**(2,766)**	**41**	**(27,759)**	**(27,211)**	**548**
Contribution	**738**	**899**	**161**	**6,745**	**7,228**	**484**



Income is above plan this month with Regular Day Attenders, Chemotherapy and MDTs exceeding plan, culminating to a balanced year to date patient care income position.

In terms of Non-clinical income, there was a surplus this month in relation to catch-up of the Macmillan recharging for last month, reducing the year to date deficit against plan.

Haemophilia blood products/High cost drugs recharge is below plan £0.6m year to date which is also reflected in the underspend on the non-pay position.

Pay cost is lower than last month and is marginally overspent against budget this month, this is in relation to the vacancy factor within the budget which was based on last year's spend. Other than this, the Care Group has no material pay overspends and no agency spend.

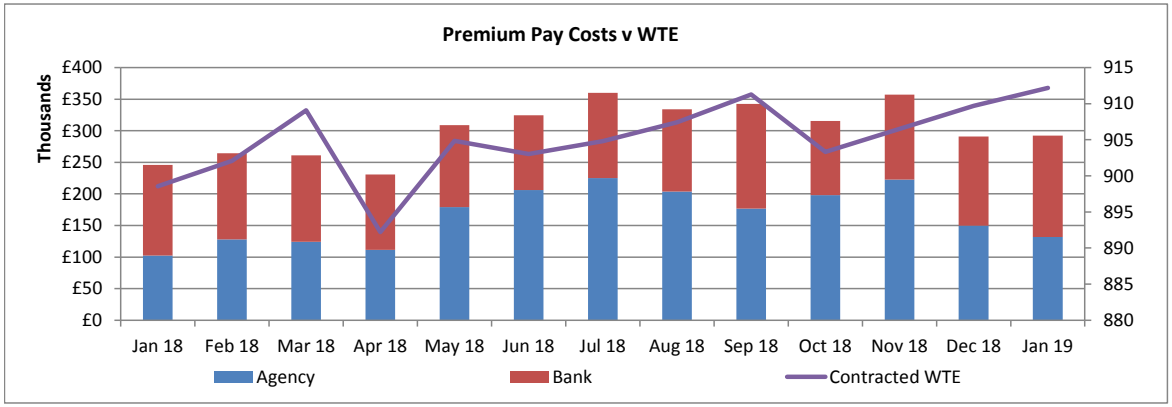
Non-pay is underspent overall, mainly on drugs expenditure which is £0.6m underspent year to date. Clinical Haemophilia is underspent £0.9m in total on blood products. This is offset partly by Oncology drugs which are £0.2m above plan (Rechargeable to commissioners).

The CIP delivered against target has been exceeded year to date by £0.13m so far this year with further to be booked for January next month (£0.05m).

Women's and Children's Services

Month 10 (January) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	583	475	(107)	5,630	4,914	(716)
Non-Electives	2,593	2,555	(38)	26,324	25,567	(757)
Accident & Emergency	0	0	0	0	0	0
Outpatients	713	635	(78)	6,934	6,372	(563)
High Cost Drugs	33	40	7	331	260	(70)
Private Patients		0	()	2	2	()
Other NHS Clinical	2,693	2,628	(65)	25,880	24,838	(1,042)
Other Clinical	18	10	(8)	182	68	(114)
Prior Month Adjustment	0	319	319	0	()	()
Total Clinical Income	**6,633**	**6,663**	**30**	**65,283**	**62,021**	**(3,262)**
Non Clinical Income	91	83	(8)	897	875	(22)
Total Income	**6,723**	**6,746**	**22**	**66,180**	**62,896**	**(3,284)**
Expenditure						
Substantive Staff	(3,694)	(3,874)	(180)	(36,908)	(37,874)	(966)
Bank	(103)	(161)	(58)	(1,031)	(1,351)	(320)
Agency	(89)	(132)	(43)	(910)	(1,805)	(895)
Total Pay	**(3,885)**	**(4,167)**	**(281)**	**(38,849)**	**(41,031)**	**(2,181)**
Non Pay	(432)	(406)	26	(4,263)	(3,791)	472
Total Expenditure	**(4,318)**	**(4,573)**	**(255)**	**(43,112)**	**(44,822)**	**(1,709)**
Contribution	**2,405**	**2,173**	**(232)**	**23,068**	**18,074**	**(4,993)**



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, but overall activity continues to fall below the plan.

Non-elective income also continues to fall below plan and is predominantly due to a declining birth rate, which is consistent with lower levels seen throughout the year to date. Gynaecology income was stable in month but is £0.2m below year to date plan. Obstetric income is £0.7m below the year to date plan.

Overall outpatient income was notably 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. Subject to approval, Gynaecology are employing NHS locum resource to help recover their 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, although overall income was still below plan in January, maternity pathway was actually favourable to plan in January (the second consecutive month).

Overall pay was significantly overspent in January and year to date. Savings shortfalls (£0.1m in month) are a key driver. Temporary pay costs are also, on average, £0.1m a month higher than last year with junior/middle grade vacancies/sickness/maternity leave being particular issues. However, recruitment into middle/junior grade roles and into midwifery has led to recent improvements-Agency costs were £50k lower this month than the average for the year. Recruitment into Padua remains an issue though and agency expenditure is not expected to improve here over the remainder of the year.

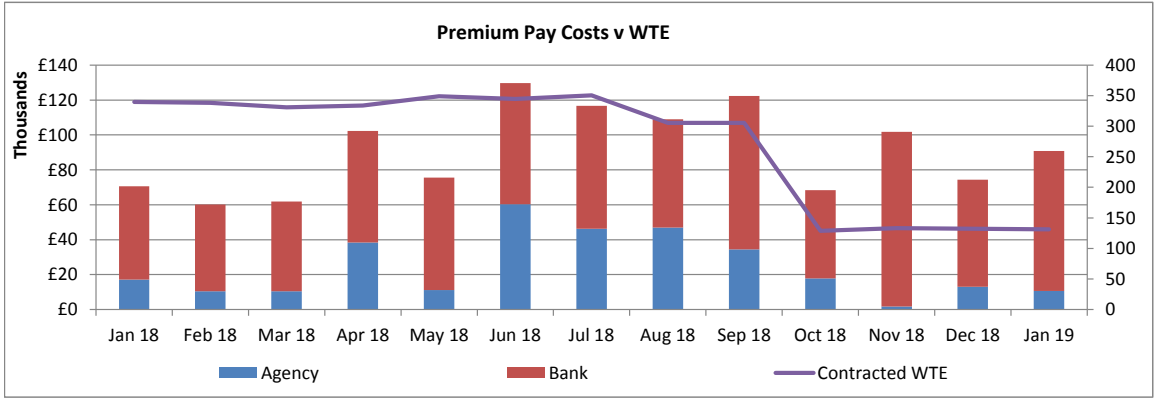
Non-pay is underspent due to the receipt a CNST incentive bonus. This has offset overspends relating to clinical supplies and dictation services.

Overall CIP performance is above plan year to date, however a small deficit of £40k is forecast due to the phasing of schemes in the second half of the year. The forecast recurrent shortfall is £0.9m. The Care Group is investigating what further measures can be taken to improve recurrent performance- a freeze has been put on discretionary expenditure.

Strategic Development and Capital Planning

Month 10 (January) 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	1,024	1,697	673	9,335	10,762	1,427
Total Income	**1,024**	**1,697**	**673**	**9,335**	**10,762**	**1,427**
Expenditure						
Substantive Staff	(473)	(475)	(3)	(8,433)	(7,984)	449
Bank	(60)	(80)	(20)	(507)	(710)	(204)
Agency	10	(11)	(20)	(164)	(281)	(116)
Total Pay	**(523)**	**(566)**	**(43)**	**(9,105)**	**(8,975)**	**130**
Non Pay	(5,099)	(5,340)	(241)	(38,473)	(40,213)	(1,740)
Total Expenditure	**(5,621)**	**(5,906)**	**(284)**	**(47,577)**	**(49,188)**	**(1,611)**
Contribution	**(4,597)**	**(4,209)**	**389**	**(38,243)**	**(38,426)**	**(184)**



The position as at month 10 is £(184)k adverse.

Income is £1.4m favourable YTD, the majority of which relates to provisions being released for PAS/ SaCP and invoices being raised to 2gether which offset pay and non pay following the transfer of services. Pay £130k favourable and non pay adverse £(1.7)m, as said above the majority is offset by income.

The income position in month is favourable £673k, which is mostly due to the SacP/PAS income being released in full, but also car parking being £28k favourable in the month. These offset adverse variances of £(120)k on the Operated Healthcare Facility line which has arisen due to a discrepancy with tenancy income following the transfer to 2gether - this is currently being negotiated.
The rest is due to income from 2gether which offsets pay/non-pay expenditure.
The position YTD is mostly attributable to the SaCP/PAS income, car parking £250k favourable YTD, laundry, accommodation and income for 2gether recharges.

Pay is favourable £130k YTD and adverse £(43)k in month; £(12)k in month and £(40)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 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 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 £(241)k in month and £(1.7)m YTD.
The position is offset by income from 2gether equating to £83k in month and £609k YTD. Therefore after adjusting for this the actual position in month is £(159)k adverse in month and adverse £(1.13)m YTD.

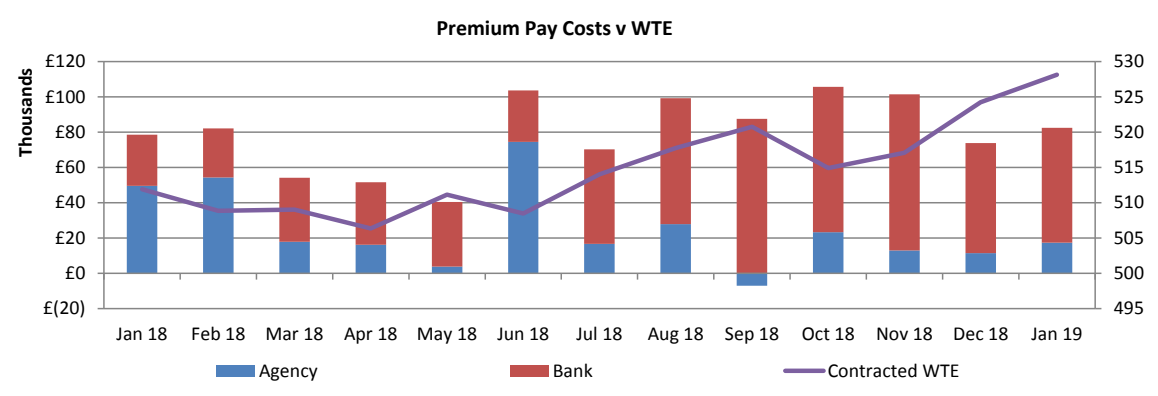
The adverse position in month is due SaCP/PAS expenditure £(709)k and £(620)k YTD which is offset by the income (see above). This is partly offset by Operated Healthcare Facility favourable variance of £519k in month (b/e YTD), this is following the correction of the 2gether OHF budget pending CCN negotiations.
As previously reported, YTD adverse variances are due to waste £(91)k, laundry adverse on non pay but this is offset by income, utilities £(26)k still o/s issues around billing / rates raised as a cost pressure and escalated with Procurement.

In addition to this, £(205)k adverse variance YTD shows subjectively under non pay on the CIP report due to non pay schemes being substituted with other schemes. Savings are £(78)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 10 (January) 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	1,655	1,671	16	15,009	14,996	(13)
Total Income	**1,655**	**1,671**	**16**	**15,009**	**14,996**	**(13)**
Expenditure						
Substantive Staff	(2,165)	(2,078)	86	(21,189)	(20,068)	1,122
Bank	(3)	(65)	(62)	(31)	(612)	(581)
Agency	0	(17)	(17)	0	(197)	(197)
Total Pay	**(2,168)**	**(2,161)**	**7**	**(21,221)**	**(20,877)**	**344**
Non Pay	(2,649)	(2,433)	217	(25,421)	(25,474)	(53)
Total Expenditure	**(4,817)**	**(4,593)**	**224**	**(46,641)**	**(46,351)**	**291**
Contribution	**(3,162)**	**(2,923)**	**239**	**(31,633)**	**(31,355)**	**278**



The position is £278k favourable as at Month 10

Income is favourable £16k in month and £(13)k YTD There are some minor adverse areas within each directorate which are being reviewed.

Pay is favourable £7k in month and favourable £344k YTD. The current vacancy rate is just under 40 WTE.
The largest adverse variance in month and YTD is within Operations, which is due to two issues arising from the restructure 1) additional cost centres being transferred and 2) higher staff costs being incurred, these are being reviewed. These are being offset by pay underspends in the rest of the Corporate Care Group.
The percentage vacancy rates, budgeted against contracted, are on average 5% 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 costs for the use of temporary/bank staff is being funded by the existing vacancies within each dept, the PMO have now appointed into substantial posts so the temporary staff costs should stop soon.

Non pay is favourable £217k in month and £(53)k adverse YTD.
The position in month is mainly attributable to LDA funding being received on PGME for retrospective study leave claims position YTD correct, also an underspend of £95k on Finance and Performance which is due to recoding of Month 9 PAS validation costs to IT PAS/SaCP report.

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 £(117)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 £(65)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 10 (January) 2018/19

	Year to Date	Prior Year to Date	Year on Year	
	Actual	Actual	Variance	Variance %
Income				
Electives	76,945	74,016	2,930	4.0%
Non-Electives	140,777	134,278	6,499	4.8%
Accident and Emergency	24,316	21,870	2,446	11.2%
Outpatients	63,546	64,524	(978)	(1.5%)
High Cost Drugs	44,811	46,327	(1,516)	(3.3%)
Private Patients	261	214	46	21.7%
Other NHS Clinical Income	101,855	96,294	5,562	5.8%
Other Clinical Income	1,415	1,589	(174)	(10.9%)
Total Clinical Income	**453,928**	**439,113**	14,815	3.4%
Non Clinical Income	43,944	44,884	(940)	(2.1%)
Total Income	**497,872**	**483,997**	13,875	2.9%
Expenditure				
Substantive Staff	(264,906)	(250,298)	(14,607)	(5.8%)
Overtime	(4,583)	(4,207)	(377)	(9.0%)
Waiting List Payments	(2,267)	(1,825)	(441)	(24.2%)
Medical Locums/Short Sessions	(2,658)	(2,960)	303	10.2%
Bank	(12,820)	(11,104)	(1,717)	(15.5%)
Agency	(30,212)	(16,966)	(13,246)	(78.1%)
Direct Engagement - Agency	(675)	(2,942)	2,267	77.0%
Total Pay	**(318,121)**	**(290,302)**	(27,818)	(9.6%)
Non-Pay				
Drugs	(53,934)	(56,282)	2,348	4.2%
Clinical Supplies and Services - Clinical	(45,297)	(57,696)	12,399	21.5%
Supplies and Services - Non-Clinical	(40,215)	(17,549)	(22,666)	(129.2%)
Purchase of Healthcare	(8,485)	(6,735)	(1,750)	(26.0%)
Education & Training	(1,530)	(2,157)	628	29.1%
Consultancy	(737)	(619)	(119)	(19.2%)
Premises	(16,732)	(15,863)	(869)	(5.5%)
Clinical Negligence	(17,296)	(17,975)	679	3.8%
Transport	(2,869)	(3,094)	225	7.3%
Establishment	(3,071)	(2,944)	(127)	(4.3%)
Other	(3,703)	(5,385)	1,682	31.2%
Total Non-Pay	**(193,870)**	**(186,300)**	(7,570)	(4.1%)
Total Expenditure	**(511,991)**	**(476,603)**	(35,388)	(7.4%)
EBITDA	**(14,118)**	**7,394**	(21,513)	(290.9%)
Non-Operating Expenses	(54,177)	(21,104)	(33,073)	(156.7%)
Income and Expenditure Surplus/(Deficit)	**(68,295)**	**(13,710)**	(54,586)	(398.2%)

Clinical Income

- Non Elective income and A&E Activity is higher, with electives and outpatients being lower.
- Other NHS Clinical Activity in the current year includes the 2018/19 pay award.

Non Clinical Income

- No PSF income 18-19 but £6.9m in 17-18
- PAS Project income 18-19 change £1.5m
- Serco contract early exit fee £2.1m 18-19
- Recharges to 2gether Support Solutions as part of OHF set up arrangements £1.7m 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.
- 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
- Clinical Negligence - 18-19 delivery of Mat Incentive Scheme and non recurrent rebate
- 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 10 (January) 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	Actual	Forecast	Forecast
7,157	**Opening Bank Balance**	3,879	8,708	4,828	7,157	16,287	4,760	7,090	15,985	9,247	5,129	6,416	3,368	8,708	8,699	2,752
61,429	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	5,773	5,770	5,770
99,579	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	9,622	9,619
113,322	South Kent Coast CCG	11,105	10,831	(275)	12,809	10,529	12,943	11,220	10,846	10,829	12,745	9,740	10,832	10,831	10,456	10,827
78,722	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				
583	Dartford, Gravesham & Swanley CCG	38	39	1	38	38	38	63	92	45	38	39	152	39	38	38
1,848	Medway CCG	164	173	9	263	165	190	174	173	180	182	174	174	173	164	164
2,472	Swale CCG	306	304	(2)	306	306	299	323	304			301	330	304	338	306
4,281	West Kent CCG	449	430	(19)	377	377	531	427	428	427	428	427	429	430	449	449
81,625	NHS England	8,059	8,328	269	8,082	7,728	8,453	7,346	9,707	7,657	8,006	8,013	8,304	8,328	8,071	8,059
36,726	All Other NHS Organisations	5,107	7,344	2,237	5,317	1,119	801	5,645	2,866	2,447	6,396	2,560	2,232	7,344	1,303	1,223
0	Capital Receipts															
42,733	All Other Receipts	1,783	5,746	3,963	2,664	2,277	2,274	3,976	2,866	1,672	4,389	4,976	11,892	5,746	3,261	2,646
5,603	Provider Sustainability Fund							5,603								
26,568	Working Capital Facility	2,659	2,037	(622)	2,234			3,410	3,708	5,103		4,869	5,207	2,037	2,192	13,362
	Working Capital Facility Repaid Permanent Loan															
556,066	**Total Receipts**	**53,482**	**58,457**	**4,975**	**58,633**	**45,202**	**53,184**	**60,772**	**54,222**	**51,585**	**56,010**	**55,226**	**62,774**	**58,457**	**49,499**	**60,297**
	Payments															
(273,157)	Monthly Payroll inc NI & Super	(27,885)	(27,558)	327	(26,383)	(26,617)	(26,681)	(27,120)	(28,165)	(28,308)	(27,351)	(27,453)	(27,520)	(27,558)	(27,773)	(27,618)
(266,447)	Creditor Payment Run	(25,682)	(29,560)	(3,878)	(21,600)	(27,605)	(23,054)	(24,445)	(31,892)	(23,180)	(26,586)	(30,054)	(28,471)	(29,560)	(23,277)	(24,001)
(11,312)	Capital Payments	(904)	(1,286)	(382)	(1,503)	(2,508)	(1,085)	(312)	(848)	(861)	(729)	(767)	(1,414)	(1,286)	(4,187)	(3,225)
(2,634)	PDC Dividend Payment									(2,634)						(3,007)
(975)	Interest Payments		(61)	(61)	(18)		(34)		(55)	(719)	(57)		(30)	(61)	(210)	(704)
(554,524)	**Total Payments**	**(54,471)**	**(58,466)**	**(3,995)**	**(49,503)**	**(56,730)**	**(50,854)**	**(51,877)**	**(60,960)**	**(55,703)**	**(54,723)**	**(58,274)**	**(57,435)**	**(58,466)**	**(55,446)**	**(58,555)**
1,542	**Total Movement In Bank Balance**	**(989)**	**(9)**	**980**	**9,130**	**(11,527)**	**2,330**	**8,895**	**(6,738)**	**(4,118)**	**1,287**	**(3,048)**	**5,339**	**(9)**	**(5,947)**	**1,743**
8,699	**Closing Bank Balance**	**2,890**	**8,699**	**5,808**	**16,287**	**4,760**	**7,090**	**15,985**	**9,247**	**5,129**	**6,416**	**3,368**	**8,708**	**8,699**	**2,752**	**4,495**
	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	5,808	(138)	802

Clinical Income - by Commissioner

Month 10 (January) 2018/19

	This Month £000			Year to Date £000			Annual £000
Commissioner	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**
NHS Ashford CCG	5,932	6,227	294	57,847	61,172	3,325	69,236
NHS Canterbury & Coastal CCG	9,980	10,254	273	96,376	98,820	2,444	115,422
NHS South Kent Coast CCG	11,171	11,184	14	108,499	110,576	2,077	129,925
NHS Thanet CCG	8,084	8,401	317	78,510	79,879	1,370	94,021
East Kent CCGs	35,167	36,065	898	341,232	350,447	9,216	408,603
NCA - England	310	380	69	3,957	4,134	177	4,686
NHS England - Armed Forces	16	23	6	139	157	18	159
NHS England - Specialised Services	6,604	6,859	255	66,305	67,334	1,028	79,165
NHS England - Health In Justice	10	7	(2)	97	73	(24)	116
NHS England - Secondary Dentistry	559	553	(6)	5,383	5,435	52	6,429
NHS England - Public Health	684	564	(120)	6,443	5,599	(844)	7,811
Kings	22	20	(2)	220	218	(2)	264
NCA - Wales	12	5	(7)	119	89	(30)	142
NCA - Northern Ireland				4	7	3	5
NCA - Scotland	2	4	2	19	19	1	22
Other Trusts	149	188	38	1,495	1,962	467	1,793
East Kent Overseas	(3)	35	38	1	503	501	
NHS Dartford, Gravesham & Swanley CCG	27	81	54	408	402	(6)	455
NHS Medway CCG	151	223	71	1,760	1,828	68	2,075
NHS Swale CCG	282	279	(3)	3,088	2,889	(199)	3,643
NHS West Kent CCG	438	507	70	4,313	4,943	630	5,122
Other Organisations	1,626	127	(1,499)	13,251	2,739	(10,512)	16,059
Cancer Drugs Fund	251	177	(74)	2,506	2,327	(179)	3,007
Adjust Prior Month Reported Position		175	175				
Prior year Income		15	15		2,823	2,823	
Local Authority					1	1	
Total	46,308	46,287	(22)	450,739	453,929	3,189	539,558

East Kent Commissioner contracts are all over performing YTD and in month. NHSE Specialised Services is also ahead of Contract YTD and has moved back to over performing in month. The Cancer Drugs Fund is showing an underperformance YTD which is a continuation from last month and relates to some drugs moving over the NHSE. West Kent CCG is ahead of Contract YTD, while the North Kent CCGs are collectively behind Contract however have had an improving position in the last four months. Other Organisations include provisions for risks along with the planned CIP schemes and £4.3m 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 have reduced from £2m in July to £360k in December, however the level of conceded challenges is still low in comparison to the overall value challenged. Commissioners and the Trust are working together to improve the processes used for the 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 10 (January) 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	47,085		
	Variance	-479	1,367	482	1,687	2,377	694	791	-576	-9,113	85		
	Quarterly rolling average spend	43,089	44,782	45,617	47,395	47,342	47,389	47,442	47,247	42,954	42,696		
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	6,120		
	Variance	-146	54	1,258	2,096	104	139	586	-158	8,046	2,546		
	Quarterly rolling average spend	5,875	6,087	3,914	4,672	4,687	4,309	3,832	3,773	6,407	7,055		
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	-34,743		
	Variance	-481	-1,326	-1,090	-1,631	-3,534	-2,918	-3,192	-3,340	-2,717	-3,449		
	Quarterly rolling average spend	-31,203	-31,818	-31,882	-32,216	-32,859	-33,352	-33,894	-33,935	-33,949	-34,238		
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	-19,289		
	Variance	1,335	-251	-707	-2,182	623	750	9	1,768	545	-215		
	Quarterly rolling average spend	-19,920	-20,168	-18,795	-19,715	-19,418	-18,726	-18,497	-18,066	-18,133	-18,086		
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	-1,774		
	Variance	110	14	49	16	59	289	-33,648	521	1,418	483		
	Quarterly rolling average spend	-1,942	-1,971	-2,170	-2,202	-2,189	-2,113	-13,336	-13,186	-12,817	-1,447		
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	-3,239		
	Variance	-1,337	-2,219	-1,647	-1,859	-1,489	-1,533	-1,564	-1,653	-1,172	-1,961		
	Quarterly rolling average spend	-3,237	-3,484	-3,457	-3,532	-3,208	-3,114	-2,976	-2,975	-2,801	-2,882		
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	2,349		
	Variance	-348	224	75	723	-378	303	-132	-113	1,079	-856		
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	8,699		
	Variance	704	901	3,561	8,102	5,777	-25	789	-125	4,828	5,808		

Cost Improvement Summary

Month 10 (January) 2018/19

Planned Summary	2018 - 2019			Target Variance	
Programme Care Groups £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Clinical Support	4,159	3,680	3,675	(479)	(484)
General & Specialist Medicine	4,321	4,188	4,172	(133)	(149)
Urgent & Emergency Care	2,477	987	987	(1,491)	(1,491)
Surgery & Anaesthetics	6,075	4,466	4,331	(1,609)	(1,743)
Surgery - Head and neck, Breast Surgery and Dermatology	1,137	859	850	(278)	(287)
Women's & Children's	2,913	2,877	2,877	(36)	(36)
Cancer	567	790	790	223	223
Corporate	71	384	384	313	313
SD&CP	1,300	1,294	1,246	(6)	(54)
Procurement	2,693	1,606	1,606	(1,087)	(1,087)
Medicines Value	871	1,527	1,527	656	656
Sub-total	**26,584**	**22,658**	**22,446**	**(3,926)**	**(4,138)**
Central	3,416	6,241	6,241	2,825	2,825
Grand Total	**30,000**	**28,899**	**28,687**	**(1,101)**	**(1,313)**

