REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM SEPTEMBER 2018

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)** Substantive Chief Executive at Dartford and Gravesham NHS Trust (DGT). A memorandum of understanding has been signed to mitigate the risks with the substantive role and the interim role. No longer a Board member at DGT. Discussed and accepted at the Board meeting held on 6 October 2017 **(5)**	Appointed 1 April 2018
ADEUSI, SUNNY	Non Executive Director	None	1 November 2015 (First term)
CAVE, PHILIP	Director of Finance and Performance Management	Wife works as a Senior Manager for 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)**	1 September 2014

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM SEPTEMBER 2018

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) **(1)**	(First term) 1 July 2017
MARTIN, LEE	Chief Operating Officer	None	Interim from May 2018 Substantive from August 2018
OLLIS, JANE	Non Executive Director	Quvium UK **(1)** The Heating Hub **(1)** Board Member of the Kent Surrey Sussex Academic Health Science Network (AHSN) **(1)**	8 May 2017 (First term)
PALMER, KEITH	Non Executive Director	Managing Director of Silverfox Consultancy Ltd **(1)** Sole shareholder of Silverfox Consultancy Ltd **(3)** 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	January 2004
SMITH, SALLY	Chief Nurse and Director of Quality	Nil	Interim from 1 April 2015 Substantive from 28 July 2015

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM SEPTEMBER 2018

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)**	June 2013
WILDING, BARRY	Senior Independent Director	Trustee of CXK, a Charity in Ashford inspiring people to thrive **(4)**	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 EIGHTY-SEVENTH MEETING OF THE BOARD OF DIRECTORS THURSDAY 6 SEPTEMBER 2018 AT 9.45 AM IN SEMINAR ROOMS 1 & 2, BUCKLAND HOSPITAL, DOVER

PRESENT:

Professor S Smith	Chair	StS
Ms S Acott	Chief Executive Officer	SAc
Mr P Cave	Director of Finance and Performance Management	PC
Ms W Cookson	Non-Executive Director	WC
Mr N Mansley	Non-Executive Director	NM
Mr L Martin	Chief Operating Officer	LM
Ms J Ollis	Non-Executive Director	JO
Mr K Palmer	Non-Executive Director	KP
Mr S Reynolds	Non-Executive Director	SRe
Ms L Shutler	Director of Strategic Development and Capital Planning/Deputy Chief Executive	LS
Dr S Smith	Chief Nurse and Director of Quality	SSm
Dr P Stevens	Medical Director	PS
Mr B Wilding	Non-Executive Director	BW

IN ATTENDANCE:

Ms A Ashman	Deputy Director of Human Resources (representing Ms S Le Blanc, Director of Human Resources)	AA
Mrs A Fox	Trust Secretary	AF
Ms S Robson	Board Support Secretary (Minutes)	SRo
Ms N Yost	Director of Communications	NY

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Ms S Andrews	
Mr K Rogers	
Mr J Ransley	
Mrs J Whorwell	
Ms L Wright	
Mr N White	NaW
Mr N White	NiW

MINUTE NO.		ACTION
77/18	**CHAIRMAN'S WELCOME** The Chair welcomed attendees to the meeting. The Chair welcomed Sean Reynolds, the newly appointed Non-Executive Director (NED), who started his first term of office with the Trust on 20 August as a NED. The Chair extended thanks to Colin Tomson, Non-Executive Director, for all his hard work and support whilst he has worked with the Trust. Colin stood down from his role as a NED and left the Trust at the end of August.	

78/18 **APOLOGIES FOR ABSENCE**

Apologies were noted from Ms S Le Blanc (SLB), Director of Human Resources; and Mr S Adeusi (SA), Non-Executive Director.

79/18 **DECLARATION OF INTERESTS**

The Chair declared that he had become a Trustee of the Epilepsy Society.

BW noted that he was now in his second, rather than his first term of office as a Non-Executive Director.

80/18 **MINUTES OF THE PREVIOUS MEETING HELD ON 10 AUGUST 2018**

PS noted at minute 65/18, he felt 'indication' should read 'investigation'. He also noted that in the final paragraph in page 4, it should read 'triangulation of mortality indices demonstrated…' rather than 'the mortality index demonstrated…'

The Chair noted at 66/18, in the fourth paragraph on appraisals, it should say that the Board were looking for Urgent Care & Long Term Conditions (UC&LTCs) to achieve the same level of appraisal performance that the other divisions had achieved.