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	3,650	3,650	(1,767)	(1,767)
Workforce *	170	587	587	416	416
Procurement	1,982	1,029	1,029	(953)	(953)
Medicines Value	871	1,527	1,527	656	656
Division Schemes **	16,584	18,324	18,112	1,740	1,528
Sub-total	**26,025**	**25,117**	**24,905**	**(908)**	**(1,120)**
Central	3,975	3,782	3,782	(193)	(193)
Grand Total	**30,000**	**28,899**	**28,687**	**(1,101)**	**(1,313)**

Cost Improvement Phasing

Month 10 (January) 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	391	322	290	281	3,650
Workforce	22	53	2	25	44	44	44	46	155	70	39	39	587
Procurement	35	44	59	106	54	52	82	123	142	176	79	77	1,029
Medicines Value	42	57	109	222	194	161	102	167	118	130	110	116	1,527
Clinical Support	157	184	234	330	357	144	161	276	268	226	320	320	2,980
General & Specialist Medicine	1	67	87	100	255	207	171	126	222	209	273	273	1,992
Urgent & Emergency Care	-	-	-	80	20	20	20	20	20	20	20	20	240
Surgery & Anaesthetics	132	583	366	445	302	260	369	367	214	526	383	383	4,331
Surgery - Head and neck, Breast Sur	9	94	64	82	41	11	54	86	73	150	93	93	850
Women's & Children's	89	82	131	184	164	482	174	469	359	233	240	250	2,857
Cancer Services	113	110	84	51	89	3	71	50	73	(1)	73	73	790
Corporate - Other	-	11	7	7	7	7	754	407	407	407	406	406	2,825
SD&CP	20	198	108	113	172	105	120	95	116	92	92	15	1,246
Sub-total	**1,055**	**1,758**	**1,604**	**2,054**	**1,935**	**1,703**	**2,383**	**2,528**	**2,558**	**2,561**	**2,419**	**2,347**	**24,905**
Central	100	-	-	2,000	(100)	(100)	383	284	1,461	(212)	(36)	3	3,782
Grand Total	**1,155**	**1,758**	**1,604**	**4,054**	**1,835**	**1,603**	**2,766**	**2,811**	**4,019**	**2,349**	**2,384**	**2,350**	**28,687**

Debtor Balances

Month 10 (January) 2018/19

Debtor	Top ten debtor balances outstanding as at 31/01/2019						Creditor balance as at 31/01/2019	Notes
	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total		
51136-EAST KENT MEDICAL SERVICES	53,856	127,011	183,488	3,789	1,837,808	2,205,952	1,507,468	Reciprocal payment arrangement in place
61865-NHS CANTERBURY AND COASTAL CCG	(84,992)	4,134	130,936	133,385	1,370,686	1,554,149	74,762	£1.0m 1718 overperformance, £0.3m 1819 overperformance
62033-NHS THANET CCG	(76,423)	2,030	10,350	133,859	1,290,377	1,360,193	80,522	£0.9m 1718 overperformance, £0.4m 1819 overperformance
61818-NHS ASHFORD CCG	(81,644)	3,083	5,957	6,291	1,129,197	1,062,885	57,352	£0.6m 1718 overperformance, £0.4m 1819 overperformance
62003-NHS SOUTH KENT COAST CCG	(132,881)	5,158	12,973	348,441	748,599	982,288	115,728	£1.0m 1718 overperformance
51708-MEDWAY NHS FOUNDATION TRUST	51,966	137,831	6,020	51,174	705,736	952,727	1,121,503	Trust creditor balance wth Medway is larger than the debtor balance. Difference being reduced as invoices are authorised.
62048-NHS WEST KENT CCG	7,364	13,211	8,843	18,346	791,000	838,764		1617 overperformance in dispute
76480-2GETHER SUPPORT SOLUTIONS LTD	425,746	70,458	250,916	0	53,413	800,532	2,743,589	
50010-MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	169,925	1,602	100,571	0	374,826	646,925	1,165,026	Trust creditor balance wth MTW is larger than the debtor balance. Difference being reduced as invoices are authorised.
59742-HEALTHEX	24,374	0	12,187	0	536,218	572,778		Unpaid loan interest and capital 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		
	2,255,923	1,252,748	1,250,656	1,150,880	12,031,935	17,942,141	6,865,951	

Creditor Balances

Month 10 (January) 2018/19

Unpaid at last Payment Run

Supplier Name	Total
Other Creditors	1,937
NHS Professionals Ltd	2,011
Allscripts Healthcare (IT) UK Ltd	1,281
IHSS Ltd	289
Abbott Medical UK Ltd	272
Novartis Pharmaceuticals UK Ltd	240
Bayer PLC	191
2gether Support Solutions Ltd	165
Halden Heights Ltd	148
Alcura UK Ltd	147
Roche Products Ltd	135
Total	**6,816**

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 £6.8m unpaid due to low liquidity.

Aged Creditors now stands at £29.6m.

The Accounts Payable team prioritises key suppliers and those threatening to restrict supplies.

Top Ten Aged Creditor

Supplier Name	Current	30-Jan	31-60	60-90	90 +	Total
Other Creditors	6,181	4,556	404	344	2,607	14,092
NHS Professionals Ltd	2,581	2,022	1	4	24	4,632
2gether Support Solutions Ltd	2,373	66	66	209	31	2,744
Allscripts Healthcare (IT) UK Ltd		1,554				1,554
East Kent Medical Services Ltd T/a The Spencer Wing		649	189		1,048	1,507
Maidstone & Tunbridge Wells NHS Trust (RWF)	518	297	19	36	296	1,165
Medway NHS Foundation Trust (RPA)	11	160	150	210	590	1,122
NES Holdings (UK) Ltd	107	285	172	175	210	949
Healthcare At Home Ltd	588	56			0	644
Comparex UK Ltd	608					608
AAH Pharmaceuticals LTD	491	81	0	0	0	572
Total	**13,458**	**9,724**	**623**	**978**	**4,806**	**29,589**

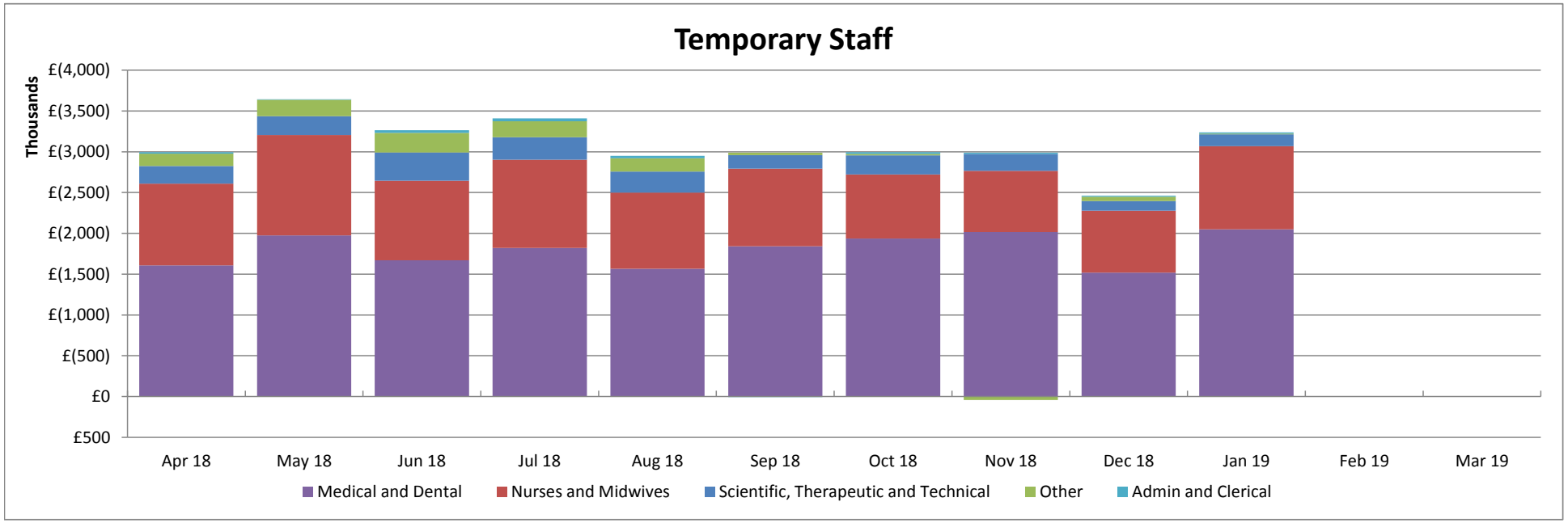
Aged Creditor By Reason

Reason Description	Current	30-Jan	31-60	60-90	90 +	Total
Current	13,458					13,458
Cash Flow		6,655	3	144	21	6,816
Waiting on a GRN		1,845	764	458	1,369	4,436
Disputed		16	77	99	1,893	2,054
Creditor Debit Balance					1,004	1,004
Waiting on Authorisation		808	484	208	120	652
Not Recorded		235	211	54	138	637
Purchase Order Value Exceeded		183	32	6	111	332
Price Query		11	17	9	84	121
Order Raised after Invoice Received		4	8	1	63	76
Other			0		2	2
Total	**13,458**	**9,724**	**623**	**978**	**4,806**	**29,589**

Pay Analysis - Temporary Staff

Month 10 (January) 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)**	**(2,050)**		
Agency	(1,476)	(2,079)	(1,571)	(1,702)	(1,515)	(1,741)	(1,765)	(2,006)	(1,480)	(1,998)		
Direct Engagement	(132)	103	(99)	(121)	(51)	(100)	(173)	(11)	(39)	(52)		
Scientific, Therapeutic and Technical	**(217)**	**(231)**	**(348)**	**(275)**	**(257)**	**(168)**	**(234)**	**(207)**	**(120)**	**(146)**		
Agency	(217)	(231)	(348)	(275)	(257)	(168)	(234)	(207)	(120)	(146)		
Nurses and Midwives	**(1,002)**	**(1,230)**	**(974)**	**(1,080)**	**(933)**	**(951)**	**(784)**	**(751)**	**(757)**	**(1,019)**		
Agency	(1,002)	(1,230)	(974)	(1,080)	(933)	(951)	(784)	(751)	(757)	(1,019)		
Admin and Clerical	**(18)**	**(6)**	**(33)**	**(36)**	**(28)**	**7**	**(23)**	**(13)**	**(11)**	**(16)**		
Agency	(18)	(6)	(33)	(36)	(28)	7	(23)	(13)	(11)	(16)		
Other	**(150)**	**(201)**	**(239)**	**(198)**	**(164)**	**(29)**	**(17)**	**43**	**(53)**	**(8)**		
Agency	(150)	(201)	(239)	(198)	(164)	(29)	(17)	43	(53)	(8)		
Total	**(2,995)**	**(3,637)**	**(3,231)**	**(3,375)**	**(2,921)**	**(2,990)**	**(2,973)**	**(2,933)**	**(2,450)**	**(3,223)**		



Pay Analysis - Temporary Staff

Month 10 (January) 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	0.88	0.29	0.03		1.19		0.36
Urgent and Emergency Care	0.47	0.59			1.06	0.19	0.54
Surgery and Anaesthetics	0.46	0.11	0.03		0.60	0.03	0.16
Surgery - Head and neck, Breast Surgery and Dermatol	0.10				0.10	0.06	0.07
Clinical Support Services	0.05		0.08		0.13	(0.13)	(0.11)
Cancer Services							
Women's and Children's Services	0.10	0.04			0.13	(0.05)	
Strategic Development and Capital Planning				0.01	0.01	(0.02)	(0.01)
Corporate				0.02	0.02		
Central						0.07	0.05
Total	**2.06**	**1.03**	**0.14**	**0.03**	**3.26**	**0.15**	**1.06**
Variance v 2018/19 average	0.25	0.07	(0.07)	(0.10)	0.15		
Variance v 2017/18 average	0.70	0.42	(0.01)	(0.04)	1.07		

Temporary Staff Year to Date £m	M & D	N & M	PAMS	A&C Other	Total	Average per Month
General and Specialist Medicine	8.11	2.99	0.26	0.57	11.92	1.19
Urgent and Emergency Care	3.70	4.83		0.14	8.66	0.87
Surgery and Anaesthetics	4.08	1.27	0.30		5.65	0.57
Surgery - Head and neck, Breast Surgery and Dermatol	0.39	0.02			0.41	0.04
Clinical Support Services	0.92		1.66	0.01	2.60	0.26
Cancer Services				0.03	0.03	
Women's and Children's Services	1.42	0.34		0.04	1.81	0.18
Strategic Development and Capital Planning				0.28	0.28	0.03
Corporate		0.01		0.19	0.20	0.02
Central	(0.61)	0.03	(0.02)	(0.06)	(0.67)	(0.07)
Total	**18.01**	**9.49**	**2.20**	**1.20**	**30.90**	**3.09**
Average per month	1.80	0.95	0.22	0.12	3.09	

INTEGRATED PERFORMANCE REPORT **18/138.1**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 2019**
SUBJECT:	**INTEGRATED PERFORMANCE REPORT (IPR)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: INTEGRATED PERFORMANCE REPORT – JANUARY 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 January 2019 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

January 2019 performance for the organisation against the 4 hour target was 74.2%; against the NHS Improvement trajectory of 88.4%.This represents a decrease in performance compared to the previous month (79.4%), but an improvement on the Trust wide compliance on the previous January (69.3% in 2018). There were no 12 Hour Trolley Waits in January.

The number of patients who left the department without being seen remained compliant at 3.02%.

The unplanned re-attendance position remains high at 9.59%. Time to treatment improved above 50% following performance drop in the previous month (December) to 48.7%.

18 Weeks Referral to Treatment (RTT) Standard

January performance improved to 76.10% against an improvement trajectory of 81.16%. The Planned Care Activity Recovery Plan includes a work stream to maximise outpatient clinic utilisation and reducing the number of "Did Not Attends" 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 38. This is within the trajectory of 125 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

January 2019 performance for 62 day treatments is currently 67.92% against the

improvement trajectory of 85.31%, validation continues until the beginning of March in line with the national timetable. There were 10 patients waiting 104 days or more for treatment or potential diagnosis.

2ww performance has been achieved at 96.45% against a performance standard of 93% and has shown a significant improvement over the past three months.

All patients on a 2ww pathway and those who are over 73 days are reviewed daily and into patient level detail. There is also a weekly cancer PTL meeting to progress patient pathways.

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 is compliant for January with a compliance of 99.73% against a trajectory of 99.11% and has maintained a compliant and improving position for the last four months.

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 highlights were reported:

- The Friends and Family test inpatient satisfaction rate remains positive at 96%.
- The compliments to complaints ratio is registering green this month with 49 compliments for every complaint.
- Complaints performance has improved in January with 3 day acknowledgement registering 100%. However, there is further work to do with regard to response times within timescales agreed with the client which is registering amber at 84%. Part of the reason for the drop in performance is due to focussed work on the backlog. Improvement work and a review of the complaint process by an external expert is being planned.
- We have seen an improvement this month in 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.
- Patients' perception of cleanliness, hospital food and knowing who is in charge, have also all improved in January.
- There had been a continued 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 above 99%, rising above the upper control limit. As part of this both the pressure ulcer rate and falls rates have come down in January.
- *Clostridium difficile* infections continue to report just below the Department of Health trajectory.

Despite the improvement in *E.coli* bacteraemia, Healthcare Associated Infections remains an area of challenge requiring further improvement concentrating on embedding of good infection prevention and control practice and full implementation of the aseptic non touch technique principles.

VTE assessment recording for this month has improved in comparison to last month but is below the target of 95%.

Masked by the overall Trust value of 91.8% are areas of good practice reaching 100% offset by other areas where performance is below 90%. This will remain under constant review with the Care Groups until performance is sustained.

Patient flow has been severely compromised due to low discharge profile for all sites. The

significant reduction in capacity for discharge has caused an increase in site occupancy transfers to Canterbury and over 7 day patients admitted.

In January there were 23 unjustified mixed sex occurrences reported. This is similar to last month but remains half the number reported in the Summer last year. The reason for the breaches is to maintain safety and flow through the Emergency Departments (ED).

Improvement work is in place across the paediatric pathway (from ED to ward / theatres). The Trust continues to receive daily assurance that safety checks are completed and that safe staffing levels are in place within these areas.

Financial Performance

The Trust has generated a consolidated deficit in month of £2.5m (£0.6m behind plan) and a year to date (YTD) deficit of £67m which is £41.2m 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. In addition, there was 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. 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 two months which, if not delivered, will lead to a failure to deliver the revised financial forecast. Care groups are meeting weekly with the Chief Operating Officer and Director of Finance to improve the elective trajectory.

The Trust's detailed finance position can be found on page 43 of the report. We continue to work with our regulators to monitor the Trust's Financial Recovery plan.

Human Resources

The vacancy rate increased to 13.0% (up from 12.9%) for the average of the last 12 months, which is higher than last year. More work is being undertaken to target hard to fill vacancies, particularly within nursing and some Medical specialties.

The Turnover rate in month remained 12.0% (last month 12.0%), but the 12 month average increased to 14.0% (13.9% 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.

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	**Patients:** Help all patients take control of their own health.

INTEGRATED PERFORMANCE REPORT **18/138.1**

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	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.

East Kent Hospitals University NHS Foundation Trust

JANUARY 2019

INTEGRATED PERFORMANCE REPORT

NHS
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Understanding the IPR

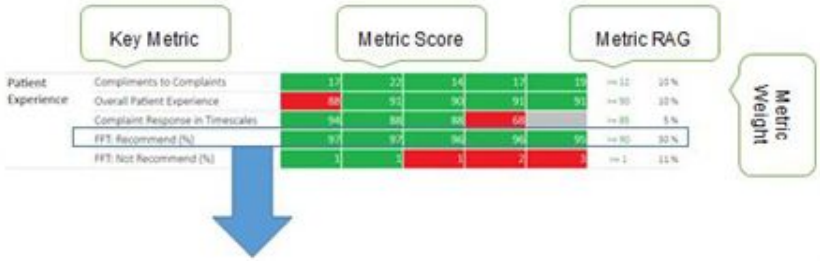
1 **Headlines**: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that the CQC organises its inspection into specific areas.

2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall domain score. The second page illustrates key (but not all) metrics measured within that sub-domain.
This is important as it explains why the sum of each metric doesn't total 100%. A list of all metrics used in the calculation is summarised in the Glossary pages.

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.

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Strategic Priorities

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Headlines

	Positives	Challenges	
Caring	The Friends and Family test inpatient satisfaction rate remains positive at 96%. The compliments to complaints ratio is registering green this month with 49 compliments for every complaint. Complaints performance has improved in January with 3 day acknowledgement registering 100%. 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. Patients' perception of cleanliness, hospital food, knowing who is in charge have also all improved in January. Care, Staff attitude and Implementation of care are the three top positive themes from the Friends & Family returns for January.	In January 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. This month we have reported amber for complaint response times within timescales agreed with the client registering 84%. Part of the reason for the drop in performance is because we have been focusing on the backlog which have already breached. Improvement work and a review of the complaint process by an external expert is being planned. Two of the three top negative themes for the trust in the Friends & Family returns were also Care and Staff Attitude, demonstrating the importance of good patient communication with a positive staff attitude, the third was waiting times to be seen.	S O N D Jan  Sally Smith

Effective	Beds During January the multi disciplinary team daily board rounds have identified patients who will be simple or complex to discharge and with an added focus on patients with a length of stay 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 The DNA rate for new and follow up patients has improved slightly in month. The Planned Care Activity Recovery Plan includes actions to improve the Trust DNA rates. Productivity The Planned Care Activity Recovery Plan includes actions to improve theatre productivity, including pre-assessment, theatre utilisation and productivity to improve patient experience and reduce cancellations.	Beds Patient flow has been severely compromised due to low discharge profile for all sites. The significant reduction in capacity for discharge has caused an increase in site occupancy transfers to Canterbury and over 7 day patients admitted. Clinical Outcomes Readmissions for elective and non-elective discharges has remained static. Demand and Capacity To reduce the number of DNA's by fully booking out patient appointments; in particular for 2ww cancer pathway patients by ensuring patients. Productivity To reduce the number of non clinical and clinical cancellations for theatre whilst increasing theatre productivity. To improve length of stay by reducing internal and external delays, particularly in January when there has been a reduction in availability of external capacity.	S O N D Jan	 Lee Martin

Responsive	4 hour Emergency Access Standard January performance for the 4 hour target is 74.20% excluding the community MIU and 77.93% including and against a NHS Improvement trajectory of 88.4%. There were no 12 Hour Trolley Waits. The number of patients who left the department without being seen continued to be compliant 3.02%. Time to treatment (60 minutes) has improved and is compliant at 50.5%. RTT January performance improved to 76.10% against an improvement trajectory of 81.16%. The Planned Care Activity Recovery Plan includes a work stream to maximise out patient 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 38. This is within the trajectory of 125 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 January with a compliance of 99.73% against a trajectory of 99.11% and has maintained a compliant and improving position for the last four months. Cancer January performance for 62 day treatments is currently 67.92% against the improvement trajectory of 85.31%, validation continues until the beginning of March in line with the national timetable. There were 10 patients waiting 104 days or more for treatment or potential diagnosis. 2ww performance has been achieved at 96.45% against a performance standard of 93% and have show a significant improvement over the past three months. All patients on a 2ww pathway and those who are over 73 days are reviewed daily and into patient level detail. There is also a weekly cancer PTL meetings to progress patients pathways.	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. Unfortunately, patient flow has been severely compromised due to low discharge profile for all sites. The significant reduction in capacity for discharge has caused an increase in site occupancy transfers to Canterbury and over 7 day patients admitted. This increased pressure has put additional strain on all staff groups coordinating patient discharges. RTT Ensuring that all out patient outcome forms are completed in real time in the OPD environment. It is a key action with the Planned Care Activity Recovery Plan to prioritise the booking of all out patient clinic activity and to ensure that clinic capacity is fully booked and utilised. CANCER To continue to reduce the time a patient is seen at their first 2ww appointment to 7 days or below and to also progress patients through their pathway in order to achieve any necessary treatment within the 62 day pathway. DM01 Maintaining excellent performance consistently across all diagnostic modalities.	S O N D Jan	 Lee Martin

Safe	Positives this month include a continued 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 above 99%, rising above the upper control limit. As part of this both the pressure ulcer rate and falls rates have come down in January. Clostridium difficile infections continue just below the DH trajectory. Care, Staff attitude and Implementation of care are the three top positive themes from the Friends & Family returns for January.	Despite the improvement in E.coli bacteraemia Healthcare Associated Infections remains an area of challenge requiring further improvement concentrating on embedding of good infection prevention and control practice and full implementation of the aseptic non touch technique principles. VTE assessment recording for this month has improved in comparison to last month but is below the target of 95%. Hidden behind the overall Trust value of 91.8% are areas of good practice reaching 100% offset by other areas where performance is below 90%. This will remain under constant review with the Care Groups until performance is sustained. Two of the three top negative themes for the trust in the Friends & Family returns were also Care and Staff Attitude, demonstrating the importance of good patient communication with a positive staff attitude, the third was waiting times to be seen.	S O N D Jan	 Paul Stevens

Well Led	Vacancy (M10 - 12.1% , M9 - 13%) improved and Staff Turnover (M10 - 14.4%, M9 - 14.4%) rates have remained unchanged in month. I&E CIPS of £24.0m are reported up to Month 10 against a plan of £23.3m . 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 £2.5m deficit (after NHSi adjustments) in Month 10 which was £0.6m behind plan. This brings the YTD position to a deficit of £32.4m which is behind plan by £7.4m (consolidated position including Spencer Wing and 2geather Support Solutions and is after technical adjustments). The key drivers to the deteriorating financial position are: under performance on the elective plan, in year winter pressures and high agency usage. Trust Pay is £1.4m over plan in month and £13m over plan YTD. The main overspend is in Agency costs (£14.6m over plan YTD) offset by an underspend on permanent staffing (£3.2m 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 £72.8m. Staff sickness (M10 - 4%, M9 - 3.9%) have worsened in month.	S O N D Jan	 Susan Acott

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Caring

	S	O	N	D	Jan	
OVERALL DOMAIN SCORE						Weight
Patient Experience						100 %

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Caring

		Sep	Oct	Nov	Dec	Jan	Green	Weight
Patient Experience	Mixed Sex Breaches	19	0	22	23	34	>= 0 & <1	10 %
	Number of Complaints	87	78	63	64	85		
	AE Mental Health Referrals	81	116	113	93	87		
	IP FFT: Recommend (%)	97	97	97	97	96	>= 95	30 %
	IP FFT: Not Recommend (%)	1.2	1.3	1.0	1.1	1.4	>= 0 & <2	30 %
	IP Survey: Overall, did you get the care			47.6	44.4	44.9		
	Number of Compliments	1322	1836	2477	2236	1813	>= 1 & <1	15 %
	Complaint Response in Timescales %	75.7	72.1	81.6	94.6	84.2	>= 85	15 %

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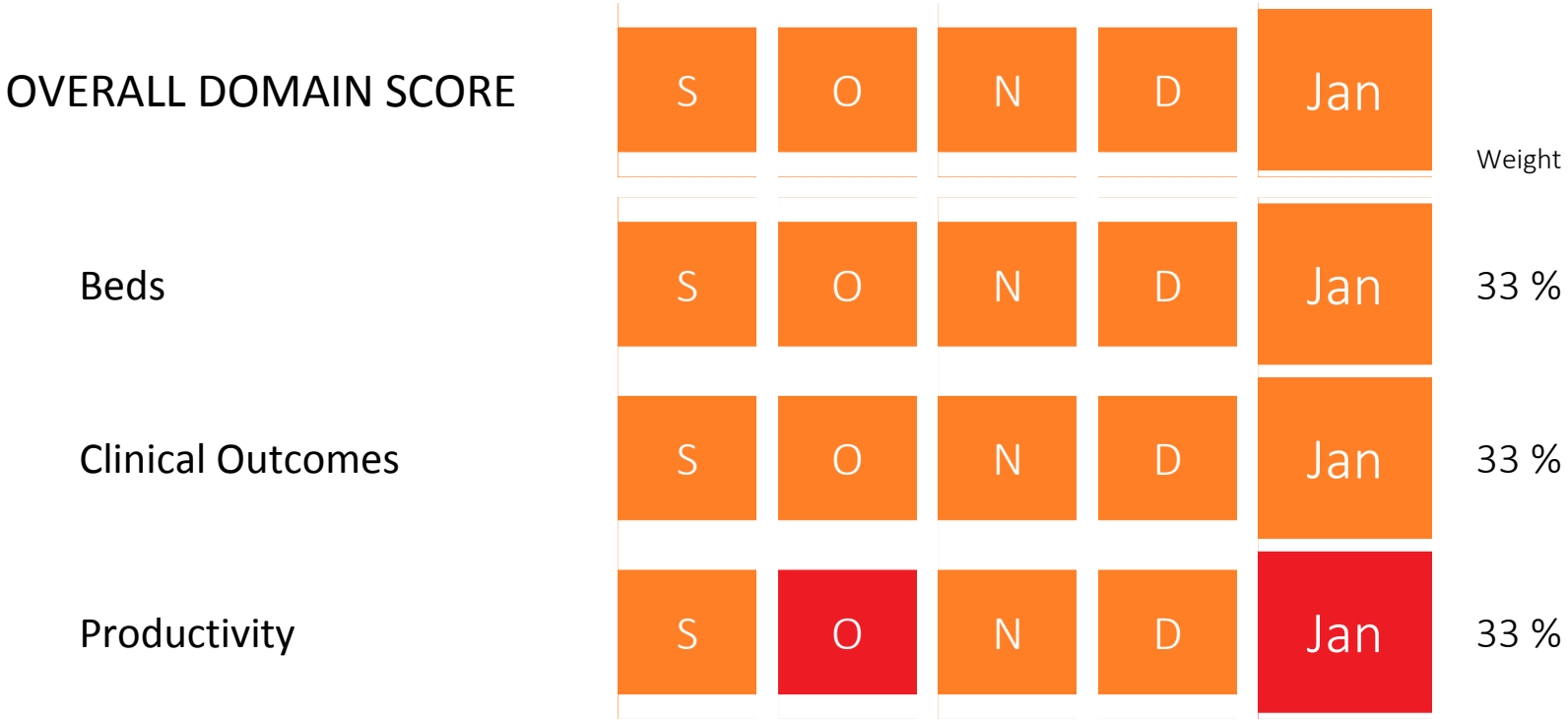
Effective



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Effective

		Sep	Oct	Nov	Dec	Jan	Green	Weight
Beds	DToCs (Average per Day)	48	48	55	53	54	>= 0 & <35	30 %
	Bed Occupancy (%)	82	84	89	90	94	>= 0 & <92	60 %
	IP - Discharges Before Midday (%)	17	14	15	15	15	>= 35	10 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3.9	3.7	3.5	3.9		>= 0 & <2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	15.8	15.5	15.5	15.2		>= 0 & <15	15 %
	Audit of WHO Checklist %	100	99	99	99	99	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	9.0	8.8	7.9	9.0	8.4	>= 0 & <7	
	DNA Rate: Fup %	8.2	9.2	7.6	8.9	8.5	>= 0 & <7	
	New:FUp Ratio (1:#)	1.8	1.9	1.9	1.9	2.0	>= 0 & <7	
Productivity	LoS: Elective (Days)	3.2	3.4	3.0	3.4	3.2		
	LoS: Non-Elective (Days)	6.1	6.3	5.9	6.2	6.5		
	Theatres: Session Utilisation (%)	79	81	80	78	80	>= 85	25 %
	Theatres: On Time Start (% 15min)	46	51	50	44	40	>= 90	10 %
	Non-Clinical Cancellations (%)	1.4	2.2	1.3	1.3	1.8	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	0	0	0	0	0	>= 0 & <5	10 %
	EME PPE Compliance %	79	79	77	76	77	>= 80	20 %

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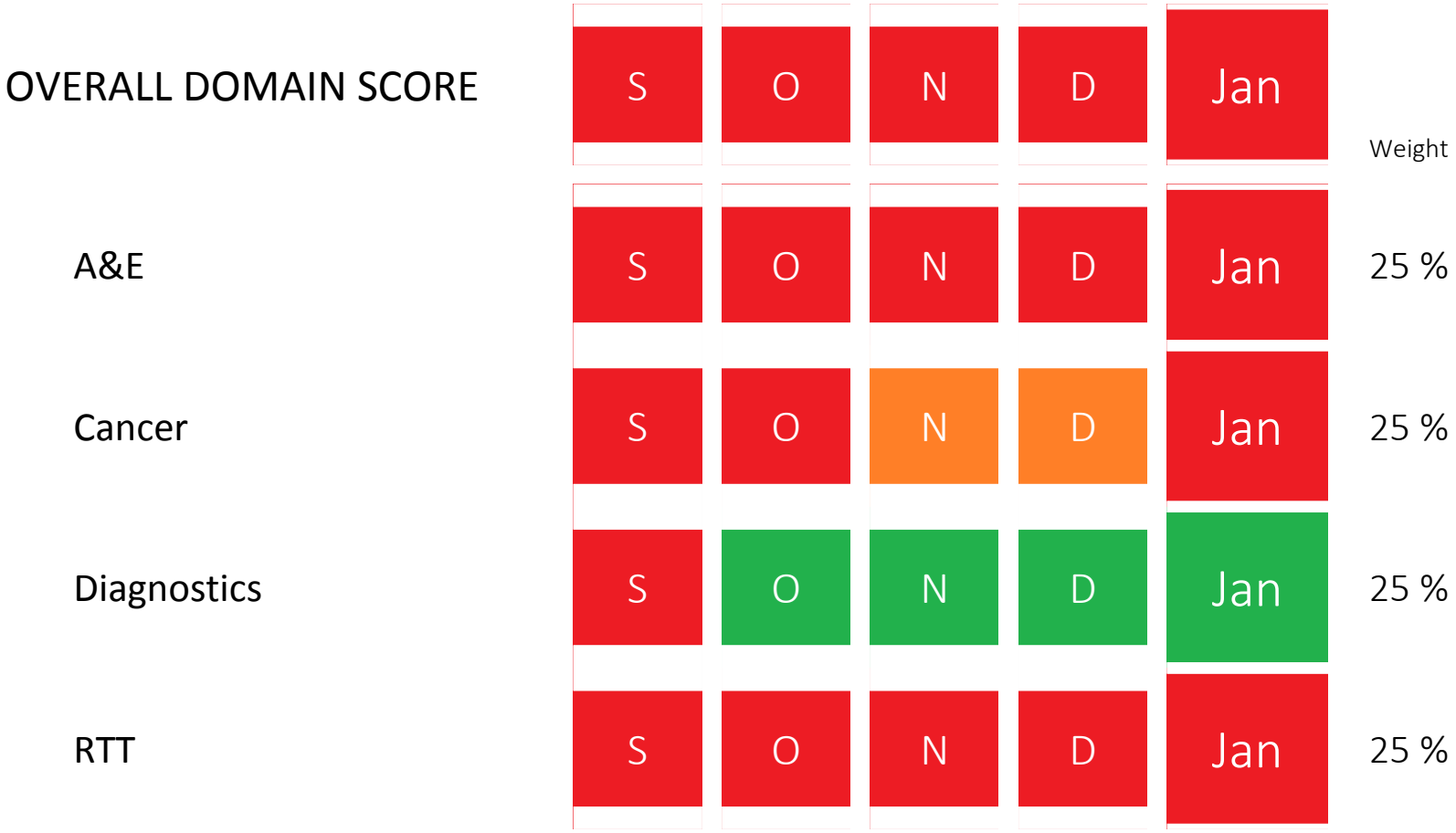
Responsive



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Responsive

		Sep	Oct	Nov	Dec	Jan	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	81.02	83.88	84.50	82.25	77.93	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	77.15	80.89	81.74	79.36	74.20	>= 95	1 %
Cancer	Cancer: 2ww (All) %	90.96	83.54	93.29	96.75	96.45	>= 93	10 %
	Cancer: 2ww (Breast) %	94.39	68.70	84.03	95.00	97.22	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	96.83	97.52	97.08	97.00	95.40	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	96.08	91.67	100.00	97.06	95.45	>= 94	5 %
	Cancer: 31d (Drug) %	97.83	99.21	98.15	100.00	97.50	>= 98	5 %
	Cancer: 62d (GP Ref) %	71.14	77.05	71.35	81.93	67.63	>= 85	50 %
	Cancer: 62d (Screening Ref) %	81.48	87.50	84.21	87.50	100.00	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	76.00	82.14	85.29	73.91	85.19	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	98.53	99.31	99.66	99.56	99.72	>= 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 (%)	76.27	74.89	72.16	72.42	76.10	>= 92	100 %
	RTT: 52 Week Waits (Number)	129	120	102	74	38	>= 0	

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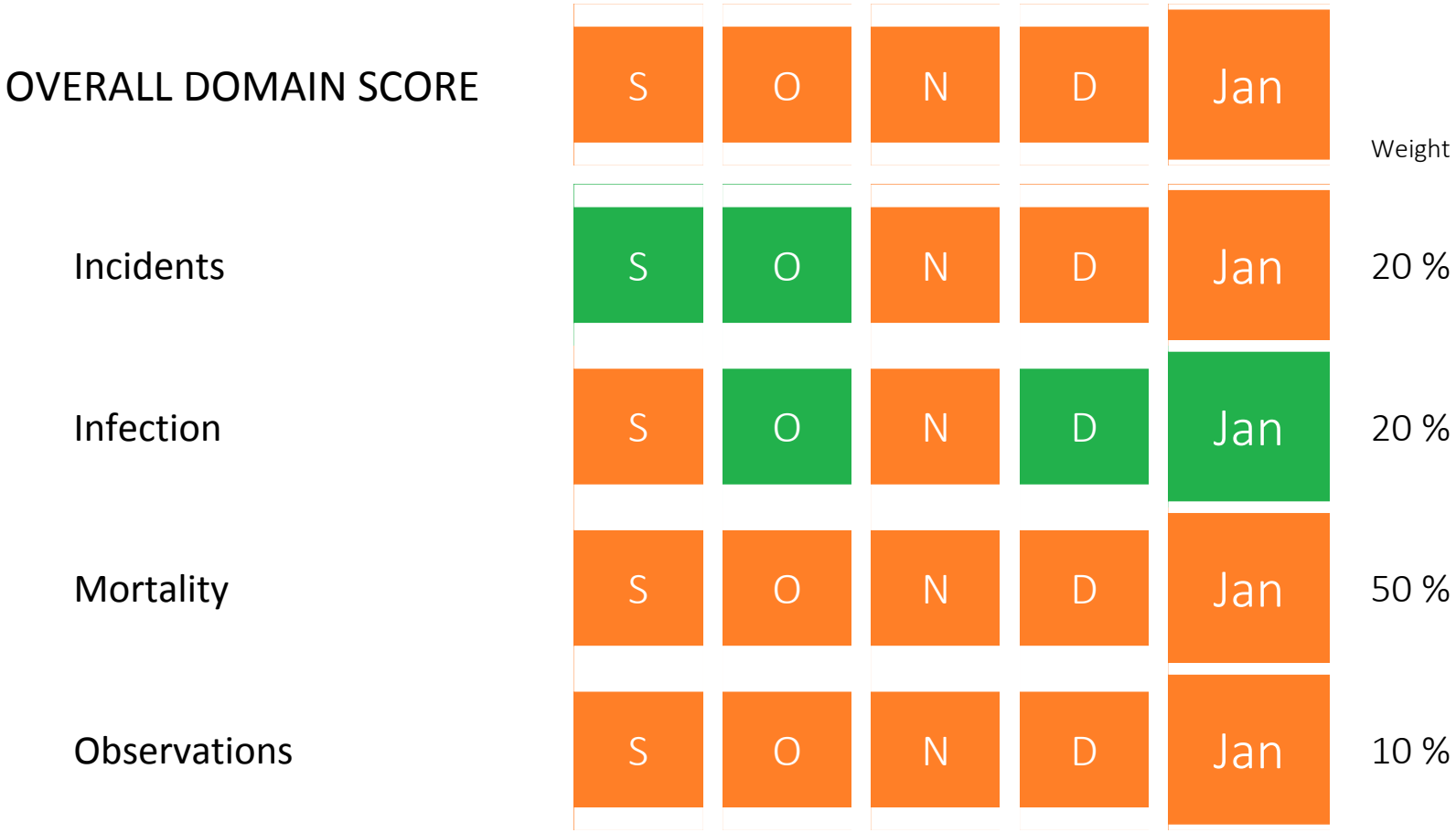
Safe



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Safe

		Sep	Oct	Nov	Dec	Jan	Green	Weight
Incidents	Clinical Incidents: Total (#)	1,271	1,385	1,502	1,437	1,571		
	Serious Incidents (STEIS)	9	12	14	10	10		
	Harm Free Care: New Harms (%)	98.8	99.0	98.8	98.7	99.4	>= 98	20 %
	Falls (per 1,000 bed days)	5.30	5.64	5.18	5.65	5.00	>= 0 & <5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.13	0.14	0.18	0.18	0.12	>= 0 & <0.15	10 %
Infection	Cases of C.Diff (Cumulative)	25	26	26	32	36	<= Traj	40 %
	Cases of MRSA (per month)	1	0	2	0	0	>= 0 & <1	40 %
	Hand Hygiene Audit	96.8	92.1	96.2	94.0	94.0	>= 95	
Mortality	HSMR (Index)	96	96	97	97		>= 0 & <90	35 %
	Crude Mortality EL (per 1,000)	0.7	1.2	0.9	0.9	0.6	>= 0 & <0.33	10 %
	Crude Mortality NEL (per 1,000)	27.3	25.9	28.2	33.5	34.7	>= 0 & <27.1	10 %
	RAMI (Index)	89	89	90	90	93	>= 0 & <87.45	30 %
Observations	Cannula: Daily Check (%)	65.6	65.9	65.9	62.9	62.2	>= 50	10 %
	Catheter: Daily Check (%)	36.9	39.6	39.4	36.7	40.9	>= 50	10 %
	Central Line: Daily Check (%)	62.3	63.8	62.3	58.7	61.1	>= 50	10 %
	VTE: Risk Assessment %	90.2	90.1	91.8	90.1	91.8	>= 95	20 %
	Obs. On Time - 8pm-8am (%)	91.5	92.1	92.2	94.3	95.6	>= 90	25 %
	Obs. On Time - 8am-8pm (%)	89.4	89.7	89.3	92.2	94.1	>= 90	25 %

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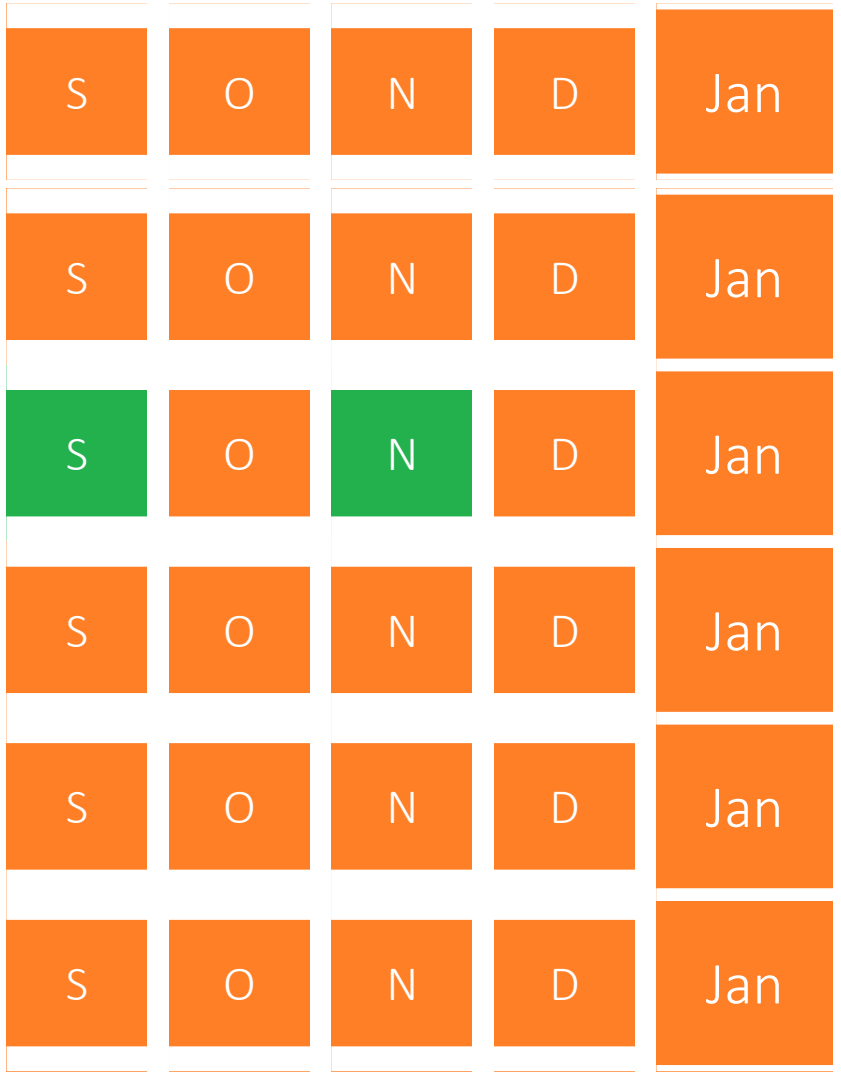

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Well Led

		Sep	Oct	Nov	Dec	Jan	Green	Weight
Data Quality & Assurance	Uncoded Spells %	0.7	0.4	0.5	0.3	0.9	>= 0 & <0.25	25 %
Finance	Forecast £m	-29.9	-29.9	-29.9	-41.8	-42.2	>= 0	10 %
	Total Cost £m (Trust Only)	-52.5	-88.8	-53.0	-53.0	-54.6	>= 0	20 %
	Cash Balance £m	5.1	6.4	3.4	8.7	8.7	>= 0	20 %
	I&E £m (Trust Only)	-2.1	-37.6	-3.4	-6.2	-3.2	>= 0	30 %
Health & Safety	Formal Notices	0	0	0	0	0	>= 0 & <1	15 %
	RIDDOR Reports (Number)	1	1	4	2	2	>= 0 & <3	20 %
Staffing	Sickness (%)	3.8	3.8	3.8	3.9	4.0	>= 0 & <3.3	10 %
	Agency %	7.4	7.6	8.0	7.3	8.3	>= 0 & <10	
	Bank Filled Hours vs Total Agency Hours	59	58	59	61	59		1 %
	Shifts Filled - Day (%)	93	97	98	95	98	>= 80	15 %
	Shifts Filled - Night (%)	102	105	106	104	106	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	11	11	11	12	11		
	Staff Turnover (%)	14.2	14.6	14.5	14.4	14.4	>= 0 & <10	15 %
	Vacancy (%)	13.8	13.2	12.6	13.0	12.1	>= 0 & <7	15 %
	Total Staff In Post (SiP)	7076	6928	6998	6996	7058		1 %
Training	Appraisal Rate (%)	76.3	77.2	75.4	79.6	80.3	>= 85	50 %
	Statutory Training (%)	98	97	97	96	98	>= 85	50 %

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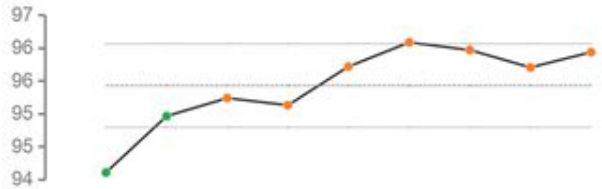
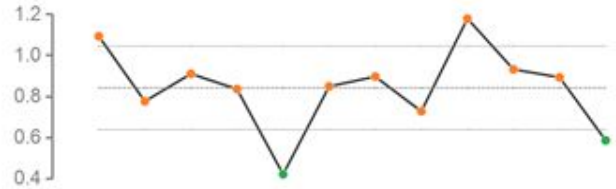
Strategic Theme: Patient Safety

Mortality

Jan	HSMR (Index)	95 (2.2%)		Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.
Jan	RAMI (Index)	89 (1.5%)		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.
Jan	Crude Mortality EL (per 1,000)	0.8 (38.5%)		"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."

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Jan

Crude Mortality NEL (per 1,000)

29.4 (-5.5%)

"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:

The non-elective crude mortality and RAMI this month have both breached the upper control limit. This is related to the expected seasonal variation and the overall 2 year crude mortality rate remains unchanged at 1.4%. RAMI for the latest 12 month period (December 2017 to November 2018) is 90.2 and sits just above the 50th centile in comparison to peer.

HSMR also undergoes seasonal variation and follows the same pattern as crude mortality although interpretation is complicated by the in-year rebasing, nevertheless HSMR is sitting just below the upper control limit. Peer comparison puts the Trust just below the 50th centile for the latest 12 month period.

Comparison of the 2 acute sites for crude mortality indicate that crude mortality at QEQMH is 0.2% higher (2.0% versus 1.8%). However, risk adjusted mortality is lower at QEQMH (91.5 versus 98.2).

The latest data for the national summary hospital mortality index covers up to September 2018. SHMI is not shown on this report but is relevant to understanding overall Trust mortality data.The value of 1.06 is banded as expected. During this latest period 35.2% (1493/4237) were attributed to Out of Hospital Deaths, this is at variance with the England average of 29.1% and is a consistent finding. As previously reported 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). In the future we will also be able to look at SHMI comparisons between sites.

Further analysis of mortality indices again flags septicaemia and this is also evident in the SHMI indicator.

Actions to be completed
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. Repeat in depth analysis of a random sample of deaths coded as septicaemia.

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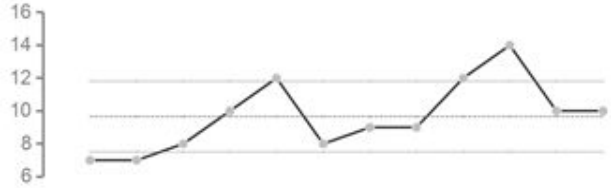
Strategic Theme: Patient Safety

Serious Incidents

Jan	Serious Incidents (STEIS)	116 (87.1%)		"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."

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Jan

Never Events (STEIS)

5 (-28.6%)

"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 January 2019: 93 (including 10 new).
SIs under investigation: 45
Breaches: 5
Non-breaches: 40
Waiting EKHUFT non-closure response: 16
Waiting CCG response: 32

Supporting Narrative:
The number of breached cases is five. Breaches are due to delays in report writing and gaps in and the rigour of the analysis. The Executive weekly 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 and take actions to unblock delays.

Actions:
Performance management of the RCA timelines is being strengthened through the SI panel
Presentation at the panel of RCAs enables critique and extraction of Trust wide learning to be shared
The next SI panel will include a refresh of the procedure, standards and expected timelines for the Governance Teams
Reporting to the Patient Safety Committee is being strengthened
Collaborative work with the CCGs is in place to ensure more timely closure of cases
Learning is shared via Risk Wise and the Care Group meetings.

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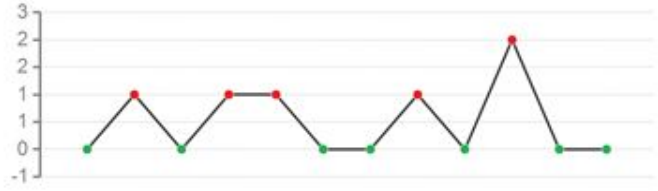
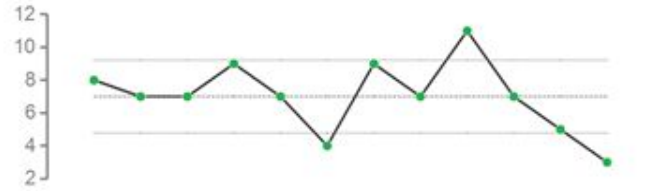
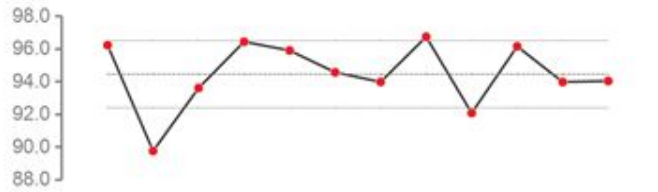
Strategic Theme: Patient Safety

Infection Control

Jan	Cases of MRSA (per month)	6 (-40.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Jan	Cases of C.Diff (Cumulative)	36 (12.5%)		"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."
Jan	E. Coli	84 (-1.2%)		"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."
Jan	MSSA	30 (-11.8%)		"The total number of MSSA bacteraemia recorded, post 48hrs.
Jan	Hand Hygiene Audit	94.2 (-0.5%)		"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"

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 22/2/2019 was 38 against a trajectory set for the year by the Department of Health of 41.

New Actions:

1. The IPC nursing team are continuing to undertake a rolling programme of education and training with ward staff particularly with respect to environmental cleaning and appropriate use of the Diarrhoea Assessment Tool.
2. The educational programme for trainee and junior doctors from the microbiologists will be reviewed to ensure consistency in IP&C approach.
3. Following receipt of the Kent & Medway DIPC stocktake report the IP&C Trust Action Plan will be refreshed accordingly.

MRSA

Year to date there have been 6 hospital onset MRSA bacteraemias. How this compares with peers is best looked at by the rate per 100,000 occupied bed days. Our rate this financial year to date is 1.78/100,000 bed days, other acute Trusts in the South region range from 0.00 to 7.02 but the distribution is skewed to lower rates and the average is 1.03/100,000 bed days.