Subject to the above changes, the minutes were **APPROVED** as a true record.

81/18 **MATTERS ARISING FROM THE MINUTES ON 10 AUGUST 2018**

The updates on the actions were noted, which were all closed, there were no comments raised.

82/18 **CHAIR'S REPORT**

The Chair stated that Sunny Adeusi's (SA) and BW's second term of office as Non Executive Directors had been approved by the Council of Governors. Colin Tomson (CT) had left the Trust from his role as a Non Executive Director at the end of August. He welcomed SRe to his first Board meeting, who had joined the Trust on 20 August as a Non Executive Director and member of the Board.

WC added that there had been a visit to the William Harvey Hospital (WHH) that had taken place on 29 August with herself representing the Non Executive Directors and two Governors.

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

83/18 **CHIEF EXECUTIVE'S REPORT**

SAc reported that she had met with the Chief Executive of NHS Improvement (NHSI), Ian Dalton (ID), to provide assurance around the Trust's improving performance and outlining the assistance that was being sought to support the Trust's winter plans.

Overall, the Care Quality Commission (CQC) report had rated the Trust as 'requiring improvement', but a number of outstanding practice areas had been identified as requiring action, which included the Emergency Department (ED) and Maternity. IT usage had been identified as outstanding, in regards to patients and staff, and hospital coordination. For the Board, wards and departments, it also provided a view of where improvements were needed.

In regards to the CQC report, KP noted that NHSI had been very positive in asking local stakeholders to support the Trust. SAc agreed, and noted that the CQC had recognised that in development of a clinical strategy, the Trust would require partner buy-in, as well as the entire local health economy to contribute to the strategy. NM queried whether there were implementation action plans. SAc reported that a workshop was planned for 17 September to discuss this with staff, who were ambitious to improve and it was important that the Board provided the necessary support to facilitate this.

SAc reported that the consultation on the proposed new management structure had closed the previous night, and that feedback would be assessed.

SAc reported that electronic referrals from GPs via the NHS e-Referral System (e-RS) had been introduced nationally, and the Trust was working to ensure these electronic referrals were increased to around 50% to 60%. The Chair felt that once this system was fully operational, it would be very beneficial to the Trust.

SAc reported that all Serco staff had now been transferred to the NHS wholly-owned subsidiary 2gether Support Solutions (2SS). The Serco staff had received a warm welcome into the Trust.

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

84/18 **PATIENT EXPERIENCE STORY**

PS presented the report and recounted NiW and NaW's story. NiW and NaW provided the Board with their account of what had happened in relation to their experiences of the treatment and service received.

PS noted that there was a contractual requirement to provide 2 weeks' worth of medication, which had been poorly understood by the doctors, and had resulted in NiW's colitis being more serious and would have been more easily managed. The intensivist was a good and experienced intensivist, but in this case had come across slightly non-empathic.

NaW thanked PS for all his support and outlined his experiences to the Board. The Chair acknowledged that NiW and NaW had had 'an inexcusable experience'. He noted the clinical issues around behaviour of consultant staff and that it had taken a year to resolve. He queried where the Trust were in responding to these issues. PS reported that the majority of what went wrong in these incidents was underpinned by communication. Throughout the process, people had been very defensive. The Chair noted that the Board could introduce a mechanism where if by a certain point if an acceptable outcome had not been resolved, the complaint would need to be appropriately escalated.

LM reported that the new care groups would be in place within a few weeks, which would provide the opportunity to drill down into governance. The national standard for complaints was contact within 24 hours from a senior person, and an investigation within 30 days. LM and SSm had been working on embedding this within the care groups. He commented that it would be beneficial for him and SSm to meet with NiW and NaW to discuss the personal impacts, and to help with culture change. NiW agreed with this suggestion. He noted that aside from PS, he had felt abandoned. He understood that it had not been intentional, but he wanted to ensure that no other patient went through what he had. The Chair noted that whilst PS was responsible for the medical staff and SSm for the nursing staff, the Board was responsible for making sure that the system worked, which it had not done so in this case.