MSSA

The number of Trust apportioned MSSA bacteraemias year to date is 25. Our rate this financial year to date is 7.4/100,000 bed days, other acute Trusts in the South region range from 4.09 to 18.75, average 8.55/100,000 bed days.

Actions:

Staphylococcus aureus, whether MRSA or MSSA, is found on people's skin and in the respiratory tract and therefore easily colonises ulcers and wounds etc. Care of indwelling devices that breach natural defences is therefore an integral part of prevention of both MRSA and MSSA bacteraemias and becomes even more important when bed occupancy rates are in excess of 100%. the key actions are to:

1. Continue to reinforce the basic principles of IP&C in all our clinical areas
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, an encouraging reduction. Our Trust rate per 100,000 occupied bed days this financial year to date is 20.13, the South region range is 7.02 to 29.0 and average 18.22. 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. Of note the community onset rate of E.coli bacteraemia is 124.4/100,000 occupied bed days versus a South region average of 97.0. The underlying causes of community onset E.coli bacteraemia are similar and work to reduce E.coli bacteraemia centres around a collaborative led by the Kent & Medway DIPC aiming to reduce those bacteraemias associated with urinary tract infection through introduction of catheter bundles in the community as well as in hospital.

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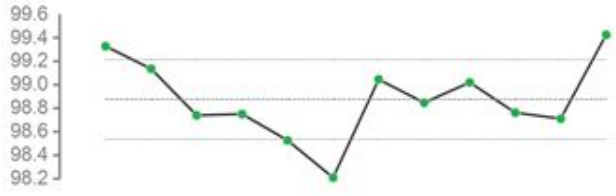
Strategic Theme: Patient Safety

Harm Free Care

Jan	Harm Free Care: New Harms (%)	98.9 (0.5%)		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.
Jan	Harm Free Care:All Harms (%)	91.9 (-0.5%)		"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 Jan-19 (94.36%) shows a significant improvement since last month (91.87%). A marked improvement to 100% is seen in Women's and Children's (97.74% Dec-18).

Actions include:

- 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
- Patient centred wound care group continues and wound care passport nearing completion for the launch trust-wide
- 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 99.43% shows an improvement from last month (98.81% Dec-18). The prevalence of New VTEs; New Pressure Ulcers; Falls with Harm and Catheters and New UTIs with Harm continues to remain below the national average for Acute Hospitals.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Pressure Damage

Jan	Pressure Ulcers Cat 2 (per 1,000)	0.17 (-20.1%)		"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."

NHS East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Jan

Pressure Ulcers Cat 3/4 (per 1,000)

0.00 (-70.9%)

"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:

January 2019

There were a total of 43 category 2 and above hospital acquired pressure ulcers reported, 5 less than last month. 30 of these were category 2 ulcers a decrease of 5. At time of writing the report the trust was below 0.15 avoidable incidence/1000 bed days this month with a result of. 0.142/1000 bed days. However it should be noted that due to retrospective amendments made to PAS records after the event the denominator will alter the avoidable incidence calculation. 5 were avoidable equal to last month. Three affected the sacrum; these were avoidable due to poor documentation and late provision of an active mattress.

There was 1 confirmed avoidable category 3. This was a sacral ulcer reported on Kings C2 and will require further investigation. The trust were below the trajectory with a result of 0.028/1000 bed days. There were no confirmed category 4 pressure ulcers.

Twelve potential deep ulcers were reported. One of these was avoidable, a decrease of 1 from last month. This was Cambridge K and a sacral ulcer due to limited repositioning evidence. The trust were below the trajectory with a result of 0.028/1000 bed days.

Actions:

- Active mattress trials due to commence in February 2019 to involve ITU at QEQM and K&C
- Hybrid trial extended at QEQM which will mean that over 200 mattresses and 100 pumps will be available. This allows active mattresses to be released to the other sites to relieve equipment pressures there.
- ED checklist reviewed to include skin inspection by hour 4 as opposed to within 6 hours of decision to admit.
- Pressure ulcer policy has been simplified and is now ratified and available on policy centre
- Multi-disciplinary meeting regarding leg ulceration with the development of a simplified pathway to include the removal of bandages and the care of heel pressure ulcers.
- Teaching took place with Ami group to improve pressure ulcer prevention and management within this community setting

Recommendations:

- Continue to implement changes as per NHSI document
- Bespoke teaching to be held in areas of concern
- Site based study days to be held on all 3 main hospital sites
- Further analysis of on admission pressure damage to monitor trends and also of hospital acquired deep pressure damage to target areas of concern
- Annual audit to be carried on 13th February 2019 with a trust wide action plan formulated according to results.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Falls

Jan	Falls (per 1,000 bed days)	5.19 (-24.1%)		"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."

Highlights and Actions:

Falls incidents have reduced in January.

There were a total of 171 patient falls including 43 at K&CH , 48 at QEQMH and 171 at WHH.

QEQM of specific note:
- 1 fall on the observational ward caused a humeral fracture. This is being investigated.
- 7 falls on Fordwich (1 patient fell twice)

KCH of specific note:
- 9 falls on Invicta (two patients fell 3 twice).

WHH of specific note:
- 9 falls occurred on Kings C2 (1 patient fell twice).
- 1 fall on Kings C1 resulted in an elbow fracture and is being investigated.

All patients who had more than one fall were assessed by the Falls Team and measures put in place to prevent falls.

Actions:
1. FallStop February launched with a focus on medication reviews and correct manual handling after a fall.
2. Working with Pharmacy to integrate ward whiteboard data to Pharmacy PTL, to enable high risk patients to be identified, enabling triage of medication reviews.
3. Ongoing FallStop training increased to target staff during Trust clinical induction programme.

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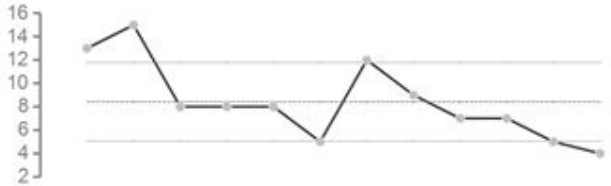
Strategic Theme: Patient Safety

Incidents

Jan	Clinical Incidents: Total (#)	16,888 (3.0%)		"Number of Total Clinical Incidents reported, recorded on Datix.
Jan	Blood Transfusion Incidents	101 (-28.4%)		"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."
Jan	Medicines Mgmt. Incidents	1,801 (11.3%)		"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."

Strategic Theme: Patient Safety

Highlights and Actions:

A total of 1570 clinical incidents have been logged as occurring in Jan-19 compared with 1436 recorded for Dec-18 and 1448 in Jan-18.
In Jan-19, 10 incidents have been reported on StEIS. 21 serious near miss incidents have been reported. Comparison of moderate harm incidents reported: 19 in Jan-19 and 11 in Dec-18, and 2 in Jan-18.
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 4 Blood Transfusion related incidents in January 2019 (5 December 2018 and 7 in January 2018).

Of the 4 incidents 3 were graded as no harm and 1 as low harm.

Reporting by site: at 1 QEQM and 3 at K&CH.

As of 22/02/2018 the total number of medication related incidents reported in January 2019 was 199. These included 149 no harm, 48 low harm, 1 moderate harm and 1 severe harm incident. The severity of medication related incidents reported in January 2019 shows that 74.9% of medication related incidents reported were no harm incidents.

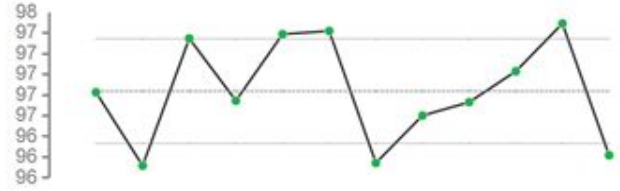
There were 54 incidents in January 2019 categorised as 'omitted medicine/ingredient', representing 27.1% of all medication related incidents reported in January. The data produced by the Medication Safety Thermometer in January 2019 was taken from 19 wards across the sites, and has shown that the percentage of patients with an omitted dose of medication was 14.5% and the percentage of patients with a missed critical medicine was 4.5% in January.

The Medication Safety Officer continues to work with the Heads of Nursing to commit to protecting the drug round and avoiding distractions when a nurse is administering medicines, and to checking drug charts at the end of the shift to ensure that all medications that have been given are signed. This will be an integral part of Medicine Management March that will raise awareness of medication safety issues.

NHS East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Friends & Family Test

Jan	IP FFT: Response Rate (%)	35 (-2.3%)		"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."
Jan	IP FFT: Recommend (%)	97 (0.4%)		
Jan	IP FFT: Not Recommend (%)	1.3 (-22.5%)		"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 9797 responses were received (41% eligible patients). Overall response rates improved for day cases and maternity and fell in inpatients and EDs. Response rate for the EDs was 18.6% (41.6% Dec-18), inpatients 33.5% (37.6% Dec-18), maternity; birth only 17.7% (7.4% Dec-18) and day cases 29.3 (27.6% Dec-18).

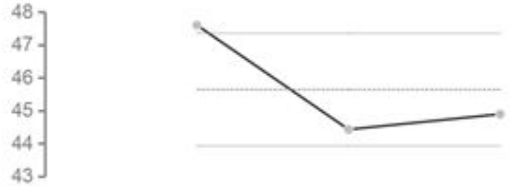
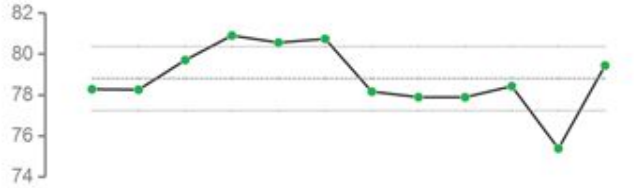
The Trust star rating in January is 4.54 (4.58 Dec-18). 90.5% of responders would recommend us to their friends and family and 5.5% would not. Recommendations by patients in January improved in outpatients, however fell in day cases, inpatients, EDs and maternity. The total number of inpatients, including paediatrics, who would recommend our services 96.5% (97.5% Dec-18), EDs 81.8% (85.4% Dec-18), maternity 96.8% (97.7% Dec-18), outpatients 92.4% (91.9% Dec-18) and day cases 94.4% (96.2% Dec-18).

Care, Staff attitude and Implementation of care are the three top positive themes for January-19. 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.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 1

Jan	IP Survey: Overall, did you get the care that matters to you?	45.3		Inpatient Survey: Patients views on if they got the overall care that mattered to them as a %
Jan	IP Survey: Are you aware of which nurse is in charge of your care each shift? (%)	79 (0.9%)		IP Survey: Are you aware of nurse in charge of your care each shift? (%)
Jan	IP Survey: Encouraged to get up and wear own clothes (%)	64		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 2766 completed inpatient surveys, an improvement from 2196 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 patients getting the care that matters to them, 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 increase is seen in all four of these important elements of patient experience. This local survey supports our improvement priorities, with progress monitored through the Patient Experience Group

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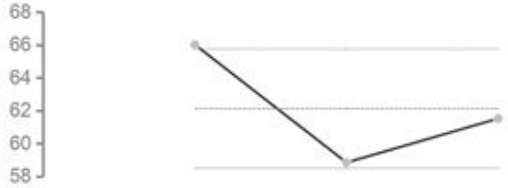
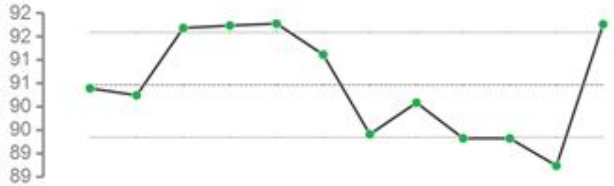
Strategic Theme: Patient Safety

Patient Experience 2

Jan	IP Survey: Help from Staff to Eat Meals (%)	62		Responses taken from the Inpatient Survey. Question: "Did you get enough help from staff to eat your meals?"
Jan	Cleanliness %	91 (0.6%)		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.

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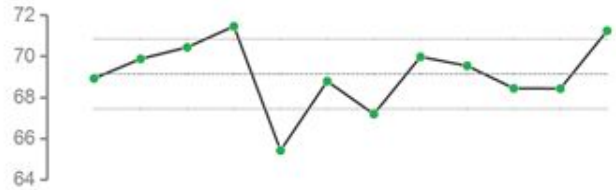
Strategic Theme: Patient Safety

Jan

Hospital Food? %

69
(-1.0%)



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. All wards, except two have reported their performance (against the patient experience metrics) through the inpatient survey in January-19. The IT team are currently working with one ward to solve the on-going issue; the second ward has been reinstated and an I pad is being sourced.

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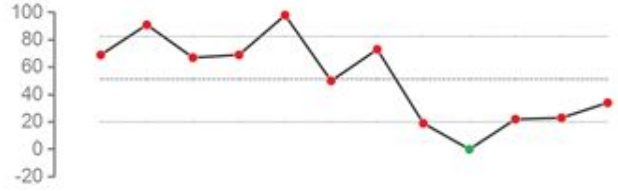
Strategic Theme: Patient Safety

Mixed Sex

Jan	Mixed Sex Breaches	615 (-37.3%)		"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 16 mixed sex accommodation occurrences in total, affecting 121 patients.

Incidence of mixed sex accommodation breaches increased Jan-19 from Dec-18 and there were 7 non-justifiable affecting 34 patients; occurrences within the WHH AMU B linked to flow and capacity issues (6) and Mount McMaster (1) K&C. The remaining incidents occurred in WHH CCU (6) and QEQM Fordwich (3), which were justifiable based on clinical need. This information has been reported to NHS England.

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. The Privacy and Dignity and Eliminating mixed sex accommodation Policy is updated to reflect National guidance

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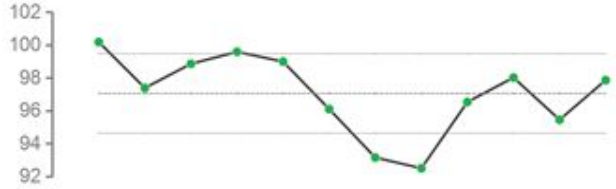
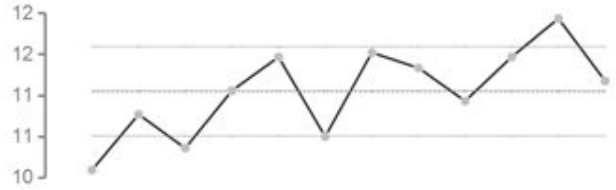
Strategic Theme: Patient Safety

Safe Staffing

Jan	Shifts Filled - Day (%)	97 (-1.7%)		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.
Jan	Shifts Filled - Night (%)	105 (-2.3%)		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.
Jan	Care Hours Per Patient Day (CHPPD)	11 (-4.2%)		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.

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 which shows the average overall fill rate improved to 101.3% from 98.5% in Dec-18.

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 23.59hrs each day during the month. CHPPD is slightly lower than Dec-18 but 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.

Further detail is provided in the appended paper submitted to the Quality Committee and reported by the Chair at Board of Directors.

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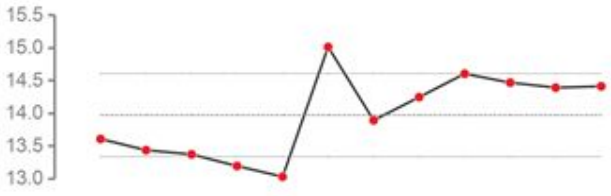
Strategic Theme: Human Resources

Gaps & Overtime

Jan	Vacancy (%)	13.0 (14.1%)		"% 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."
Jan	Staff Turnover (%)	14.0 (7.1%)		"% 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."
Jan	Sickness (%)	3.9 (-1.6%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Jan

Overtime %

9.3
(3.8%)

% of Employee's that claim overtime.

Highlights and Actions:

Gaps and Overtime

The vacancy rate increased to 13.0% (up from 12.9%) for the average of the last 12 months, which is higher than last year. However, the monthly rate remained below 10% at 9.28% (down from 9.78%). 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. This includes approximately 300 Nursing and Midwifery staff (including ODPs) and 70 Medical and Dental staff.

The Turnover rate in month remained 12.0% (last month 12.0%), but the 12 month average increased to 14.0% (13.9% 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. Some areas have seen a large decline in their Turnover in the past 12 months, in particular Surgery and Anaesthetics (from 12.1% to 9.9%).

The in month sickness absence position for December was 3.95% - which is n decrease from 4.20% in November. The 12 month average is 3.9%, and remains on a downward trajectory. 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.

Overtime as a % of wte decreased substantially last month, from approximately 9% to approximately 7%, and is the lowest level for the last 12 months. As a result of this, the average over the last 12 months decreased to 9.3% from 9.5% last month. All metrics are reviewed and challenged at a Care Group level in the monthly Executive Performance Reviews.

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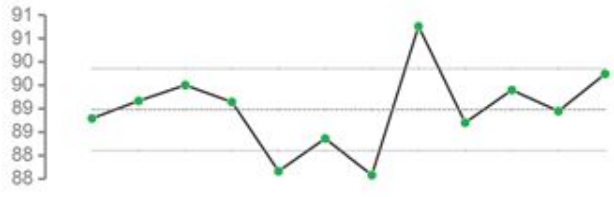
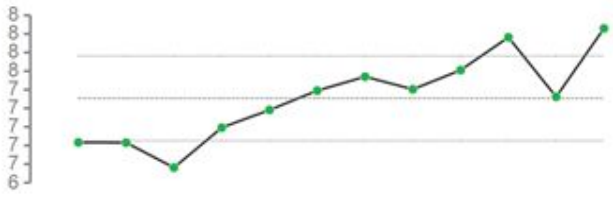
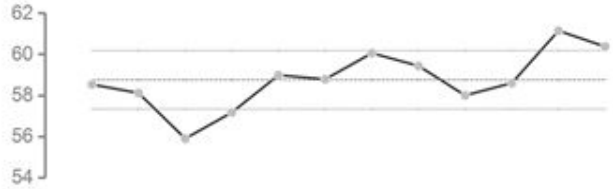
Strategic Theme: Human Resources

Temporary Staff

Jan	Employed vs Temporary Staff (%)	89.0 (0.2%)		"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."
Jan	Agency %	7.3 (22.0%)		% of temporary (Agency and Bank) staff of the total WTE
Jan	Bank Filled Hours vs Total Agency Hours	59 (0.6%)		% 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) increased in January to 7078.15 (up from 7013), which left a vacancy factor of approx. 724 wte across the Trust (753 wte in December).

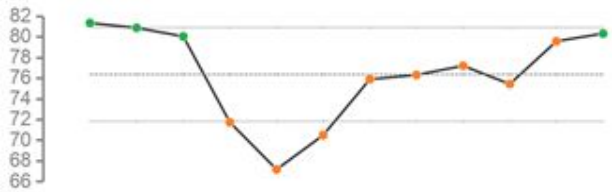
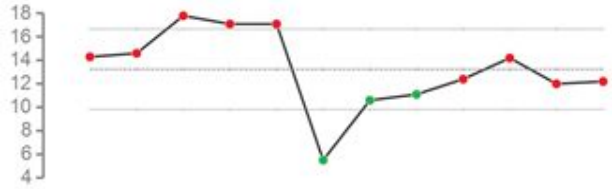
The average percentage of employed staff vs temporary staff over the last 12 months was 89.0% (88.9% last month), and remains lower than the previous 12 months.

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.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Jan	Statutory Training (%)	98 (1.3%)		"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. "
Jan	Appraisal Rate (%)	76.4 (-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.
Jan	Time to Recruit	13 (4.9%)		"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."

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Strategic Theme: Human Resources

Jan

Total Staff In Post (SiP)

7058
(0.9%)

Count of total staff in post (WTE)

Highlights and Actions:

Workforce & Culture

Average Statutory training 12 month average is 90% and increased to 91% 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 remained 80% in month for January, with Surgery & Anaesthetics achieving 91% compliance and General & Specialist Medicine achieving 82% compliance, which is the highest compliance rate for this area in the last 12 months. 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 continues to see the appraisal compliance increase.

The average time to recruit is 11 weeks, which is the same as 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. To support this reduction, the team are now fully established and Advisors have been allocated to Care Groups to support improvements.

East Kent Hospitals University NHS Foundation Trust

Activity vs. Internal Business Plan

Key Performance Indicators

Jan

	Jan-19				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	14,653	13,358	1,295	10%	147,550	141,189	6,361	5%	147,550	144,362	3,188	2%	<=0%
Referral Non-Primary Care	15,816	12,359	3,457	28%	149,393	134,720	14,673	11%	149,393	136,866	12,527	9%	<=0%
OP New	17,947	19,266	(-1,319)	-7%	178,123	188,448	(-10,325)	-5%	178,123	182,481	(-4,358)	-2%	>=0%
OP Follow Up	40,618	43,472	(-2,854)	-7%	393,553	415,943	(-22,390)	-5%	393,553	398,306	(-4,753)	-1%	>=0%
Elective Daycase	6,762	7,262	(-500)	-7%	62,602	67,701	(-5,099)	-8%	62,602	62,105	497	1%	>=0%
Elective Inpatient	1,228	1,276	(-48)	-4%	12,668	13,531	(-863)	-6%	12,668	12,473	195	2%	>=0%
A&E	18,462	16,678	1,784	11%	184,535	175,124	9,411	5%	184,535	173,814	10,721	6%	>=0 & <5%
Non-Elective Inpatient	6,965	6,953	12	0%	67,860	67,637	223	0%	67,860	67,108	752	1%	>=0 & <5%
Chemotherapy	1,268	1,173	95	8%	12,155	11,794	361	3%	12,155	12,030	125	1%	>=0%
Critical Care	1,892	1,716	176	10%	17,921	16,466	1,455	9%	17,921	18,194	(-273)	-2%	>=0%
Dialysis	5,527	7,126	(-1,599)	-22%	65,714	70,631	(-4,917)	-7%	65,714	69,617	(-3,903)	-6%	>=0%
Maternity Pathway	1,213	1,194	19	2%	11,344	11,778	(-434)	-4%	11,344	11,957	(-613)	-5%	>=0%
Pre-Op Assessments	3,293	3,664	(-371)	-10%	32,955	34,174	(-1,219)	-4%	32,955	30,263	2,692	9%	>=0%
Diagnostic	27,572	27,877	(-305)	-1%	4,123,757	3,944,406	179,351	5%	4,123,757	4,358,033	(-234,276)	-5%	<=0%
Other	3,694	2,790	904	32%	48,680	46,287	2,393	5%	48,680	48,687	(-7)	0%	>=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 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.

January 2019

Summary Performance

Elective Care

In January Primary Care referrals were 10% (+1,295) above expected levels growing the YTD variance to +5% (+6,361). Non Primary Care referrals were also significantly above expected levels, 28% (+3,497) in month and 11% (+14,673) YTD.

The Trust under-achieved the new outpatient plan in January with appointments 7% below planned levels, generating a YTD variance of -5%. The biggest drivers behind the under-performance are Trauma and Orthopaedics, Urology, Paediatrics and Gynaecology.

The Trust under-performed the Follow up plan in January (-7%) with YTD performance now underachieving by -5%. The biggest drivers behind the under-performance are Physiotherapy, Trauma and Orthopaedics, Rheumatology and Ophthalmology.

In January the Trust under-achieved the Daycase plan by 500 patients with YTD performance underachieving by -8%. T&O (-1,827), Dermatology (-1,370) and Pain Management (-1,101) continue to underperform the business plan.

Elective Admissions are 6% below plan YTD. Large underperformance remains in the Urology service (-541) and Gynaecology (-428).

East Kent Hospitals University NHS Foundation Trust

Summary Actions

- Continue the daily focus on data quality issues impacting duplicate referrals.
- 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.
- 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.