KP noted that the Care Quality Commission (CQC) report had positively highlighted the Trust's communication, but communication to patients was generally an issue in the NHS. The Chair acknowledged that the length of time that NiW and NaW had waited for a response was unacceptable, and a mechanism was needed to ensure action was taken. As an organisation, it was the Trust's responsibility to ensure that contact was appropriate.

The Chair thanked NiW and NaW for attending, and assured them that the Board would take the matter seriously and that actions would be implemented.

ACTION: Meet with Mr White outside of the Board meeting to have an in-depth discussion regarding his patient experience and how his complaint was dealt with. In relation to what lessons can be learnt around embedding improvements within the organisation. — LM/ SSm

ACTION: Provide an update report to the Board on Mr White's patient experience story. In relation to the conclusion of the review of this complaint and that this complaint has been appropriately addressed, responded and closed in line with the complaints process. — PS

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

85/18 **MEDICAL DIRECTOR'S REPORT**

PS highlighted the World Sepsis Day on 13 September, Human Factors Training, and Patient Reported Outcome Measures (PROMs).

NM queried whether there was a lessons learned process. PS reported that this was an action arising out of the Care Quality Commission (CQC) report. He emphasised the importance of staff meeting together in a learning environment, which was difficult in a pressurised operational sphere. BW felt that it was important to address the difference that was being made. The Chair was keen for real action to come out of this and the Patient Story presented at this Board meeting. BW noted that there this was a particular focus of the Quality Committee.

SAc commented that the Quality Committee should monitor acknowledgements of complaints, the number of complaints and the period in which complaints were dealt with, and there should be a formal escalation process for complaints that have significantly exceeded the required response time standard.

ACTION: Produce an escalation process for complaints that have significantly exceeded the required response time standard. Along with producing a procedure for embedding within the Divisions around taking forward lessons learnt and human factors training to improve the complaints process and response times.
The Board discussed and **NOTED** the report.

SSm/ Executive Team

86/18 **QUALITY COMMITTEE – CHAIR REPORT**

The Board noted the contents and **APPROVED** the report.

87/18 **STRATEGIC WORKFORCE COMMITTEE – CHAIR REPORT**

- **WARD ESTABLISHMENT REVIEW**

The Chair queried where the Trust's staff turnover sat nationally. JO reported that in terms of vacancy rates and staff turnover, the Trust was in the middle nationally. PS emphasised that this was an average, and that there were areas of difficulty to recruit to that were being targeted.

NM queried the reduction in time to recruit. AA reported that there had been a significant reduction, and a paper was expected to be presented to the next Strategic Workforce Committee (SWC) meeting. The reduction had been so significant that the Executive Management Team wanted to see what could be learned from it.

SAc outlined the need to be innovative and creative, but to ensure that staff were still fit for the work being done.

LM outlined a 10-week programme within the Emergency Department (ED) to review all staff, and look at what was needed for the patients, and extrapolate the staff capacity needed. There was now had a pipeline of staff recruited above vacancies for ED.

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

88/18 **FINANCE AND PERFORMANCE COMMITTEE – CHAIR REPORT**

WC and NM emphasised the importance of providing support with training with the production of business cases. PC reported that there was advice available; however, there was more that could be done to help staff with producing business cases.

PC reported that it had been queried with NHS Improvement (NHSI) what needed to be done for the Trust to exit financial special measures. It was noted that it had not yet been made clear what was required.

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

89/18 **CORPORATE REPORTING:**

89.1/18 **INTEGRATED PERFORMANCE REPORT (IPR)**

PS reported that in the recent Quality Committee meeting it had been discussed that the narrative underlying the separate areas needed to reflect that most of the data was being reported with upper and lower control limits.

PC outlined that from a finance perspective there was a year-to-date plan for an £11 million deficit, which had been delivered. The savings target of £7.9 million year-to-date had been overachieved. The annual forecast was still for a £29.8 million deficit. From a cash perspective, the Trust had £8 million more than planned, driven by unanticipated over-performance payments from the Clinical Commissioning Groups (CCGs).