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YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	11,915	13,337	-11%	-1,422
300 - General Medicine	114	1,082	-89%	-968
120 - Ear, Nose & Throat	8,832	9,489	-7%	-657
104 - Colorectal Surgery	7,770	7,089	10%	681
320 - Cardiology	14,271	13,473	6%	798
420 - Paediatrics	5,330	4,432	20%	898
410 - Rheumatology	3,459	2,521	37%	938
103 - Breast Surgery	6,830	5,887	16%	943
330 - Dermatology	12,304	10,791	14%	1,513
110 - Trauma & Orthopaedics	9,710	7,546	29%	2,164
Total	**147,550**	**141,189**	**5%**	**6,361**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	26,026	28,889	-10%	-2,863
301 - Gastroenterology	2,756	2,163	27%	593
655 - Orthoptics	1,921	1,195	61%	726
191 - Pain Management	1,441	695	107%	746
340 - Respiratory Medicine	3,210	2,129	51%	1,081
800 - Clinical Oncology	10,802	9,580	13%	1,222
300 - General Medicine	3,202	1,816	76%	1,386
100 - General Surgery	4,303	2,564	68%	1,739
130 - Ophthalmology	14,489	10,326	40%	4,163
110 - Trauma & Orthopaedics	19,592	15,323	28%	4,269
Total	**149,393**	**134,720**	**11%**	**14,673**

OP New

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	13,532	15,700	-14%	-2,168
101 - Urology	6,984	9,115	-23%	-2,131
502 - Gynaecology	11,508	12,995	-11%	-1,487
420 - Paediatrics	6,925	8,293	-16%	-1,368
650 - Physiotherapy	14,765	16,030	-8%	-1,265
120 - Ear, Nose & Throat	10,946	12,142	-10%	-1,196
400 - Neurology	4,193	4,955	-15%	-762
100 - General Surgery	4,119	4,859	-15%	-740
320 - Cardiology	5,384	4,634	16%	750
330 - Dermatology	11,825	10,836	9%	989
Total	**178,123**	**188,448**	**-5%**	**-10,325**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
650 - Physiotherapy	48,525	53,597	-9%	-5,072
110 - Trauma & Orthopaedics	34,929	39,734	-12%	-4,805
410 - Rheumatology	8,471	11,745	-28%	-3,274
130 - Ophthalmology	43,050	45,580	-6%	-2,530
300 - General Medicine	1,782	4,171	-57%	-2,389
120 - Ear, Nose & Throat	13,447	15,108	-11%	-1,661
400 - Neurology	7,254	8,245	-12%	-991
655 - Orthoptics	7,343	8,148	-10%	-805
191 - Pain Management	4,319	5,055	-15%	-736
420 - Paediatrics	8,469	9,134	-7%	-665
Total	**393,553**	**415,943**	**-5%**	**-22,390**

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Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	3,960	5,787	-32%	-1,827
330 - Dermatology	2,972	4,342	-32%	-1,370
191 - Pain Management	1,831	2,932	-38%	-1,101
130 - Ophthalmology	3,945	4,499	-12%	-554
502 - Gynaecology	2,003	2,511	-20%	-508
120 - Ear, Nose & Throat	2,075	2,562	-19%	-487
320 - Cardiology	2,558	2,750	-7%	-192
303 - Clinical Haematology	2,942	2,724	8%	218
301 - Gastroenterology	1,373	798	72%	575
800 - Clinical Oncology	5,031	4,288	17%	743
Total	**62,602**	**67,701**	**-8%**	**-5,099**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
101 - Urology	2,381	2,922	-19%	-541
502 - Gynaecology	958	1,386	-31%	-428
100 - General Surgery	903	1,014	-11%	-111
320 - Cardiology	169	254	-33%	-85
107 - Vascular Surgery	292	353	-17%	-61
300 - General Medicine	1,595	1,652	-3%	-57
811 - Interventional Radiology	153	86	79%	67
104 - Colorectal Surgery	430	348	24%	82
303 - Clinical Haematology	211	101	108%	110
503 - Gynaecology Oncology	343	233	47%	110
Total	**12,668**	**13,531**	**-6%**	**-863**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	20,419	21,592	-5%	-1,173
430 - HCOOP	8,229	9,153	-10%	-924
560 - Midwifery	1,861	2,331	-20%	-470
502 - Gynaecology	1,984	2,139	-7%	-155
340 - Respiratory Medicine	529	361	46%	168
420 - Paediatrics	7,780	7,593	2%	187
301 - Gastroenterology	552	323	71%	229
104 - Colorectal Surgery	381	77	393%	304
101 - Urology	3,632	3,193	14%	439
100 - General Surgery	5,779	4,929	17%	850
Total	**67,860**	**67,637**	**0%**	**223**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	4123757	3944406	5%	179,351
A&E	184535	175124	5%	9,411
Dialysis	65714	70631	-7%	-4,917
Other	48680	46287	5%	2,393
Critical Care	17921	16466	9%	1,455
Pre-Op	32955	34174	-4%	-1,219
Maternity Pathway	11344	11778	-4%	-434
Chemotherapy	12155	11794	3%	361

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4 Hour Emergency Access Standard

Key Performance Indicators

74.20%

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Green
4 Hour Compliance (EKHUFT Sites) %*	73.75%	75.08%	76.93%	80.80%	82.73%	79.18%	80.04%	77.15%	80.89%	81.74%	79.36%	74.20%	95%
4 Hour Compliance (inc KCHFT MIUs)	77.76%	78.78%	81.73%	83.95%	85.81%	82.95%	83.52%	81.02%	83.88%	84.50%	82.25%	77.93%	95%
12 Hour Trolley Waits	0	2	1	0	0	0	0	0	0	0	0	0	0
Left without being seen	2.26%	2.61%	2.70%	2.39%	2.05%	2.75%	2.44%	3.52%	3.09%	2.77%	3.03%	3.02%	<5%
Unplanned Reattenders	8.92%	9.11%	9.69%	9.12%	9.31%	9.84%	9.91%	10.23%	9.82%	9.56%	9.46%	9.59%	<5%
Time to initial assessment (15 mins)	95.3%	94.4%	94.2%	95.3%	93.2%	94.4%	91.4%	72.8%	71.4%	70.9%	65.0%	66.3%	90%
% Time to Treatment (60 Mins)	48.0%	42.5%	46.4%	49.5%	51.6%	42.7%	48.1%	45.7%	50.7%	52.7%	48.7%	50.5%	50%

2018/19 Trajectory (NHSI return 2nd May)

-14.17 %

	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
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%	74.2%			

*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

East Kent Hospitals University NHS Foundation Trust

January performance for the organisation against the 4 hour target was 74.2%; against the NHS Improvement trajectory of 88.4%.This represents a decrease in performance compared to the previous month (79.4%), but an improvement on the Trust wide compliance on the previous January (69.3% in 2018). There were no 12 Hour Trolley Waits in January. The number of patients who left the department without being seen remained compliant at 3.02%. The unplanned re-attendance position remains high at 9.59%. Time to treatment improved above 50% following a performance drop in December to 48.7%.

ED Summary Actions

- Continue to implement ED Improvement Plan and Winter Capacity plan actions.
- Maintain health economy focus on patient flow, in particular for complex discharge.
- Continue the daily focus on internal and external delays to reduce stranded and super stranded patients by identifying whether patients will be complex or simple to discharges to proactively manage discharge plans.
- Prioritise recruitment and retention actions for medical and nursing workforce.


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Cancer Compliance

Key Performance Indicators

67.63 %

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Green
62 day Treatments	73.40%	71.88%	66.32%	64.85%	65.79%	65.52%	66.13%	71.14%	77.05%	71.35%	81.93%	67.63%	>=85%
>104 day breaches	23	30	27	31	34	36	24	12	9	4	8	10	0
Demand: 2ww Refs	2,734	3,250	3,193	3,406	3,243	3,204	3,100	2,875	3,485	3,308	2,662	3,429	2990 - 3305
2ww Compliance	97.10%	91.42%	89.06%	93.81%	94.22%	94.94%	93.64%	90.96%	83.54%	93.29%	96.75%	96.45%	>=93%
Symptomatic Breast	98.50%	90.28%	75.16%	84.46%	94.12%	93.18%	86.32%	94.39%	68.70%	84.03%	95.00%	97.22%	>=93%
31 Day First Treatment	97.74%	96.08%	95.24%	96.42%	96.51%	95.73%	94.58%	96.83%	97.52%	97.08%	96.99%	95.40%	>=96%
31 Day Subsequent Surgery	91.43%	89.47%	86.11%	80.95%	82.61%	94.87%	95.65%	96.08%	91.67%	100.00%	97.06%	95.45%	>=94%
31 Day Subsequent Drug	98.33%	98.21%	97.94%	98.92%	98.13%	99.20%	98.98%	97.83%	99.21%	98.15%	100.00%	97.50%	>=98%
62 Day Screening	79.31%	100.00%	93.75%	84.09%	100.00%	81.63%	94.37%	81.48%	87.50%	84.21%	87.50%	100.00%	>=90%
62 Day Upgrades	77.27%	100.00%	89.19%	77.42%	85.29%	85.00%	94.74%	76.00%	82.14%	85.29%	73.91%	85.19%	>=85%

2018/2019 Trajectory

-17.68 %

	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%	64.85%	65.79%	65.52%	66.13%	71.14%	77.05%	71.35%	81.93%	67.63%			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.

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Summary Performance

January 62 day performance is currently 67.63% against the improvement trajectory of 85.31%, validation continues until the beginning of March in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,371 and there were 10 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 by 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.
- Be sighted on demand weekend at the front end of each pathway to mitigate earlier decisions and actions required.

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62 Day Performance Breakdown by Tumour Site

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
01 - Breast	83.3%	100.0%	92.9%	96.6%	92.0%	93.8%	81.5%	86.1%	74.5%	72.4%	89.7%	64.4%
03 - Lung	100.0%	81.0%	62.8%	91.7%	73.0%	70.6%	73.3%	60.0%	56.0%	59.4%	90.9%	60.7%
04 - Haematological	33.3%	33.3%	50.0%	25.0%	54.5%	70.6%	13.3%	61.1%	54.5%	71.4%	75.0%	40.0%
06 - Upper GI	64.3%	73.3%	69.0%	69.2%	79.3%	93.3%	66.7%	62.5%	70.6%	60.0%	100.0%	57.9%
07 - Lower GI	43.8%	63.2%	61.1%	46.5%	64.6%	68.3%	75.0%	68.4%	84.8%	45.2%	55.0%	58.8%
08 - Skin	100.0%	88.9%	88.0%	88.2%	97.2%	97.7%	97.1%	100.0%	100.0%	90.0%	96.8%	94.9%
09 - Gynaecological	63.6%	75.0%	30.8%	32.0%	42.1%	55.6%	75.0%	85.2%	71.4%	100.0%	80.0%	80.0%
10 - Brain & Nervous System			100.0%					100.0%				
11 - Urological	63.5%	63.2%	59.3%	50.0%	38.2%	39.4%	51.0%	52.0%	70.5%	68.5%	76.8%	64.8%
13 - Head & Neck	85.7%	78.6%	20.0%	38.9%	94.1%	50.0%	60.0%	60.0%	100.0%	60.0%	86.7%	57.9%
14 - Sarcoma	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%			100.0%		100.0%	
15 - Other	0.0%		50.0%		100.0%	100.0%	100.0%	100.0%	100.0%		63.6%	70.0%

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18 Week Referral to Treatment Standard

Key Performance Indicators

76.10 %

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Green
Performance	77.03%	76.08%	76.66%	78.56%	79.02%	79.65%	79.06%	76.27%	74.88%	72.16%	72.42%	76.10%	>=92%
52w+	141	201	222	218	201	167	125	129	120	102	74	38	0
Waiting list Size	54,306	54,519	54,979	54,964	53,411	53,193	53,552	54,712	55,607	54,492	53,169	50,134	<38,938
Backlog Size	12,474	13,039	12,830	11,785	11,207	10,824	11,212	12,983	13,966	15,170	14,662	11,984	<2,178

2018/2019 Trajectory

-5.07 %

	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%	76.10%			Sept

-87

	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	38			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%.

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Summary Actions

- Elective care recovery plan to be delivered.
- Maximise all outpatient clinics to ensure capacity is fully booked and prioritising new outpatient appointments.
- To ensure that outpatient clinic outcome forms are fully completed and 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.
- Additional internal and external capacity to be sourced.

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6 Week Referral to Diagnostic Standard

Key Performance Indicators

99.72 %

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Green
Performance	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%	98.57%	99.31%	99.65%	99.56%	99.72%	>=99%
Waiting list Size	14,125	14,174	14,597	15,192	16,350	16,888	15,126	12,750	12,820	13,329	12,235	12,949	<14,000
Waiting > 6 Week Breaches	62	49	91	106	149	264	298	182	88	46	54	36	<60
Average Wait													<4

2018/19 Trajectory

0.62 %

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
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%
Performance	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%	98.57%	99.31%	99.65%	99.56%	99.72%

Summary Performance

The standard has been met for January 19 with a compliance of **99.72%**. As at the end of the month there were **36** patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 3
- Cardiology: 5
- Urodynamic: 24
- Sleep Studies : 0

- Cystoscopy : 3
- Colonoscopy : 0
- Neurophysiology : 1
- Gastroscopy : 0
- Flexi Sigmoidoscopy: 0

Summary Actions

- Continue recruitment to respiratory and cardiac physiologist vacancies.
- Provide additional through additional lists for Cardiac CT.

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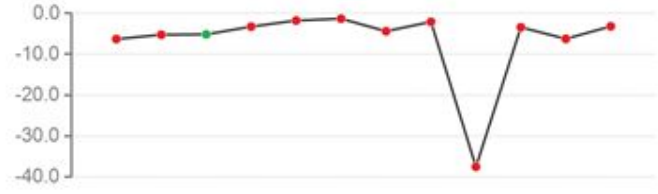
Strategic Theme: Finance

Finance

Jan	I&E £m (Trust Only)	-68.3 (-49.1%)		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.
Jan	Cash Balance £m	8.7 (-0.1%)		Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.
Jan	Total Cost £m (Trust Only)	-54.6 (3.0%)		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.
Jan	Forecast £m	-42.2 (0.8%)		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.

Highlights and Actions:

The Trust has generated a consolidated deficit in month of £2.5m (£0.6m behind plan) and a year to date (YTD) deficit of £67m which is £41.2m 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. In addition there was a slowing down of outpatient work following the PAS implementation. The main specialties showing performance behind plan are Trauma & Orthopaedic (T&O), Urology, Pain Management 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 two months which, if not delivered, will lead to a failure to deliver the revised financial forecast. Care groups are meeting weekly with the COO and FD to improve the elective trajectory.

Strategic Theme: Finance

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 10 (January) was £32.4m (consolidated position including subsidiaries and after technical adjustments) against a planned deficit of £24.9m, £7.4m worse than plan. A revised full year forecast of £42.2m deficit has been approved by the Board and submitted to NHSi.

The year to date position now includes a £360k impact on consolidation relating to intercompany trading between 2gether and the Trust which was highlighted when the full Q3 accounts were completed for NHS I. The M10 YTD position is slightly better than expected however due to outstanding risks the forecast is held at £42.2m.

Trust unconsolidated pay costs in month of £32.4m are £0.9m more than December. Substantive costs have increased £0.1m due to the payment of Bank holiday pay and agency staffing costs have increased £0.8m in month due to higher levels of Agency cover being available to fill open shifts. During the Christmas period it is normal for these staffing groups to reduce as workers are less willing to cover the holiday period. When measured against Budget, pay is over spent by £1.4m in month and £13m YTD. The main driver for the over spend continues to relate to above plan usage of clinical agency and bank staff. All Care Groups contribute to the over spend. The pay spend includes £4m year to date and £0.4m in month of pay awards relating to Agenda for change not previously budgeted. Agency costs are now £14.6m 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 on plan in month. Once the impact of pay awards income funding (£0.6m, not included in the plan) is adjusted the net position in £0.6m less than plan for the month. The YTD position is now £3.2m ahead of plan but once pay awards income funding (YTD £4.2m) and prior year reserve releases (£3m) are removed the net position is £4m 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 however this underperformance has significantly reduced in month. Month on month income has increased £4.8m due to more activity in almost all areas, other than A&E, driven by additional available working days and a care group focus on increasing elective activity. Other income is £1.4m ahead of plan in month (driven by increased education income and the release of deferred income to match PAs costs) and above plan £7.3m YTD, driven by the month 10 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, £24m of CIPS have been delivered YTD against a target of £23.3m, £0.7m ahead of plan. CIPs achieved in Month 10 were £2.3m, £0.9m behind plan due to Agency and Patient flow schemes slightly under delivering in month and phasing differences. CIPs in January amounted to £1.7m recurrent and £0.6m on a non-recurrent basis. The YTD position is recurrent £14.9m and non-recurrent £9.1m.
The Trusts cash balance as at the end of September was £8.7m, which is £5.8m above plan. The Trust's total cash borrowing is now £72.8m 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 is seeking to mitigate these risks as we move through the remainder of the year by weekly meetings between care groups and executive team members.

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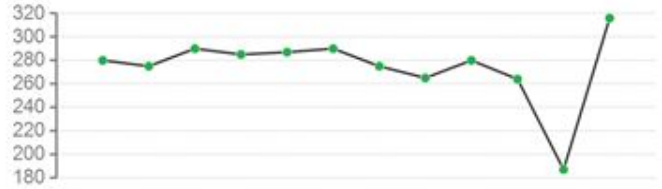
Strategic Theme: Health & Safety

Health & Safety 1

Jan	Representation at H&S	748 (0.7%)		"% of Clinical Divisions representation/attendance at each site's Health & Safety Committee.
Jan	RIDDOR Reports (Number)			"RIDDOR reports sent to HSE each month.
Jan	Formal Notices	0 (-100.0%)		"Formal notices from HSE (Improvement Notices, Prohibition Notices).
Jan	Health & Safety Training	3294 (18.6%)		H&S Training includes all H&S and risk avoidance training including manual handling

Highlights and Actions:

H&S attendance at committees has declined in January. The Strategic H&S Committee has discussed this downward trend and escalated the issue with the care group leaders.

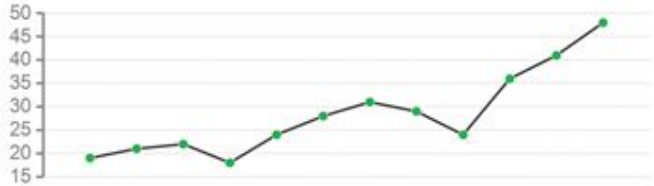
There were 2 RIDDORs in month.

There were no formal notices in January.

H&S training returned to positive levels after the Christmas break. This returns the number of staff receiving H&S to good levels.

Strategic Theme: Health & Safety

Health & Safety 2

Jan	Accidents	341 (8.9%)		"Accidents excluding sharps (needles etc) but including manual handling.
Jan	Fire Incidents	116 (-4.1%)		"Fire alarm activations (including false alarms).
Jan	Violence & Aggression	353 (-11.3%)		"Violence, aggression and verbal abuse.

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Strategic Theme: Health & Safety

Jan

Sharps

111
(-12.6%)

"Incidents with sharps (e.g. needle stick).

Highlights and Actions:

The number of accidents increased in January. This shows a continued increase from October. Although this is still green it does show a trend and will be discussed at the next H&S committee. Historically the number of accidents, most of which are minor, does increase at this time of year.

The number of fire incidents decreased in January and returns this KPI to green. This is positive given that last two months had moved this KPI into Red. It's important to note that these are largely false alarms and the significant majority occur in the resident kitchens as a result of cooking.

The number of violence and aggressive incidents increased in January, partly related to how busy the sites are. Although the KPI is green it will continue to be monitored in the comings months. Conversely the number of sharps incidents deceased in month.

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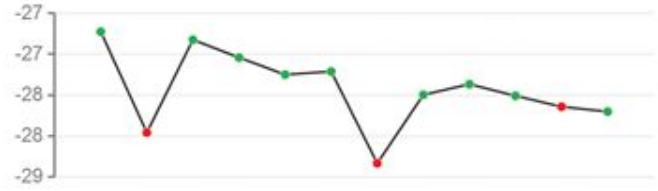
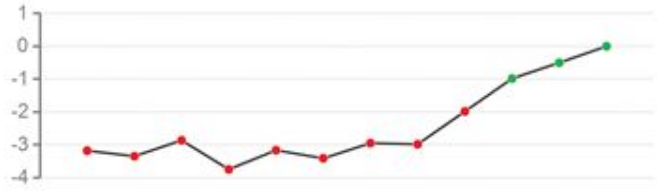
Strategic Theme: Use of Resources

Pay Independent

Jan	Payroll Pay £m	-27.7 (0.2%)		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.
Jan	Agency Spend £m	0.0 (-100.0%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Jan	Independent Sector £k	-673 (-15.5%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Highlights and Actions:

Pay performance is adverse to plan in January by £1.4m and by £13m 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 4.0m ytd. The main driver of pay relates to agency usage covered below.

Total expenditure on pay in December was £32.3m, £0.9m higher than in December with the increase relating to agency usage to keep the wards and A&E safe.

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 .

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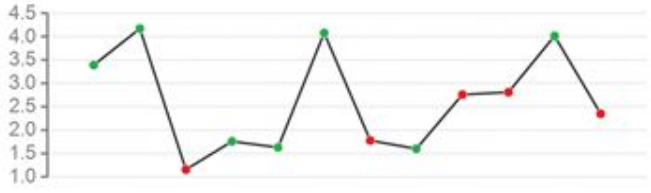
Strategic Theme: Use of Resources

Balance Sheet

Jan	CIPS £m	23.9 (-41.5%)		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.
Jan	Cash borrowings £m	73.5		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Use of Resources

Jan

Capital position £m

11.5
(50.7%)

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 £12.4m to £16.1m. The largest debtors at 31st January were East Kent CCGs £5.1m and East Kent Medical Services £2.2m. Agreement has now been reached with CCGs in respect of 1718 overperformance, £3.5m is expected to be paid in February.

CREDITORS
The management of creditors continues to be an issue and in January the Trust commenced paying invoices at 20 days behind creditor terms on average (from 17 days).

CAPITAL
Total YTD expenditure for Mth 10 2018/19 is £2m 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 £14.1m

CASH
The closing cash balance for the Trust as at 31st January was £8.7m

FINANCING
£1.7m of interest was incurred in respect of the drawings against working capital facilities to 31st January 2019.

NHS East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Improvement Journey

		Sep	Oct	Nov	Dec	Jan	
MD02 - Emergency Pathway	ED - 4hr Compliance (incl KCHFT MIUs) %	81.02	83.88	84.50	82.25	77.93	>= 95
	ED - 1hr Clinician Seen (%)	45	51	52	48	50	>= 55 & <55
MD04 - Flow	DToCs (Average per Day)	48	48	55	53	54	>= 0 & <35
	IP - Discharges Before Midday (%)	17	14	15	15	15	>= 35
	Medical Outliers	51	57	49	63	89	
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	71.14	77.05	71.35	81.93	67.63	>= 85
MD07 - Maternity	Midwife:Birth Ratio (%)	28	28	25	24	26	>= 0 & <28
	Staff Turnover (Midwifery)	13	14	14	13	13	>= 0 & <10
	Vacancy (Midwifery) %	5	4	5	5	6	>= 0 & <7
MD08 - Recruitment & Staffing	Staff Turnover (%)	14.2	14.6	14.5	14.4	14.4	>= 0 & <10
	Vacancy (%)	13.8	13.2	12.6	13.0	12.1	>= 0 & <7
	Staff Turnover (Nursing)	14	14	14	14	14	>= 0 & <10
	Staff Turnover (Medical)	14	14	14	14	14	>= 0 & <10

MD08 - Recruitment & Staffing	Vacancy (Nursing) %	17	15	15	15	15	>= 0 & <7
	Vacancy (Medical) %	13	13	12	13	12	>= 0 & <7
MD09 - Workforce Compliance	Appraisal Rate (%)	76.3	77.2	75.4	79.6	80.3	>= 85
	Statutory Training (%)	98	97	97	96	98	>= 85
KF01 - Complaints	Complaint Response within 30 days %	16.0	21.4	36.8	13.3	23.9	>= 85
	Complaint Response in Timescales %	75.7	72.1	81.6	94.6	84.2	>= 85
KF09 - Medicines Management	Pharm: Drug Trolleys Locked (%)	99	48	97	99	49	>= 90 & <90
	Pharm: Resus. Trolley Check (%)	92	94	96	96	84	>= 90 & <90
	Pharm: Drug Cupboards Locked (%)	78	74	86	88	81	>= 90 & <90
	Pharm: Fridges Locked (%)	86	78	83	84	79	>= 95
	Pharm: Fridge Temps (%)	82	82	91	95	87	>= 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 %
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 in 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 %
	RIDDOR Reports (Number)	"RIDDOR reports sent to HSE each month.	>= 0 & <3	20 %

Health & Safety	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 or 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	IP Survey: Are you aware of which nurse is in charge of your care each shift? (%)	IP Survey: Are you aware of nurse in charge of your care each shift? (%)	>= 89	4 %
	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	15 %
	Cleanliness %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	5 %
	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		
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	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: 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 %

Patient Experience	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 %
	IP Survey: Overall, did you get the care that matters to you?	Inpatient Survey: Patients views on if they got the overall care that mattered to them as a %		10 %
	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 %
	Number of Complaints	"The number of Complaints recorded overall . Data source - Patient Experience Team"	>= 0 & <1	15 %
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		

Staffing

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	
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 %
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 %

Staffing

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 direction of arrow and %) against the previous 12 months."	>= 0 & <10	
Staff Turnover (Nursing)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Nurses. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 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 in 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	
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 %
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 direction 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 %
	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	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow.	>= 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	
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		

Data Assurance Stars

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

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

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

East Kent Hospitals University NHS 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 %	2.2	1.4	13.6	7.8	3.8	26.2	4.7	6.0
Employed vs Temporary Staff (%)	91.9	90.4	82.9	97.4	98.1	75.5	91.5	92.1
Sickness (%)	4.2	4.0	3.9	4.2	2.4	4.9	3.7	4.4
Staff Turnover (%)	13.5	12.8	18.4	13.6	11.6	18.4	13.3	12.4
Statutory Training (%)	97	95	99	99	101	100	96	97
Total Staff In Post (SiP)	180	947	1405	1495	174	399	1572	887
Vacancy (%)	8.1	9.6	18.0	3.1	1.4	24.5	16.2	7.9

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NHS
East Kent Hospitals University
NHS Foundation Trust

Patient Safety Heatmap - JANUARY 2019

KEY

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

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	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 (%)	IP Survey: Overall, did you get the care	IP Survey: Help from Staff to Eat Meals	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
K&C - KENT & CANTERBURY HOSPITAL																	
CAN (Cancer)																	
KBRA - K&C BRABOURNE WARD	100.0	0	0	98.2	0	0	0	7	44	100	0.0	100.0	0	101.1	87	100	15
KCADU - K&C CATHEDRAL UNIT	N/A	0	0	43.9	0	0	0	0	N/A	N/A	N/A	NULL	NULL	83.0	N/A	N/A	N/A
GSM (General and Specialist Medicine)																	
KACU - K&C AMBULATORY CARE UNIT	N/A	0	0	NULL	0	0	0	0	N/A	N/A	N/A	NULL	NULL	89.9	N/A	N/A	N/A
KHAR - K&C HARBLEDOWN WARD	100.0	2	6	100.0	2	0	2	47	32	100	0.0	100.0	100	69.8	77	115	5
KINV - K&C INVICTA WARD	100.0	1	9	97.3	0	0	0	0	11	100	0.0	33.3	87	87.5	117	113	6
KKIN - K&C KINGSTON WARD	100.0	0	7	100.0	0	0	1	0	17	100	0.0	50.0	60	75.2	77	108	5
KMARL - K&C MARLOWE WARD	100.0	1	2	100.0	1	1	1	73	50	98	0.0	50.0	77	90.1	96	97	6
KMM - K&C MOUNT MCMASTER WARD	100.0	1	5	100.0	0	0	0	0	39	100	0.0	50.0	50	76.7	104	114	5
KNRU - K&C EAST KENT NEURO REHAB	94.7	0	5	66.7	0	0	0	3	67	75	0.0	50.0	100	NULL	81	101	5
KTRE - K&C TREBLE WARD	100.0	0	1	NULL	0	0	0	0	28	100	0.0	100.0	100	79.8	94	98	7
S&A (Surgery & Anaesthetics)																	
KCLK - K&C CLARKE WARD	100.0	3	0	100.0	0	0	1	104	19	99	0.0	50.0	80	89.8	90	96	6
KDSC - K&C DAY SURGERY	NULL	0	1	NULL	0	0	0	0	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL
KITU - K&C INTENSIVE CARE UNIT	100.0	1	1	100.0	0	0	0	55	N/A	N/A	N/A	NULL	NULL	80.0	82	82	31
KSLA - K&C ST LAWRENCE WARD	100.0	0	3	NULL	0	0	0	0	60	98	0.0	100.0	100	64.1	NULL	NULL	NULL
KWURO - K&C UROLOGY SUITE	N/A	0	0	NULL	0	0	0	0	N/A	N/A	N/A	NULL	NULL	109.9	N/A	N/A	N/A
W&C (Womens and Childrens)																	
KDOLP - K&C DOLPHIN WARD	N/A	0	0	NULL	0	0	0	352	N/A	N/A	N/A	NULL	NULL	101.2	N/A	N/A	N/A
QEQM - QUEEN ELIZABETH QUEEN MOTHER HOSPITAL																	
CAN (Cancer)																	
QVDM - QEQM VIKING DAY UNIT	N/A	0	1	80.0	0	0	1	0	N/A	N/A	N/A	NULL	NULL	101.4	N/A	N/A	N/A
GSM (General and Specialist Medicine)																	

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	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	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 (%)	IP Survey: Overall, did you get the care	IP Survey: Help from Staff to Eat Meals	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
QCCU - QEQM CCU	NULL	0	0	91.2	0	2	1	7	115	100	0.0	100.0	77	79.7	95	100	7
QDEA - QEQM DEAL WARD	95.0	0	1	98.7	0	2	0	0	16	83	8.3	50.0	100	109.1	124	143	6
QFOR - QEQM FORDWICH WARD	100.0	1	7	100.0	0	1	1	0	77	90	9.5	100.0	100	89.2	93	118	7
QQX - QEQM QUEX WARD	95.8	0	3	87.5	0	0	1	14	8	88	0.0	NULL	NULL	98.4	108	129	6
QSAN - QEQM SANDWICH WARD	100.0	2	2	99.4	0	0	0	1	18	100	0.0	50.0	18	96.7	138	165	7
QSTA - QEQM ST. AUGUSTINES WARD	96.6	0	5	NULL	0	0	1	1	47	96	0.0	50.0	75	82.7	100	130	5
QSTM - QEQM ST. MARGARETS WARD	95.0	0	1	94.2	0	0	0	14	74	97	0.0	50.0	93	80.7	110	124	6
S&A (Surgery & Anaesthetics)																	
QBIS - QEQM BISHOPSTONE WARD	100.0	2	1	NULL	0	0	1	0	110	96	1.5	100.0	3	79.7	70	94	7
QCSF - QEQM CHEERFUL SPARROWS WAR	100.0	0	4	100.0	0	0	1	1	78	98	0.0	33.3	69	108.2	115	124	7
QCSM - QEQM CHEERFUL SPARROWS WA	100.0	2	2	NULL	0	0	1	0	28	97	0.0	50.0	98	89.9	115	130	6
QDSU - QEQM DAY SURGERY WARD	NULL	0	0	66.7	0	0	0	0	N/A	N/A	N/A	NULL	NULL	NULL	N/A	N/A	N/A
QITU - QEQM INTENSIVE CARE UNIT	100.0	1	0	89.8	0	0	0	32	N/A	N/A	N/A	NULL	NULL	90.2	98	119	24
QSAL - QEQM SURGICAL ADMISSIONS LO	NULL	0	0	NULL	0	0	0	0	N/A	N/A	N/A	NULL	NULL	0.0	N/A	N/A	N/A
QSB - QEQM SEA BATHING WARD	100.0	0	0	NULL	0	0	0	0	80	97	0.0	100.0	50	82.9	101	114	6
UEC (Urgent and Emergency Care)																	
QAMUB - QEQM ACUTE MEDICAL UNIT B	100.0	3	6	NULL	0	1	0	2	35	83	10.9	NULL	NULL	62.7	NULL	NULL	NULL
W&C (Womens and Childrens)																	
KIN - QEQM KINGSGATE WARD	NULL	0	0	100.0	0	0	2	0	N/A	N/A	N/A	NULL	NULL	86.6	88	87	22
QBIR - QEQM BIRCHINGTON WARD	100.0	0	2	100.0	0	0	0	33	4	100	0.0	50.0	25	99.8	97	134	6
QRAI - QEQM RAINBOW WARD	100.0	0	0	94.7	0	0	0	0	23	100	0.0	NULL	NULL	96.3	93	110	16
QSCB - QEQM SPECIAL CARE BABY UNIT	100.0	0	0	100.0	0	0	0	0	N/A	N/A	N/A	NULL	NULL	93.9	111	101	10
WHH - WILLIAM HARVEY HOSPITAL																	
CAN (Cancer)																	
WCBC - WHH CELIA BLAKEY CENTRE	N/A	0	0	NULL	0	0	0	0	N/A	N/A	N/A	NULL	NULL	103.4	N/A	N/A	N/A
GSM (General and Specialist Medicine)																	
WBAR - WHH BARTHOLOMEW WARD	100.0	0	0	81.5	0	0	0	0	69	100	0.0	50.0	26	82.3	109	102	13
WCCU - WHH CARDIAC CARE UNIT	100.0	0	0	NULL	0	0	0	1	65	100	0.0	50.0	71	N/A	N/A	N/A	N/A
WCJ - WHH CAMBRIDGE J WARD	100.0	0	0	NULL	0	0	0	0	0	NULL	NULL	100.0	27	82.3	129	165	8
WCK - WHH CAMBRIDGE K WARD	100.0	1	2	100.0	0	0	0	40	35	95	0.0	33.3	72	59.2	99	98	7
WCL - WHH CAMBRIDGE L WARD	100.0	6	4	100.0	0	0	1	5	46	100	0.0	50.0	11	76.3	97	93	6

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	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	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 (%)	IP Survey: Overall, did you get the care	IP Survey: Help from Staff to Eat Meals	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
WCM1 - WHH CAMBRIDGE M1 WARD	100.0	1	5	48.8	0	0	1	0	48	87	6.7	25.0	42	61.3	N/A	N/A	N/A
WCM2 - WHH CAMBRIDGE M2 WARD	100.0	1	6	85.0	0	0	0	67	57	100	0.0	33.3	11	85.7	101	101	6
WKC2 - WHH KINGS C2 WARD	NULL	2	9	100.0	0	0	2	0	0	NULL	NULL	NULL	NULL	NULL	72	71	5
WOXF - WHH OXFORD WARD	100.0	1	2	96.8	0	1	0	0	30	100	0.0	50.0	13	94.0	99	121	8
WRSU - WHH RICHARD STEVENS WARD	100.0	0	4	100.0	0	0	0	0	43	87	0.0	50.0	17	78.2	100	112	8
S&A (Surgery & Anaesthetics)																	
WITU - WHH INTENSIVE CARE UNIT	100.0	5	0	96.5	0	0	0	40	N/A	N/A	N/A	NULL	NULL	110.9	106	93	29
WKA2 - WHH KINGS A2 WARD	100.0	4	4	100.0	1	1	0	157	63	100	0.0	50.0	74	108.4	109	125	6
WKB - WHH KINGS B WARD	100.0	2	1	100.0	0	0	0	179	73	98	0.0	25.0	70	97.8	114	107	6
WKC1 - WHH KINGS C1 WARD	100.0	0	4	NULL	0	0	0	204	53	100	0.0	50.0	85	86.4	115	102	6
WKDF - WHH KINGS D FEMALE	94.4	5	3	100.0	0	0	1	251	51	100	0.0	50.0	92	100.8	N/A	N/A	N/A
WKDM - WHH KINGS D MALE	100.0	5	3	96.7	0	0	0	0	35	96	4.3	50.0	89	N/A	113	109	7
WSEAU - WHH SEAU	N/A	0	0	NULL	0	0	0	0	64	96	0.0	NULL	NULL	133.8	N/A	N/A	N/A
WSURA - WHH SURGICAL ADMISSIONS LO	N/A	0	0	NULL	0	0	0	0	N/A	N/A	N/A	NULL	NULL	105.6	N/A	N/A	N/A
SHN (Surgery Head & Neck)																	
WROT - WHH ROTARY WARD	100.0	1	2	100.0	0	0	1	29	42	100	0.0	33.3	51	95.1	98	106	7
UEC (Urgent and Emergency Care)																	
WAMUB - WHH ACUTE MEDICAL UNIT B	100.0	3	5	NULL	0	1	0	33	NULL	NULL	NULL	NULL	NULL	71.9	NULL	NULL	NULL
W&C (Womens and Childrens)																	
FF - WHH FOLKESTONE WARD	NULL	0	0	52.9	0	0	1	0	N/A	N/A	N/A	50.0	50	89.5	91	88	34
WKEN - WHH KENNINGTON WARD	100.0	0	1	NULL	0	0	1	0	27	90	10.0	33.3	75	73.9	97	122	6
WPAD - WHH PADUA WARD	100.0	0	0	NULL	0	0	1	1	10	100	0.0	NULL	NULL	76.1	89	109	6
WSCBU - WHH THOMAS HOBBS NEONATA	100.0	0	0	100.0	0	0	1	0	N/A	N/A	N/A	NULL	NULL	96.9	88	83	15

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FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS **18/138.2**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 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 MARCH 2019** - **APPENDIX 2: HIGHEST MITIGATED STRATEGIC RISKS DATED 01 MARCH 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 March 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 07 February 2019. 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 26 February 2019.

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 (23)

Strategic Risks (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.

Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register
Changes to residual risk scores

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

Risk Ref.	Risk Title	Residual Score Dec 18	Residual Score Feb 19	Direction of travel	Target Score
SRR 2	Failure to maintain the quality and standards of patient care *Residual score reduced due to external assurance received from the CQC regarding good practice.*	**20 Extreme**	**16 High**		**8 Moderate**

The target score for SRR 16 – Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes has increased from 6 (low) to 8 (moderate). The target score for SRR 8 – Inability to attract, recruit and retain high calibre staff (substantive) to the Trust has decreased from 15 (high) to 8 (low).

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 Dec 18	Residual Score Feb 19	Direction of travel	Target Score
CRR 19	Delays in the cancer pathway of over 100 days *Residual score reduced as the Cancer Improvement Plan is on track with additional funding provided to support redesign of gamma streams. Indicators are above trajectory.*	**20 Extreme**	**12 Moderate**		**8 Moderate**
CRR 48	Challenges in embedding a mature and developed Patient safety culture across Obstetrics and Maternity *Residual score reduced due to improvements in the CQC Inspection in May 18 with 9 areas of outstanding practice reported*	**16 High**	**12 Moderate**		**6 Low**
CRR 40	Lack of robust antenatal and new-born screening programmes *Residual risk score reduced due to the PHE review and robust action plan that is on track for delivery.*	**9 Moderate**	**6 Low**		**6 Low**

CRR 37	Operational impact on RTT of new PAS system post implementation *Residual risk score reduced due to the training and data quality issues initially reported are improving.*	**12 Moderate**	**6 Low**		**6 Low**

Risks approved for closure on the Corporate Risk Register (February 2019 - Clinical Executive Management Group)

3 There were no risks approved for closure at the February 2019 Clinical Executive Management Group.

New Corporate Risks approved by the Clinical Executive Management Group (February 2019)

4 There were no new risks added to the Corporate Risk Register in February 2019.

Risks approved for merging on the Corporate Risk Register

5 There were no risks proposed for merging by the Clinical Executive Management Group.

Key issues for the Board of Directors attention and/or discussion

6 There are no key issues for the Board of Directors attention and/or discussion.

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

FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS **18/138.2**

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.

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: 26 Feb 2019 Latest Review Date: 19 Feb 2019 Latest Review By: Paul Stevens Latest Review Comments: This risk will not be mitigated until the flow through the whole patient pathway can be improved - and this requires a major reduction in the numbers of patients remaining in an acute hospital bed longer than 7 days (currently there are 452 patients with a length of stay >452 days and 149 > 21 days)	06/07/2016	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)	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.	I = 4 L = 3 Moderate (12)
						Accident and Emergency Delivery Board in place Control Owner: Susan Acott	Limited		Review the emergency models of care in both the acute sites to establish if any changes can be made that will have a significant impact on flow at the front door Person Responsible: Richard Kingston To be implemented by: 31 May 2019	Not Set		
						Acute Medical Model in place Control Owner: Syed Gilani	Limited					
						Daily intensive review/bed matching for emergency admissions not placed at time of review Control Owner: Lee Martin	Adequate		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.	
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework Control Owner: Lee Martin	Limited					
						Health Economy Plan in place. Intensive work on relationship management and lateral integrations and partnership working. Control Owner: Lee Martin	Limited		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: 27 Sep 2019	High	**19 Feb 2019** Resolving over crowding in the A&Es is heavily dependent on creating the necessary flow through the whole hospital. Currently over 50% of all beds are occupied by people who have a length of stay greater than 7 days, and c. 150 of these have a length of stay greater than 21 days.	
						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				
						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				

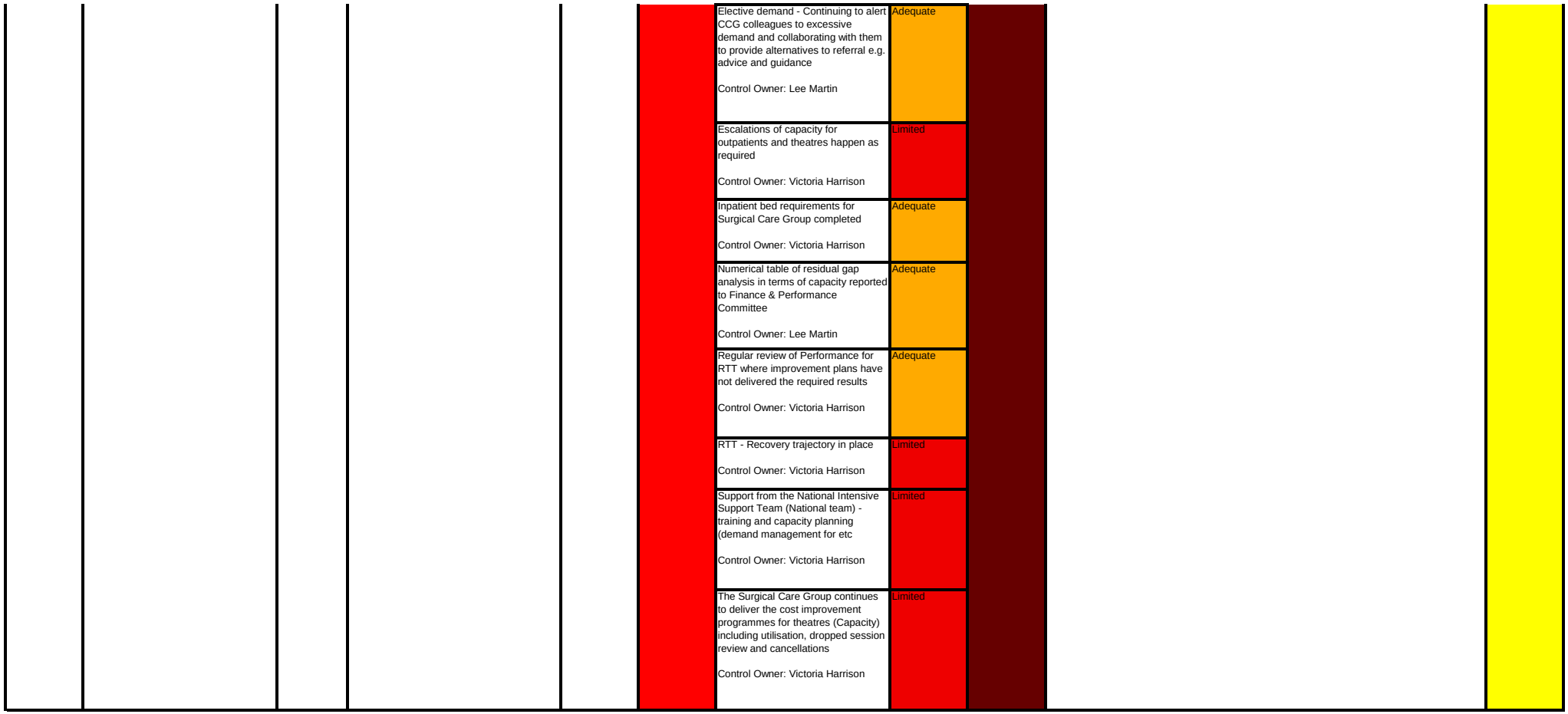
CRR 44	Failure to meet the Referral to Treatment (RTT) Standard for the Trust Risk Owner: Lee Martin Delegated Risk Owner: Vanessa Purday Last Updated: 14 Nov 2018 Latest Review Date: 14 Nov 2018 Latest Review By: Rhiannon Adey Latest Review Comments: RTT Improvement Plan in place Stage 1 - Establish 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	02/02/2017	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		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	
						Escalations of capacity for outpatients and theatres happen as required 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	
						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		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	
						Improved Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots 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	
						Recovery trajectory in place Control Owner: Julie Barton	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.	
						Saturday working in new consultants contracts across the trust to improve utilisation of theatre capacity and increase capacity Control Owner: Julie Barton	Adequate					
						The new Interactive Patient Tracking Technology is in place which allows real time recording of patient pathways and supports the operational teams in delivery Control Owner: 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					
						Validation in place Control Owner: Louise Pallas	Limited					

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: 01 Feb 2019 Latest Review By: Jonathan Purday Latest Review Comments: Each care group should shortly have a governance lead. Currently the D of C is compliant across the old specialist, surgical & CSSD divisions. The medical care groups are still non- compliant to my knowledge but are slowly improving.	20/02/2018	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 Committee 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 Surgery - Head and Neck, Breast and Dermatology Control Owner: Heather Munro	Adequate					
							Duty of Candour Action Plan in place for Urgent and Emergency Care 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					

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: Matthew Pomeroy Last Updated: 22 Feb 2019 Latest Review Date: 09 Oct 2018 Latest Review By: Sally Smith Latest Review Comments: Actions updated and risk reviewed.	18/10/2017	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: 29 Mar 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					

CRR 59	Potential delays in new and follow-up patient appointments Risk Owner: Lee Martin Delegated Risk Owner: Julia Bournes Last Updated: 13 Feb 2019 Latest Review Date: 24 Dec 2018 Latest Review By: Julia Bournes Latest Review Comments: Risk reviewed, no change	06/09/2017	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 * Lack of clinical triage * Lack of clinicians and lack of rooms * Underutilisation of capacity due to lack of booking staff or inconsistent booking processes * DNA rate * Transition to electronic referral system 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)	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.	I = 4 L = 2 Moderate (8)
						Annual right size of outpatient clinic facilities and staffing Control Owner: Julia Bournes	Limited		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	
						Daily use of free slot report to target booking Control Owner: Julia Bournes	Limited		To understand and train the organisation as the transition to the electronic referral system embeds Person Responsible: Julia Bournes To be implemented by: 30 Jun 2019	High		
						Outpatient Improvement Programme in place Control Owner: Christine Hudson	Limited		Review further innovations in patient reminders to reduce DNA's further Person Responsible: Julia Bournes To be implemented by: 31 Oct 2019	High		
						Process in place for data validation Control Owner: Lee Martin	Adequate		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 2019	High	**03 Dec 2018** Improvement work continues to reduce backlog	
						Regular reporting of number of patients in each speciality that are waiting longer to be seen than the specialty milestone Control Owner: James Bennell	Adequate		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 2019	High	**09 Oct 2018** Backlog work continues as part of the improvement plan.	
						Regular review of capacity and demand by specialty reported in performance meetings Control Owner: Lee Martin	Limited		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 2019	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.	
						Robust reminder system in place to reduce DNA rate Control Owner: Julia Bournes	Limited		Surgery and Anaesthetics Care Group to use the follow-up framework to assess their follow-up gap Person Responsible: Victoria Harrison To be implemented by: 31 Dec 2019	High	**03 Dec 2018** Improvement work continues to reduce backlog	
						Weekly KPI meeting to monitor performance Control Owner: Mary Tunbridge	Limited					

									Right size of outpatient facilities and staffing for 2019/20 Person Responsible: Julia Bournes To be implemented by: 31 Mar 2020	High	
									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
									To review booking processes across the Trust, modernise in line with implementation of ERS and centralise where appropriate Person Responsible: Julia Bournes To be implemented by: 31 Mar 2020	High	
									Understand the impact and scale of triage deficiencies and develop an action plan to address Person Responsible: Julia Bournes To be implemented by: 31 Mar 2020	High	
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: 22 Feb 2019 Latest Review Date: 22 Feb 2019 Latest Review By: Lesley White Latest Review Comments: Actions are continuing and being monitored via the RTT Improvement Action Plan and daily report monitoring actual activity. Performance has improved in month as evidenced in the monthly report on the Constitutional Standards to the Quality Committee.	05/02/2016	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 general surgery theatre lists in place Control Owner: Victoria Harrison	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	**22 Feb 2019** Actions are continuing and being monitored via the RTT Improvement Action Plan and daily report monitoring actual activity. Performance has improved in month as evidenced in the monthly report on the Constitutional Standards to the Quality Committee.	I = 3 L = 2 Low (6)
						Additional gynae theatre lists in place Control Owner: Amanda Hallums	Adequate				
						Additional head and neck theatre lists in place Control Owner: Sarah Hyett	Adequate				
						Annual business plan in place Control Owner: Mary Tunbridge	Adequate				
						Daily intensive review/bed matching in place for elective admissions Control Owner: Lee Martin	Adequate		Chronological booking of patients. Person Responsible: Victoria Harrison 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.
						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: Victoria Harrison	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: Victoria Harrison	Limited					
						Inpatient bed requirements for Surgical Care Group completed Control Owner: Victoria Harrison	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: Victoria Harrison	Adequate					
						RTT - Recovery trajectory in place Control Owner: Victoria Harrison	Limited					
						Support from the National Intensive Support Team (National team) - training and capacity planning (demand management for etc Control Owner: Victoria Harrison	Limited					
						The Surgical Care Group continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations Control Owner: Victoria Harrison	Limited					

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: 01 Feb 2019 Latest Review By: Jonathan Purday Latest Review Comments: The clinical strategy is still slowly evolving. It is hoped that we get to public consultation this year.	11/04/2017	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		Implementation of the East Kent Clinical Strategy through the STP process Person Responsible: Elizabeth Shutler To be implemented by: 27 Mar 2020	High	**01 Mar 2019** Public consultation timeline is under review	
						Patients return to the K&C site only once medically optimised Control Owner: Lee Martin	Adequate					
						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					
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.	21/08/2017	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)	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.	I = 4 L = 1 Low (4)
						4Risk Training resources in place (training videos, guidance and help manuals) Control Owner: Helen Goodwin	Adequate		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	**01 Feb 2019** Draft JD out for consultation for Governance managers in each Care Group to support senior leaders. Further training planned for Care Groups in line with the CQC must do actions.	
						Annual Risk Management Refresher Training/Workshop for Care Group Leaders Control Owner: Helen Goodwin	Limited					
						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					
						Dedicated Risk Management resource in place for the Trust (at Corporate level) 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.	
						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				
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.	10/10/2017	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)	To agree the roll out plan for T3 for each area of functionality. Person Responsible: Lindsey Shorter To be implemented by: 30 Apr 2019	Not Set	**12 Feb 2019** Paper with proposal for roll out plan to be presented at CEMG on 13/2/19.	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		To agree the resources and requirements from the Care Groups and Corporate areas in relation to a safe deployment of T3. Person Responsible: Lindsey Shorter To be implemented by: 28 Jun 2019	Not Set		
						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		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.	
						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				

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: 01 Feb 2019 Latest Review Date: 26 Feb 2019 Latest Review By: Sally Smith Latest Review Comments: Risk actions have been reviewed.	07/11/2016	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	**01 Feb 2019** Safeguarding team visiting key wards and teaching use of SMART + tool.	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		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	**26 Feb 2019** Work is still in progress.	
						Dementia friendly services, environment and specialist team Control Owner: Sally Smith	Adequate					
						Increase in cover arrangements for a 12 hour period across all 3 sites in place Control Owner: Lee Martin	Adequate		CQC registration is being explored. Person Responsible: Sally Smith To be implemented by: 31 Mar 2019	Medium	**26 Feb 2019** Discussions are taking place. Prioritisation of the actions we need to undertake is underway before registering.	
						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		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.	
						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		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	**01 Feb 2019** Training now taking place and money has been made available to KMPT for a 3 month pilot to improve ways of working in EDs.	
						Regular escalation and meeting between the Trust COO and the COO of KMPT and the CCG is in place. 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	**26 Feb 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.	
						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					
						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					
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: 01 Feb 2019 Latest Review By: Jonathan Purday Latest Review Comments: The 2019 job planning round will be opening shortly. Job planning is still slowly progressing across the Trust.	02/02/2017	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 19	Delays in the cancer pathway of over 100 days Risk Owner: Lee Martin Delegated Risk Owner: Sarah Collins Last Updated: 22 Feb 2019 Latest Review Date: 22 Feb 2019 Latest Review By: Lesley White Latest Review Comments: Risk updated	24/04/2016	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 = 4 L = 3 Moderate (12)	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	**22 Feb 2019** Timed pathways for all tumour groups have been reviewed as part of the Cancer Action Plan. A new trajectory for achieving 85% compliance has been agreed to be compliant by 31 March 2019.	I = 4 L = 2 Moderate (8)
						Diagnostic capacity is reviewed at the KPI meeting and also within the Clinical Support Care Group Control Owner: Elizabeth Mount	Limited					
						Director led daily oversight and escalation of all patients over 73 days. Process outlined for clinicians to complete initial screening of pathway delays Control Owner: Andrew Nordin	Adequate		Complete accredited training for surgeons undertaking endoscopy Person Responsible: Richard Kingston To be implemented by: 31 Mar 2019	High	**22 Feb 2019** Accredited training for surgeons undertaking endoscopy on track to be completed by end of financial year.	
						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		Urology team to implement improvement action plan. Person Responsible: Elizabeth Mount To be implemented by: 31 Mar 2019	High	**22 Feb 2019** Improvement action plan on track to be completed by end of financial year.	
						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		Implement cancer 62 day treatment recovery plan. Person Responsible: Elizabeth Mount To be implemented by: 31 Mar 2019	High	**22 Feb 2019** Timed pathway for all tumour groups have been reviewed as part of the Cancer Action Plan. A new trajectory for achieving 85% compliance has been agreed to be compliant by 31 March 2019.	
						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				
						WHH endoscopy unit JAG accredited Control Owner: Lisa Neal	Substantial				
CRR 16	Poor complaints management Risk Owner: Sally Smith Delegated Risk Owner: Jane Christmas Last Updated: 12 Feb 2019 Latest Review Date: 12 Feb 2019 Latest Review By: Sally Smith Latest Review Comments: Action updates undertaken. Additional assurance reviews added in.	24/04/2016	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	**01 Feb 2019** Action plan reviewed and refreshed. Progress against agreed metrics reviewed weekly by the deputy chief nurse and head of PET. Improvement in metric outcome (response within agreed time frame) reported for the third consecutive month and improvement in acknowledgement within 3 working days. Heightened monitoring (including 2 weekly follow up of all older cases with senior leads for the care group) remain in place. The scope of these meetings has been extended during Jan 2019 to include all complaints 45 + working days (rather than previous 60+ days) and this marks an increase in improvement ambition.	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				
						External review once completed. Control Owner: Sally Smith	Adequate				
						Process is in place to prevent data capture anomalies 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	**01 Feb 2019** Training programme framework identified - implementation pending organisational change (confirmation of governance structures within care groups which is led by the COO). Date not confirmed. Progress monitored monthly by the complaints steering group. Risk to the quality of complaints process has been escalated to the executive lead.
						Regular review of the complaint KPIs with Care Group leads Control Owner: Jane Christmas	Adequate				
						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		Review of the complaints process and make recommendations. Person Responsible: Jane Christmas To be implemented by: 31 Mar 2019	High	**01 Feb 2019** Monitoring against action plan and benchmarking against similar organisations remains in place. Policy completion due end of Q4. Conclusion of a review of Governance teams which support complaints is ongoing led by the COO - timeframe for conclusion and recruitment not currently confirmed. Once completed and recruited to this new governance structure will provide essential capacity to deliver required improvement.
						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		Independent review of the complaints process is being commissioned	Not Set	**12 Feb 2019**

									Person Responsible: Sally Smith To be implemented by: 31 May 2019		The Chief Nurse has made contact with a reviewer expert in complaints management. Terms of Reference and dates for the review are being arranged during February.	
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: 20 Feb 2019 Latest Review By: Lesley White Latest Review Comments: The RTT recovery action plan includes regular monitoring of outpatient letter performance with Operations Directors for Care Groups via PTL meetings and RTT recovery plan review meetings.	24/04/2016	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		
						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					

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: 19 Feb 2019 Latest Review Date: 19 Feb 2019 Latest Review By: Sally Smith Latest Review Comments: Risk reviewed and edited. Assurance added and a new control in place. Residual risk score reduced.	07/02/2017	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: *Potential harm to both pregnant women in our care and neonates * Never Event in maternity within past 12 months.	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Birthing Excellence Support Through Teamwork (BESTT) programme in place. Control Owner: Ursula Marsh	Adequate	I = 4 L = 3 Moderate (12)	Ensure mandatory training is prioritised and staff undertake the required training Person Responsible: Ursula Marsh To be implemented by: 31 Mar 2019	High	**19 Feb 2019** Safeguarding compliant. Stat and Mand monitored monthly and at Consultant appraisal.	I = 3 L = 2 Low (6)
						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		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	**19 Feb 2019** Monthly monitoring and reporting in place. We have replicated the methodology for C&YP services due to its success.	
						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					
						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					
CRR 34	Inadequate Health & Safety (H&S) systems embedded within the Care Groups Risk Owner: Elizabeth Shutler Delegated Risk Owner: Marion Clayton Last Updated: 26 Feb 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.	09/09/2016	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		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 KPIs reported to Board monthly via the IPR Control Owner: Marion Clayton	Adequate					
						H&S module part of mandatory training for all staff Control Owner: Andrea Ashman	Adequate					
						H&S Risks are recorded on Local Risk Registers on 4Risk Control Owner: Ursula Marsh	Limited					
						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	Limited					
						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	Limited					
						Oversight by Trust Board Control Owner: Elizabeth Shutler	Adequate					
						Site based H&S Committee in place Control Owner: Fin Murray	Adequate					
						Site based Health and Safety Teams in place Control Owner: Fin Murray	Adequate					
						Strategic H&S Committee in place Control Owner: Elizabeth Shutler	Adequate					
						Training programme in place Control Owner: Fin Murray	Adequate					

CRR 56	Inadequate critical care capacity Risk Owner: Sally Smith Delegated Risk Owner: Vanessa Purday Last Updated: 14 Nov 2018 Latest Review Date: 27 Feb 2019 Latest Review By: Sally Smith Latest Review Comments: Risk action updated.	02/08/2017	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	**01 Feb 2019** The business case recruitment to additional posts is underway with some success, recruitment is exceeding turn over of staff. However a risk remains that recruitment will be in sufficient by the March planned date to open the additional beds at WHH - this is identified in a separate risk for the care group.	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					

CRR 36	Inadequate Child Safeguarding training compliance Trust-wide Risk Owner: Sally Smith Delegated Risk Owner: Carol Tilling Last Updated: 12 Feb 2019 Latest Review Date: 12 Feb 2019 Latest Review By: Sally Smith Latest Review Comments: Assurance record added and actions updated.	09/09/2016	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)	Adult Safeguarding training delivered by e-Learning with face to face training every 3 years at level 2 (Adult) Control Owner: Helen Goodwin	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	**01 Feb 2019** Care groups have provided Sally Smith with their progress for this action	I = 2 L = 2 Low (4)
						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: Ursula Marsh To be implemented by: 31 Mar 2019	High	**12 Feb 2019** Level 3 compliance is met. Level 1 will be fully compliant by the end of February. Mapping of those staff requiring level 2 training has been undertaken.	
						Improvement plans and trajectory in place (Adult) Control Owner: Sally Hyde	Adequate				
						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: Heather Munro To be implemented by: 31 Mar 2019	High	**22 Feb 2019** Child Safeguarding January 2019 position is: 32 Dermatology K&CH – 3 East Kent ENT Medical Staff – 8 East Kent Maxillo Facial Medical Staff – 9 East Kent Ophthalmology Medical Staff - 3 East Kent Orthoptic Service -1 Admin (H&C) – 2 Optometry Service -3 Rotary ward - 1 Technical and Support Services - 2 Professional groups: Medical staff – 23 (26) AHP, Nurses and Admin – 9 (27) Actions; Individual emails with 121 conversations Allocation of time data with Q&R pack which was reviewed by Chaired by Chief Nurse and attended by Trust medical Director. This is also covered within the CQC monthly report and on the 4 action system under both CCG MD and HoN	
						Monthly training sessions on all sites (Adult) Control Owner: Helen Goodwin	Limited				
						Non compliant staff are known by name on a monthly basis and followed up. Control Owner: Sally Smith	Adequate				
						Safeguarding Teams 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		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	**12 Feb 2019** Due to non compliance in December, the Care Group has identified names for the medical staff who are not compliant to undertake the training. January's figures awaited.	
						Training needs analysis in place at ward/department level (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: Julie Barton To be implemented by: 31 Mar 2019	High	**01 Feb 2019** Vanessa Purday CD and Julie Barton HoN have reviewed the list of staff required to undertake level 2/3 childrens safeguarding training and have asked these staff to complete on line and attended refresher training to deliver >85% compliance by end of February 2019	

									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	**01 Feb 2019** this action will be be reviewed in light of the new intercollegiate document which is due for publication in March 2019	
CRR 47	Inability to prevent deterioration in the number of healthcare associated infections Risk Owner: Paul Stevens Delegated Risk Owner: Valerie Harmon Last Updated: 19 Feb 2019 Latest Review Date: 19 Feb 2019 Latest Review By: Paul Stevens Latest Review Comments: Implicit within the outstanding actions (but unstated) is that infection prevention and control (IP&C) is everybody's responsibility and the IP&C practices and procedures apply to all	07/02/2017	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)	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		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		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	**06 Feb 2019** Action plan is reported to PSB quarterly and following advice from NHSI is structured to follow the Hygiene Code.	
						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		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		
						Infection prevention and control work plan in place which encompasses reporting on indicators, mandatory training etc. Control Owner: Valerie Harmon	Adequate					
						Water Safety Group terms of reference updated in line with the independent review recommendations and Health Technical Memorandum 04-01: Safe water in healthcare premises Control Owner: Finbarr Murray	Adequate					

CRR 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: 26 Feb 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.	23/02/2016	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)	Ensure Medical Devices Group identifies high risk medical equipment and prioritises replacements for 2019/20 Capital allocation. Business Cases to be presented to Strategic Investment Committee for review and challenge to ensure priorities are identified and funded. Control Owner: Marion Clayton	Limited	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 high cost medical equipment in place Control Owner: Marion Clayton	Adequate					
						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 40	Lack of robust antenatal and new-born screening programmes Risk Owner: Sally Smith Delegated Risk Owner: Ursula Marsh Last Updated: 26 Feb 2019 Latest Review Date: 26 Feb 2019 Latest Review By: Sally Smith Latest Review Comments: Residual risk score reduced due to the PHE review and robust action plan that is on track for delivery.	07/11/2016	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 = 2 Low (6)	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	**26 Feb 2019** In place - progress awaited as the date has passed so that the action can be closed.	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		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	**26 Feb 2019** Awaiting update - has been progressed.	
							Antenatal and postnatal screening guidelines incorporating new standards are in place. 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	**26 Feb 2019** Electronic pathway is being implemented.	
							Antenatal Screening administrator in post Control Owner: Sharon Curtis	Limited					
							Antenatal Screening Steering Group in place for all stakeholders of the Screening Programme Control Owner: Rachael Chapman	Limited		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	**26 Feb 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.	
							Electronic referral system for US scan in place Control Owner: Rachael Chapman	Adequate					
							Failsafe system/clerk in place Control Owner: Rachael Chapman	Limited		Deliver the PHE Screening Action Plan Person Responsible: Ursula Marsh To be implemented by: 31 Dec 2019	Not Set	**26 Feb 2019** Action plan is on track for delivery.	
							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	
						Maternity Information Task and Finish Group in place to review the Maternity Pathway Control Owner: Rachael Chapman	Limited	
						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	

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: 01 Mar 2019 Latest Review By: Rhiannon Adey Latest Review Comments: The observation unit at QEQM has reduced the likelihood of the risk and audits of conveyancing will be independently conducted to assist in measuring the frequency.	03/05/2018	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 Staff working within agreed policy, SOPs and clinical guidelines to manage patients safely Control Owner: Tara Laybourne Systems wide, multi agency meetings with commissioners and regulators as part of the ED recovery programme Control Owner: Lee Martin	Limited Limited 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 Mar 2019 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 Mar 2020 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 High High	**01 Mar 2019** QEQMH Observation ward is open. The WHH Observation ward is due to open early March. The Vanguard Theatres are in place and up and running. **01 Mar 2019** Currently there is no funding available, this option will continue to be explored. **09 Oct 2018** Awaiting feedback on aggregated RCA into ambulance activity; responsibility transferred to operational and Care Group management.	I = 3 L = 1 Very Low (3)
CRR 37	Operational impact on RTT of new PAS system post implementation Risk Owner: Lee Martin Delegated Risk Owner: Mary Tunbridge Last Updated: 22 Feb 2019 Latest Review Date: 22 Feb 2019 Latest Review By: Lesley White Latest Review Comments: The RTT Improvement Action Plan, weekly KPI and the fortnightly PAS meeting monitors recovery and provides assurance that the training and data quality issues initially reported are improving.	04/10/2016	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 Lessons learned/Advise received from other Trusts that have implemented PAS Control Owner: Julia Bournes Validation and closure of open old 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 Adequate Adequate	I = 3 L = 2 Low (6)	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 Complete standard operating procedures for data validation Person Responsible: Debbie Lowes To be implemented by: 29 Mar 2019 Maintaining the PAS validation dashboard. Assessing the impact on activity and finance. Person Responsible: Simon Bailey To be implemented by: 29 Mar 2019	High Medium High	**14 Nov 2018** Weekly PAS Steering Committee continues to monitor the PAS validation dashboard including training plans for staff. **14 Nov 2018** Weekly PAS Steering Committee is developing standard operating procedures to improve PAS efficiency **14 Nov 2018** SOPs being developed to improved PAS effectiveness and efficiency.	I = 3 L = 2 Low (6)

Strategic Risks Report (By Residual Risk Ranking)

Report Date	01 Mar 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:** 11 Feb 2019 **Latest Review Date:** 11 Feb 2019 **Latest Review By:** David Baines **Latest Review Comments:** Weekly Care Group meetings now in place to control discretionary spend and monitor Elective, Out patient and Day Case activity trajectory increases to the end of the year lead by L White	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)	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		I = 5 L = 3 High (15)
						Clinical engagement in delivery of CIPs requiring Clinical Practice changes **Control Owner:** Paul Stevens	Limited					
						Contracted ex-Chief Executive to provide challenge to the Care Groups and Executives **Control Owner:** Susan Acott	Substantial		Revise 2019/20 Cost Improvement Plan following review from NHS Improvement **Person Responsible:** Philip Cave **To be implemented by:** 29 Mar 2019	Not Set		
						Cost Improvement Plan for 2019/20 developed **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.	
						Cost Improvement Plan targets in place with workstream in support **Control Owner:** Philip Cave	Adequate					
						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					

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
						Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Philip Cave	Adequate					
						Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Philip Cave	Adequate					
						Programme Support Office (PSO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Philip Cave	Adequate					
						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					
						Weekly Care group Meeting looking at improving run rate or discretionary spend and increasing Elective, Out Patient and Day Case activity trends. **Control Owner:** Lesley White						
						Workforce and Agency Control Group in place **Control Owner:** Andrea Ashman	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:** 13 Feb 2019 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** The risk has been 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					
						Ernst and Young appointed by Clinical Commissioning Groups **Control Owner:** Susan Acott			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.	
						Internal Clinical Strategy Group in place **Control Owner:** Elizabeth Shutler	Adequate					
						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:** 29 Nov 2019	High	**01 Mar 2019** Public consultation timeline is under review	

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 2	Failure to maintain the quality and standards of patient care **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 12 Feb 2019 **Latest Review Date:** 12 Feb 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk score amended. Assurance record updated and a new control and action added.	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 = 4 L = 5 Extreme (20)	Agreed Improvement Plan in place with supporting Care Group plans. **Control Owner:** Sally Smith	Adequate	I = 4 L = 4 High (16)	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	**01 Mar 2019** WHH Observation ward is due to open ealy MArch. QEQM has opened.	I = 4 L = 2 Moderate (8)
						Children and Young People's Improvement Plan is in place. Monthly reporting is in place with assurance visits. **Control Owner:** Sally Smith	Substantial		Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 30 Apr 2019	High	**12 Feb 2019** A refresh of the Quality Strategy is in progress with support from the NHSI Improvement Director. Q3 compliance will be reported in February 19.	
						External Consultancy and NHSI/E support in delivering the improvement programme. **Control Owner:** Lee Martin	Adequate		Implementation of the CYP improvement plan. **Person Responsible:** Sally Smith **To be implemented by:** 31 May 2019	Not Set	**12 Feb 2019** The Children and Young People plan is progressing well with all but 1 action either on track or completed as of February 12th. External assurance from the CCGs has enabled us to assess where we are and what new actions we need to develop as part of the plan.	
						External help from Community Trust, social care, CCGs to deliver improvements in the emergency pathway. **Control Owner:** Lee Martin	Limited					
						Local improvement plan is in place meeting weekly to deliver an improvement plan. **Control Owner:** Lee Martin	Adequate		Implementation of the system wide NHSI/NHSE/CQC - Safety Plan **Person Responsible:** Sally Smith **To be implemented by:** 30 Sep 2019	High	**12 Feb 2019** The oversight meeting that reviews this plan is being refreshed by the chair. The plan will be refreshed at the February meeting.	
						NHSI Improvement Director is working with the Trust. **Control Owner:** Sally Smith	Limited					
						Quality Strategy is in place. **Control Owner:** Sally Smith	Limited		Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 29 Nov 2019	High	**01 Mar 2019** Public consultation timeline is under review	
									Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 01 Sep 2020	High	**12 Feb 2019** The Trust wide plan is being progressed with around 25% of the actions completed. Slippage on three actions is being addressed.	

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:** 18 Feb 2019 **Latest Review Date:** 14 Feb 2019 **Latest Review By:** Simon Hayward **Latest Review Comments:** Awaiting Executive steer for shape and content of 19/20 programme	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)	Care Group Performance Meetings in place to monitor progress against transformational programmes **Control Owner:** Lee Martin		I = 4 L = 4 High (16)	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:** 29 Mar 2019	High	**14 Feb 2019** Regular agenda in place with agreed work streams for 2018/19 - on going discussion in executive on 19/20	I = 4 L = 2 Moderate (8)
						Implementation team in place for the Transformation Programme **Control Owner:** Simon Hayward	Adequate					
						Mark Hackett engaged by the Trust to review quarterly performance and provide external independent feedback to the Chief Executive and Director of Finance on maintaining the financial improvements **Control Owner:** Philip Cave	Substantial					
						Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Andrea Ashman	Adequate					
						Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS hospitals **Control Owner:** Elizabeth Shutler	Adequate					
						Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	Adequate					
						Transformation Improvement Group is in place to ensure programme is delivered **Control Owner:** Susan Acott						

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:** 13 Feb 2019 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** The NHSi BC is being submitted in March as planned. The Trust has allocated c£5m (including the standing £2.2m in PEIC) of its capital to infrastructure repairs across a wide range of patient and staff environments. These are due to complete by the end of March 2019 and are being overseen in a bi-weekly capital meeting chaired by the Deputy CEO. This work includes refurbishments to front of house, public toilets, roofs, staff facilities and plant & equipment. Additionally the Trust has secured £7.8m of SALIX funding to carry out infrastructure repairs to key energy and utilities plant and equipment over the next two years along with a successful application to NHSI of £2.2m worth of capital to replace patient and staff lighting for more reliable, safe and efficient LED technology.	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 Nov 2019	High	**01 Mar 2019** Public consultation timeline is under review	I = 4 L = 2 Moderate (8)
						Interim Estates Strategy in place **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	**13 Feb 2019** The NHSi BC is being submitted in March as planned.	
						Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Adequate					
						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:** Andrea Ashman **Delegated Risk Owner:** Andrea Ashman **Last Updated:** 05 Feb 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)	Revise and implement Care Group 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)	I = 4 L = 2 Moderate (8)
						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		Develop and agree set of KPIs to measure the effectiveness of the People Strategy which will be reported regularly to the SWC **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2019	High	**05 Feb 2019** Completing a review and refresh of the People Strategy to reflect Trust priorities, Clinical Strategy and Transformation journey. Currently in draft with action plans being developed by end Feb 19.	
						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		Develop and implement a plan to recruit nurses and Drs from the UK, Europe and other countries **Person Responsible:** Louise Goldup **To be implemented by:** 30 Apr 2019	High	**05 Feb 2019** Draft recruitment and retention strategy has been developed and will be implemented by 1st April. Procurement process for a dedicated international recruitment agency is underway and is expected to be awarded by 31st March 2019 with campaigns scheduled in Sri Lanka for Specialty Drs in March and nurse, Medical and Sonographer recruitment in June 2019. Established pipeline of Radiographer resources from Italy and this will be offered as a model to STP partners to provide and retina resources for the Region.	
						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					
						Training plans in place in each Care Group / corporate area that supports staff development. **Control Owner:** Andrea Ashman	Adequate		Workforce remodelling plans to introduce new roles, develop and retain staff and meet the clinical needs of the approved Clinical Strategy and 10 year plan. **Person Responsible:** Sarah James-Whatman **To be implemented by:** 30 Aug 2019	Not Set		
									Work as an STP region to agree common values and approach to recruitment and retention for the stability and safety of patient care within the region **Person Responsible:** Louise Goldup **To be implemented by:** 31 Dec 2019	Not Set		
									Corporate retention Group works in partnership with NHSI to monitor and continue to improve Trust retention rates. A particular emphasis needs to be placed on retention plans for Stroke, ED and General Medicine. **Person Responsible:** Sarah James-Whatman **To be implemented by:** 31 Mar 2020	Not Set		

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:** 01 Mar 2019 **Latest Review By:** Rhiannon Adey **Latest Review Comments:** Leadership training is in place for clinical directors and Care Group triumvirate. There are a large number of new managers within the Care Groups which will encourage fresh ideas. Executive level changes are in progress which gives the opportunity to review the roles and requirements.	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		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	
						Deputy Chief Operating Officers appointed with both site and portfolio responsibilities. **Control Owner:** Lee Martin	Limited		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.	
						Director of Finance in place with continuity in delivery of the FSM **Control Owner:** Susan Acott	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.	
						Experienced COO appointed **Control Owner:** Susan Acott	Adequate					
						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					
						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					
						Remuneration Committee meets bi-monthly to review Executive performance **Control Owner:** Susan Acott						
						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					

Q3 BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2018/19 18/138.3

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**7 MARCH 2019**
SUBJECT:	**BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2018/19: QUARTER 3**
BOARD SPONSOR:	**TRUST SECRETARY AND GROUP COMPANY SECRETARY**
PAPER AUTHOR:	**TRUST SECRETARY AND GROUP COMPANY SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES	**APPENDIX 1: BOARD ASSURANCE FRAMEWORK APPENDIX 2: Q3 PERFORMANCE AGAINST THE ANNUAL PRIORITIES 2018/19**

BACKGROUND AND EXECUTIVE SUMMARY

The Board agreed its 2018/19 annual priorities at the April 2018 meeting. As part of good governance the Board Assurance Framework should be reviewed on a quarterly basis. The full Board Assurance Framework is provided as Appendix 1 and the performance against each of the priorities is shown in Appendix 2. As part of this review the following elements are highlighted:

- Risk to the annual priorities – these are contained within the Board Assurance Framework with each risk being aligned with the annual priority it impacts;

- Assurance – there are two ways to look at assurance – the first relates to the level of information going to the Board for discussion so that Board members' are fully sighted on the topic; the second relates to what that assurance shows, for example and audit report may provide positive or negative assurance;

- Performance – each of the annual priorities have a number of objectives and associated metrics and quarterly reporting will show whether the quarter target was met or completed (blue); on track but there is no specific quarterly numeric target (green); delayed but still possible to deliver by the agreed date (amber); not met the quarterly numeric target (red); awaiting external input (grey).

The Board's role is to discuss the assurance levels and possible gaps in assurance to provide feedback to the Executives on the additional evidence / assurance required. Where possible the performance is taken from the Integrated Performance Report (IPR) to ensure we report consistently.

The Board Committees received and discussed their assigned elements of the Board Assurance Framework during February and March 2019 any actions agreed have been highlighted in the report below.

The table below provides an aggregated overview of the annual priorities as at quarter 3. The colour coding for "Performance" – "green" majority on-track; "amber" mixture of on-track / not met. The bracket in the Strategic Risk column indicates the Board's agreed risk appetite (the colour coding relates to whether the aggregated risk score is within the agreed appetite); more detail about the risk appetite is available in the Risk Management Strategy.

Key Points:

- The Patient Priority performance has improved from Amber in quarter 2 to Green in quarter 3;
- Following a discussion at IAGC work was undertaken to implement actions to bring the strategic risks that were out-with the Board's agreed risk appetite back in line.

This has been achieved for the majority of risks except SRR5: Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime and SRR10 Non-delivery of a timely Sustainability and Transformation Partnership that can be resourced. The Finance and Performance Committees oversees these risks and agreed that they had both crystallised.

STRATEGIC OBJECTIVE	PERFORMANCE Aggregated	STRATEGIC RISK Aggregated	ASSURANCE Aggregated
PATIENTS	**GREEN (AMBER)**	**HIGH (HIGH)**	**ADEQUATE**
PEOPLE	**AMBER**	**MODERATE (SIGNIFICANT)**	**ADEQUATE**
PARTNERSHIP	**AMBER**	**EXTREME (SIGNIFICANT)**	**ADEQUATE**
PROVISION	**RED**	**HIGH (MODERATELY HIGH)**	**ADEQUATE**

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The attached Board Assurance Framework reflects the strategic risks facing the Trust and the mitigating actions in place.
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	As highlighted in the report
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 invited to:

- Discuss how performance and assurance achievement relates to risk appetite and treatment ;
- Review the performance against annual priorities; and
- Discuss what additional assurance is required in relation to future delivery /mitigation of risks.

Q3 BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2018/19 18/138.3

QUARTER 3: BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2018/19

The Board agreed its 2018/19 annual priorities at the April 2018 meeting. As part of good governance the Board Assurance Framework should be reviewed on a quarterly basis. The full Board Assurance Framework is provided as Appendix 1 and the performance against each of the priorities is shown in Appendix 2. As part of this review the following elements are highlighted:

- Risk to the annual priorities – these are contained within the Board Assurance Framework with each risk being aligned with the annual priority it impacts;

- Assurance – there are two ways to look at assurance – the first relates to the level of information going to the Board for discussion so that Board members' are fully sighted on the topic; the second relates to what that assurance shows, for example and audit report may provide positive or negative assurance;

- Performance – each of the annual priorities have a number of objectives and associated metrics and quarterly reporting will show whether the quarter target was met or completed (blue); on track but there is no specific quarterly numeric target (green); delayed but still possible to deliver by the agreed date (amber); not met the quarterly numeric target (red); awaiting external input (grey).

The Board is having a development session in March 2019 to review its risk appetite and discuss risk management in general. A number of points were discussed at Committees in relation to general management of risk:

- Should the risk appetite be aligned to a risk area (such as finance, reputation etc) or linked to the overarching strategic objective?
- Should consideration be given to having an issues log as there are a number of risks that have crystallised but require on-going oversight by the Board?
- In terms of lines of assurance, clarity on the RAG rating in the "assurance level" box with a view to using the "gap in assurance" column to identify whether the assurance provided is positive or negative.

PATIENTS

Performance: Improved from quarter 2 from "amber" to "green".

Patient Experience: Overall this is Green having met the Friends and Family Test for Emergency Department and meeting the national benchmark for patient experience. The Trust awaits the outcome of the inpatient survey.

Learning Disabilities: This remains Red as a number of the metrics are still not reported and there is a delay in work to implement best practice guidelines/NCEPOD report on mental health in general hospitals.

Patient Involvement: Ensure that EKHUFT work in partnership with our service users to define, monitor and deliver great care is currently Green with work proceeding as planned. The plan was taken to Patient Experience Group in October 2018 and this should be reviewed by Quality Committee to provide assurance that the first metric for this section can be confirmed as completed.

Patient Safety: Green in terms of embedding a patient safety culture. Work is going well with all elements on plan apart from a slight delay due to the PAS implementation.

CQC – Improvement Journey: Amber due to 2018 CQC report showing little change from the Trust's previous report and the subsequent report on children and young people's services.

The Improvement plan and Quality Strategy need to be aligned. The first metric is complete as the improvement plan is in place.

Work with academic partners: Green, all elements are on plan and good progress being made.

Risk: all patient risks are within the Board's appetite. SRR2 Failure to maintain the quality and standards of patient care – residual risk has moved from 20 to 16 as the likelihood as improved from "almost certain" to "likely".

Assurance: Adequate – there are three "limited" assurances relating to improvements in the ED pathway, namely external support from the Community Trust, NHS Improvement Director working with the Trust and having a Quality Strategy in place.

Quality Committee discussion:
The Committee was pleased to note the improvement in performance against the annual priorities and an improved level of risk.

PEOPLE

Performance: Amber: Total turnover continues to remain on target and green RAG-rated at 12.29%. This is well within the baseline target (13.50%) for 2018/19. Total turnover is currently better than in both 2016/17 (12.33%) and 2017/18 (12.77%), which signals a promising overall improvement.

Nursing turnover remains red RAG-rated at 18.18% against our baseline of 10%. However, it is worth noting this is an improvement on the last quarter (18.34%) and that nurse turnover is considerably improved against last year, which was 25%.

There remains greater work to be done to continue this improvement. The Trust has just reviewed and audited its Retention Strategy:

- Launched the Corporate Retention Group on 30th Nov 2018. A clinically-led, predominantly nurse retention focused working group that has developed a comprehensive set of objectives to tackle the turnover challenge. This group will meet bi-monthly and apply the latest learning and research from colleagues locally and nationally, working with NHS Improvement and NHS Employers.
- The Trust has voluntarily joined the NHSI Retention Direct Support Programme and is attending master-classes in retention starting 31st Jan 2019, with a Trust visit planned in both February and March.
- The Trust is also continuing to work with NHS Employers, learning from the latest national initiatives and will be attending training in Leeds on 30th Jan 2019.

Risk: Aggregated risk has improved from High to Moderate due to the likelihood of SRR8 (Inability to attract, recruit and retain high calibre staff (substantive) to the Trust) reducing from likely to possible as the actions start to impact on improved recruitment and retention. This has brought both risks within the Trust's risk appetite.

Assurance: Adequate – there are a number of "limited" assurances but actions are in place to address these, however, the Committee may wish to consider whether other assurances are required**.**

Strategic Workforce Committee
The Committee noted the improvements in risk level due to continued action; it was noted that the metric for the staff engagement priority would not be reported until April 2019.

Q3 BOARD ASSURANCE FRAMEWORK AND ANNUAL PRIORITIES 2018/19 18/138.3

PARTNERSHIP

Performance: Amber although an improving picture on quarter 2 – the main changes are:

- Work with partner organisations to develop an east Kent Accountable Care Partnership / Integrated Care System; has moved from "amber" to "green" in this quarter with the MOU signed (showing now as completed) and the appointment of a joint clinical director for frailty.
- 2gether support solutions, now showing as completed
- Kent Care Record and the programme around pathology partnership has moved from "green" in quarter 2 to "amber " in quarter 3 due to delays from other stakeholders in confirming they wish to proceed although the completion date can still be met.

Risk: extreme (no change from Q2) as delays continue in terms of delivery of the STP; this is higher that the Board's agreed risk appetite and the Committee may wish to discuss other actions / assurances to reduce the residual risk score.

Assurance: Adequate (no change from Q2), the East Kent Programme Board level of assurance remains as "limited" due to delay in action and decision making.

PROVISION

Performance: Overall – Red

Financial: Red (Amber in Q2)

- Income: achievement against plan - "The Trust planned for a reduction in income over the quarter particularly in December where historically patients do not wish to have elective and outpatient procedures and sessions are reduced over the Christmas break. The Trust has been over achieving its income targets all year due to high non elective and A&E activity out performing lower than expected levels of elective and outpatient activity. In November and December further increases in elective activity were planned to address waiting lists. The additional elective activity has not been delivered but operations are reviewing what additional internal capacity can be put in place in Q4.
- Expenditure: achievement against plan - The Trust has been over spending most of the year, the overspend is driven by the requirement for unplanned Agency and Bank Doctors and Nurses. The requirement has been driven as ED and A&E activity has remained higher than planned all year. To address both this activity and the Trusts lower than planned A&E targets additional temporary resource has been put in place which has driven up costs.
- Cost Improvement Programme: achievement against plan - Although CIPs were behind plan in October and November this is related to the timing of CIP delivery and total year to date CIPS have been ahead of the year to date plan all quarter. Although some schemes have failed to deliver as expected e.g. patient flow 2 (reductions of LOS) other schemes have more than made up for the shortfall producing a year to date over delivery of £1.4m by the end of December. The proportion of non-recurrent schemes is quite high at 38% the Trust will need to address this in 2019/20.

Emergency Department: Amber (Red in Q2), this reflects an improvement in bed occupancy and the feedback from the Friends and Family Test for ED. However as the Committee will be aware performance against the access standard, number of patients seen by a clinician in the first hour and the emergency re-admission rate remains off trajectory. The Committee will receive its usual update on January's performance which will contain the actions being taken to improve the performance.

Risk: Aggregated risk is out-with the Board's appetite which reflects the risks outlined to the Board in relation to delivery of the Trust's Operational Plan, SRR5 Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime. Weekly Care Group meetings now in place to control discretionary spend and monitor Elective, Out-

patient and Day Case activity trajectory increases to the end of the year lead by Director of Performance.

Assurance: Adequate – there are three “limited” assurances in the financial risk – again this reflects the concerns identified around another significant CIP target, meeting the trajectory to improve access standards and the concerns around the effectiveness of agency control.

Finance and Performance Committee discussion

The Committee monitor the performance against the Provision priority on a monthly basis and during the meeting there were a number of actions discussed in respect of improving both the financial position and operational performance in the access standard for the emergency department. Two of the three strategic risks had crystallised and it was agreed to include a discussion on this at the Board Development session in Match 2019.

Board Assurance Framework

Report Date	28 Feb 2019
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	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	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	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 2	Failure to maintain the quality and standards of patient care **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 12 Feb 2019 **Latest Review Date:** 12 Feb 2019 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk score amended. Assurance record updated and a new control and action added.	**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	I = 4 L = 5 Extreme (20)	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 = 4 L = 4 High (16)	Delivery of the emergency pathway improvement work. Actions as per CRR 28 & 61 **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	**12 Feb 2019** **Sally Smith** New pathway work is being embedded. WHH Observation ward is due to open imminently during February 19.	I = 4 L = 2 Moderate (8)	Quality Committee
				Children and Young People's Improvement Plan is in place. Monthly reporting is in place with assurance visits. **Control Owner:** Sally Smith	Care Group audits		External assurance visits have shown improvement.	Substantial			Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 30 Apr 2019	**12 Feb 2019** **Sally Smith** A refresh of the Quality Strategy is in progress with support from the NHSI Improvement Director. Q3 compliance will be reported in February 19.		
				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			Implementation of the CYP improvement plan. **Person Responsible:** Sally Smith **To be implemented by:** 31 May 2019	**12 Feb 2019** **Sally Smith** The Children and Young People plan is progressing well with all but 1 action either on track or completed as of February 12th. External assurance from the CCGs has enabled us to assess where we are and what new actions we need to develop as part of the plan.		
				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.						
				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			Implementation of the system wide NHSI/NHSE/CQC - Safety Plan **Person Responsible:** Sally Smith **To be implemented by:** 30 Sep 2019	**12 Feb 2019** **Sally Smith** The oversight meeting that reviews this plan is being refreshed by the chair. The plan will be refreshed at the February meeting.		
				NHSI Improvement Director is working with the Trust. **Control Owner:** Sally Smith				Limited			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	**12 Feb 2019** **Sally Smith** The impact of the different options are being reviewed during February 19. Consultation is still expected in the Autumn.		
				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						

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
											Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 01 Sep 2020	**12 Feb 2019** **Sally Smith** The Trust wide plan is being progressed with around 25% of the actions completed. Slippage on three actions is being addressed.		

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	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:** 13 Feb 2019 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** The NHSi BC is being submitted in March as planned. The Trust has allocated c£5m (including the standing £2.2m in PEIC) of its capital to infrastructure repairs across a wide range of patient and staff environments. These are due to complete by the end of March 2019 and are being overseen in a bi-weekly capital meeting chaired by the Deputy CEO. This work includes refurbishments to front of house, public toilets, roofs, staff facilities and plant & equipment. Additionally the Trust has secured £7.8m of SALIX funding to carry out infrastructure repairs to key energy and utilities plant and equipment over the next two years along with a successful application to NHSI of £2.2m worth of capital to replace patient and staff lighting for more reliable, safe and efficient LED technology.	**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	**13 Feb 2019** **Elizabeth Shutler** PCBC now due for circulation to NHSI and NHSE March 2019.	I = 4 L = 2 Moderate (8)	Quality Committee
				Interim Estates Strategy in place **Control Owner:** Elizabeth Shutler	*Approved by Clinical Executive Management Group	- Strategy approved by the Trust Board - New NED in place to provide challenge		Adequate			The Trust has engaged with NHSI to agree priorities to spend in 18/19 and 19/20. This is with a view to reduce the Trust Backlog position further. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020	**13 Feb 2019** **Elizabeth Shutler** The NHSi BC is being submitted in March as planned.		
				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	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	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	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
SRR 8	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust **Risk Owner:** Andrea Ashman **Delegated Risk Owner:** Andrea Ashman **Last Updated:** 05 Feb 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.	**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)	Revise and implement Care Group Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 29 Mar 2019	**22 Jan 2019** **Jane Waters** 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)	I = 4 L = 2 Moderate (8)	Strategic Workforce Committee
				Care Group Great Place to Work Action Plans in place **Control Owner:** Jane Waters	- Plans available for all to access on Staff zone - Reviewed at the Care Group Business Boards	Progress of Plan reviewed quarterly at Clinical Executive Management Group and annually at the Strategic Workforce Committee		Adequate	Action Plan requires updating following receipt of the Annual NHS Staff Survey Results		Develop and agree set of KPIs to measure the effectiveness of the People Strategy which will be reported regularly to the SWC **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Mar 2019	**05 Feb 2019** **Sarah James-Whatman** Completing a review and refresh of the People Strategy to reflect Trust priorities, Clinical Strategy and Transformation journey. Currently in draft with action plans being developed by end Feb 19.		
				Hard to recruit plan in place and being implemented **Control Owner:** Louise Goldup	*Updated fortnightly by the Resourcing team *Sent to the HRBPs on a monthly basis	*Signed off at the end of July 2017 *Reported monthly as part of the high level CQC improvement plan		Adequate	Plan may not be progressing					
				Implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Discussed at the Workforce CIP meeting	Regularly reviewed at SWC (deep dives on Turnover and Exit information)		Adequate						
				Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Highlight Occupational Health reports Director and Deputy Director of HR Exit Interviews and Picker Survey reports highlight areas of concerns	Occupational Health Reports to SWC quarterly		Adequate						
				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	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
				Revised recruitment process has been implemented **Control Owner:** Andrea Ashman				Adequate			Develop and implement a plan to recruit nurses and Drs from the UK, Europe and other countries **Person Responsible:** Louise Goldup **To be implemented by:** 30 Apr 2019	**05 Feb 2019** **Sarah James-Whatman** Draft recruitment and retention strategy has been developed and will be implemented by 1st April. Procurement process for a dedicated international recruitment agency is underway and is expected to be awarded by 31st March 2019 with campaigns scheduled in Sri Lanka for Specialty Drs in March and nurse, Medical and Sonographer recruitment in June 2019. Established pipeline of Radiographer resources from Italy and this will be offered as a model to STP partners to provide and retina resources for the Region.		
				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					
											Workforce remodelling plans to introduce new roles, develop and retain staff and meet the clinical needs of the approved Clinical Strategy and 10 year plan. **Person Responsible:** Sarah James-Whatman **To be implemented by:** 30 Aug 2019			
											Work as an STP region to agree common values and approach to recruitment and retention for the stability and safety of patient care within the region **Person Responsible:** Louise Goldup **To be implemented by:** 31 Dec 2019			

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
											Corporate retention Group works in partnership with NHSI to monitor and continue to improve Trust retention rates. A particular emphasis needs to be placed on retention plans for Stroke, ED and General Medicine. **Person Responsible:** Sarah James-Whatman **To be implemented by:** 31 Mar 2020			

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	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:** 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	**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:** Steven Smith	Objectives agreed with the Chairman	Reports to the Board	Liaised with NHS Improvement	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	**22 Jan 2019** **Jane Waters** 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)	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			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			
				Care 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)		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		
				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						
				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			Design and deliver the Executive Development and Leadership Development Programme **Person Responsible:** Andrea Ashman **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.		
				Experienced COO appointed **Control Owner:** Susan Acott	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			Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Dec 2019	**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.		
				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					
				External training of Board aligned with the Well-led CQC standards. **Control Owner:** Alison Fox		Good Governance Institute undertaking training of the BoD		Adequate	One member of the BoD has resigned and a recruitment process for a replacement will be required.					

Board Assurance Framework

AO2: People: Identify, recruit and develop talented staff

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				Leadership Development Plans and targeted development plans for individuals in place (Capability) **Control Owner:** Andrea Ashman	- 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:** Andrea Ashman	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

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				Recent appointment to two key posts in the Trust below Executive Director level (Capability) **Control Owner:** Andrea Ashman	*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:** Andrea Ashman	* 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:** Andrea Ashman				Limited						
				Systems in place through the Nominations and Remuneration Committee for all Board level recruitment **Control Owner:** Andrea Ashman		Functional Nomination and Remuneration Committee with Board level reporting		Adequate						
				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

Board Assurance Framework

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

Risk Ref	Risk Title	Cause & Effect	Inherent Risk Score	Risk Control	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	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	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	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:** 11 Feb 2019 **Latest Review Date:** 11 Feb 2019 **Latest Review By:** David Baines **Latest Review Comments:** Weekly Care Group meetings now in place to control discretionary spend and monitor Elective, Out patient and Day Case activity trajectory increases to the end of the year lead by L White	**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)	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		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 for 2019/20 developed **Control Owner:** Philip Cave			Sign off of plan by NHSI	Adequate			Revise 2019/20 Cost Improvement Plan following review from NHS Improvement **Person Responsible:** Philip Cave **To be implemented by:** 29 Mar 2019			
				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			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 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			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 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			Develop Trust wide financial culture training for budget holders **Person Responsible:** Philip Cave **To be implemented by:** 28 Jun 2019	**09 Jan 2019** **Rhiannon Adey** 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.		
				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						
				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	**09 Jan 2019** **Rhiannon Adey** New Finance Director appointed for East Kent CCGs. Meeting arranged for January to begin developing relationships.		
				HFMA training available for staff across the Trust **Control Owner:** Andrea Ashman				Adequate						

Board Assurance Framework

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

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		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		Improved Business Planning process in place for 2019/20 **Control Owner:** Philip Cave				Adequate						
				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						
				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					

Board Assurance Framework

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				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						
				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						
				Weekly Care group Meeting looking at improving run rate or discretionary spend and increasing Elective, Out Patient and Day Case activity trends. **Control Owner:** Lesley White	Presentations of action items				change in KPIs proving improvement in run rates					
				Workforce and Agency Control Group in place **Control Owner:** Andrea Ashman	Chaired by Director of HR	Monthly review by FIC		Limited						

Board Assurance Framework

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

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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:** 18 Feb 2019 **Latest Review Date:** 14 Feb 2019 **Latest Review By:** Simon Hayward **Latest Review Comments:** Awaiting Executive steer for shape and content of 19/20 programme	**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)	Mark Hackett engaged by the Trust to review quarterly performance and provide external independent feedback to the Chief Executive and Director of Finance on maintaining the financial improvements **Control Owner:** Philip Cave	Reports to the Chief Executive	Independent assessment of all financial information including discussions with Exec team and senior leadership teams		Substantial		I = 4 L = 4 High (16)	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:** 29 Mar 2019	**14 Feb 2019** **Simon Hayward** Regular agenda in place with agreed work streams for 2018/19 - on going discussion in executive on 19/20	I = 4 L = 2 Moderate (8)	Board of Directors
				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:** Andrea Ashman	Implementation plan in place and completed for Phase . Alignment review completed and shared with NHSI	EMT workshops held between February and April 2017 to agree transformation work-streams linked to financial recovery CIPs and annual priorities.		Adequate						
				Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS 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.					
				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					

Board Assurance Framework

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

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

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	Control Assurance (1st Line)	Control Assurance (2nd Line)	Control Assurance (3rd Line)	Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score	Reporting Committee
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:** 13 Feb 2019 **Latest Review By:** Elizabeth Shutler **Latest Review Comments:** The risk has been 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:** 31 Jul 2019	**16 Jan 2019** **Elizabeth Shutler** New time line has been proposed by CCGs.	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 Nov 2019	**13 Feb 2019** **Elizabeth Shutler** Consultation now planned for November 2019.		

PATIENT 2018/19

Exec Lead			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	**Chief Nurse**	FFT for ED - from IPR	85%	80.60%	85%	83.20%	85%	85.50%	85%	80.00%	85%	83.70%	85%	80.10%	85%	83%	85%	85.60%	85%	85.40%						
We will improve patient experience	**Chief Nurse**	Monthly survey against national benchmark	90	91.1	90	91.4	90	91.1	90%	91.90%	90%	89.80%	90%	90.10%	90%	91%	90%	91.80%	90%	91.70%						
		Annual inpatient survey against national benchmark	Annual reporting -						National benchmark 82.3%	80%					Annual report - awaiting outcome											
Promote effective care to patients with mental health needs and Learning Disabilities	**Paul Stevens**	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.**				**Mapping against NCPOD guidance delayed but in progress completion anticipated end of Mrach 2019. In the meantime action underway to scope mental health training requirements. Training programme identified through hubs on all 3 acute sites to increase staff capability. TNA in development - completion scheduled by year end.**									
	Medical Director	Improved mortality rates	**An audit was carried out in 2015 in relation to mortality rates and a repeat audit is scheduled for February 2019.**																							
	Medical Director	Improved length of stay																								
	Medical Director	Improved readmission rates																								
Ensure that EKHUFT work in partnership with our service users to define, monitor and deliver great care	**Chief Nurse**	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.**						**Completed but evidence needs to be presented through Quality Committee to Board**									
	Chief Nurse	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).**						**Prerred model identified with service user involvement. Patient involvement strategy (including implentation and communication plan) on track for completion as planned.**									
Embed a patient safety culture	**Medical Director**	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.**						**Tool being tested in Paediatrics as the pilot area. Desktop icon/Zenworks icon in place for wider Trust roll out. Funding stream identified for data analysis and staff training however, this is in addition to the current project plan, which remains on target.**									
Deliver on our CQC Improvement journey	**Chief Nurse**	**improvement plan completion**	**Improvement plan cleansing underway**						**Work is in place to integrate CQC improvement milestones into the Trust Quality Strategy**						**Improvement Plan completed – narrative – superseded by May 18 inspection – actions still in progress have been integrated into the new plan**									
	Chief Nurse	subsequent CQC inspections	**Outcome of May and June 2018 visit(s) awaited**								**Remains "Requires Imrovement"**				**Remains "Requires Imrovement"**											
Strengthen engagement with our academic partners	**Medical Director**	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**						**Requirement sligning to Trust options 1 and 2 provided to Strategic Development**									
	Medical Director	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.**						**No response to November 2018 call. A further call was put out in January 2019. Too early to expect conversations from RSS awards to external grant funding awards.**									
	Medical Director	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.**						**As in quarter 2.**									

Exec Lead			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	**Director of HR**	Staff FFT / National Staff Survey (baseline)	Not available in Q1 - annual report						Not available in Q2 - annual report						Not available in Q3											
	Director of HR	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						FFT not run in Q3 due to Staff Survey running											
	Director of HR	Work (43%)	50%	48%	50%	48%																				
Staff retention: Retain skilled and experienced staff to provide continuity of person centred care	**Director of HR**	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	13.50	12.20	13.50	12.15	13.50	11.96						
	Director of HR	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	10.00	13.02	10.00	17.65	10.00	25.33						
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																							

PARTNERSHIP 2018/19

		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.			There has been an agreement to joinly appoint a clinical director for frailty and integration. Interviews are scheduled for mid-February. There is lots of work taking place to develop frailty pathways and it is felt that the appointment of a clinical director will assist with progressing this work.					
	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			The MOU was agreed and signed off.					
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.			In the absence of a finalised PCBC, the Trust has met with the regional Estates and Facilities lead to agree the in scope patient and staff focused backlog maintenance. This has resulted in a draft BC being developed for an application in Q4 for £32.4m. Additionally the Trust has been successful at securing SALIX funding (c£8m) for a wide range of replacement energy infrastructure on our sites along with a pre-ward of £2.2m from NHSi to fund LED projects. In addition, the Trust is working with NHSI to progress the business case for an elective orthopaedic centre. The Trust continues to develop its costs for both remaining options and has worked with Deloitte to agree a series of pre-coditions required for any future developer partnership.					
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.			Detailed work is underway to provide the necessary evidence to support the evaluation of the medium list of options. Evaluation Panels will then be convieved to evaluate the medium list options using the evidence to produce a shortlist of options or preferred option. The PCBC can then be finalised ready for the NHS England Stage 2 Assurance process to be undertaken. Formal Public Consultation will commence. This is currently scheduled for November					
	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.			The expansion of the two A&E departments at William Harvey Hospital and at Queen Elizabeth The Queen Mother Hospital has been completed. The timeline for the production of the PCBC is as outlined 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).			Work on the production of the business case for a single Pathology system continues. The Strategic Outline case was completed and presented to all 4 acute Trusts Boards in December and January. This was approved by MTW and EKHUFT. The Programme is now moving to a more detailed planning process which includes the development of Outline Business Cases for service change. Working towards establishing a single Laboratory Information Management System (LIMS) and a single managed equipment service contract. In order to ensure broad representation of views and ideas we have also refreshed the Governance arrangements for the Programme.					
	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.			2gether Support Solutions is a functioning compnay with its own Chairman/Board and MD. The company engages with the Trust as shareholder and main customer via monthly partnership group meetings, bi-monthly Subsidiary Performance Review (SPR) meetings and Quarterly Board to Board meetings. Additionally the Trust has appointed an Intenigent Clinet to oversee the contractual relationship between the company and the Trust.					
	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			The process was slightly delayed as a result of the complexity of obtaining confirmation to proceed from all stakeholders involved. The requirements have been progressively refined and the timescales for the next phase agreed. Still expecting May 2020 for first live use of the system.					

PROVISION 2018/19

Exec Lead			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	**COO**	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%	87.37%	80.89%	89.88%	81.74%	88.58%	79.36%						
	COO	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%	55%	51%	55%	53%	55%	49%						
	COO	Bed occupancy (performance)	95%	100%	95%	101%	95%	95.80%	95%	94.11%	95%	94.75%	95%	95.94%	95%	96.40%	95%	93.28%	95%	93.66%						
	COO	Friends and Family test (ED) (quality)	85%	80.60%	85%	83.20%	85%	85.50%	85%	80.90%	85%	83.75%	85%	80.13%	85%	83.00%	85%	85.58%	85%	85.36%						
	COO	Emergency re-admission rate (quality)		9.61%		9.08%		9.29%		9.8%		9.8%		8.6%		9.8%		9.6%		9.5%						
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	**DoF**	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	£50.8m	£51.2m	£49.9m	£49.6m	£46.8m	£46.7m						
	DoF	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	£49.6m	£52.8m	£49.4m	£51.2m	£48.7m	£51m						
	DoF	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	£2.9m	£2.8m	£2.9m	£2.8m	£2.9m	£4m						
CONTRIBUTION: Increase the contribution of particular services	**COO**	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						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									
	COO	Gastro / endoscopy																								
	COO	Trauma and orthopaedics																								
	COO	Vascular																								
	COO	ENT																								
	COO	Obstetrics and Paediatrics																								