PC outlined the contractual position with the CCG. SAc explained that the CCG was now in Financial Special Measures, which had impacted their behaviour with the Trust. The Trust had been in contact with NHS England to monitor the situation and avoid a deterioration in the relationship between the Trust and the CCG.

LM emphasised capacity issues in gynaecology and work to increase capacity. The Chair queried whether this was a staffing issue. LM explained that it was multifaceted, including issues with staffing, booking, and theatre sessions. A new management team had started, as had new admissions clerks.

The Chair noted that Referral to Treatment (RTT) completions were static at 76% to 79% and that the Trust expected to move toward 92%. LM explained that the agreed trajectory was not to deliver that, but to reach a certain level by December and March.

WC noted concerns raised at the Strategic Workforce Committee (SWC) about vacancy rates increasing and staff turnover reaching the upper limit, and that temporary staff employment was also approaching the control limit. She emphasised the importance of a strategic plan for staff retention, as indicators suggested that there was not yet sufficient control of this. This was noted by the Board.

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

89.2/18 **FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**

WC noted and expressed concern that risk CRR 47 - deterioration of healthcare-associated infection metrics, had not already been included on risk registers. SSm reported that a decision had been made to work with the divisions on this risk, and that it would be managed by the Infection Control Committee. PS noted that C Diff remained an area of concern, but confirmed that the Specialist division had had no cases of C Diff or MRSA.

ACTION: Retain the risk Corporate Risk Register (CRR) 47: Inability to prevent deterioration in the number of healthcare associated infection metrics, on the CRR. This risk will also be included on the Urgent Care & Long Term Conditions (UC&LTCs) divisional risk register. — SSm

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

89.3/18 **ESTATES STATUTORY COMPLIANCE AND HEALTH AND SAFETY (H&S) REPORT**

LS noted that estates statutory compliance and H&S had been covered extensively at a recent Board meeting. PS noted that significant funding had been allocated for the management of Legionella on all the hospital sites for the forthcoming year.

NM noted that remedial works were underway at Buckland Hospital, following the Trust's assessment that the installed water boilers needed upgrading to meet demands, and that this work had been completed 'at the builder's cost'.

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

90/18 **EMERGENCY PLANNING ANNUAL REPORT AND WINTER PLANNING AND CAPACITY UPDATE**

LM explained that the Trust had been rated green. He highlighted that there had been steady improvement over the last three years on all assessments. The requirement was now to look at how to move emergency planning into the front line. Every area needed a business continuity plan, and there were sessions planned to teach staff how to write their individual plans.

WC queried whether there was a business continuity plan for hot weather. LM confirmed that there was.

KP queried whether the mobile app that was about to be launched would be for all Trust staff. LM reported that it was for all staff at present, and that a second app was being developed for emergency response staff.
The Board discussed and **NOTED** the report.

91/18 **ANY OTHER BUSINESS**

There was no other business.

92/18 **QUESTIONS FROM THE PUBLIC**

Sarah Andrews expressed surprise that end of life care had been identified as an issue for improvement in the CQC report, as the Governors had found that end of life care had been flagged in '*The Times'* as a centre of excellence. She queried the dissonance. SSm expressed her own surprise and disappointment at this. She noted that some of the documentation at ward and department level was not where it should be. There had also been a national focus on end of life care, which had raised the level of service expected. SAc reported that the CQC had verbally fed back that more work was needed around the recognition of people at end of life.

Junetta Whorwell commented on the patient experience story and that it was vital that staff listen to and engage with patients and families. She felt that the importance of communication should be stressed to all staff. The Chair agreed, and noted that this story had raised issues for the Board to address in relation to introducing procedural changes to the complaints process.

A member of the public queried whether there was any need for key worker housing in relation to supporting the recruitment and retention plans at WHH. SAc reported that there was a requirement. The member of the public queried whether there was a housing needs survey, in order to support this requirement and highlight the Trust's needs to the Local Council. LS and AA would meet outside of the Board to look into the needs of Assisted Housing.

The Chair closed the meeting at 12:36 pm.

Date of next meeting in public: Thursday 4 October 2018 in the Boardroom, Kent and Canterbury Hospital, Canterbury.

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 4 OCTOBER 2018

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

ACTION NUMBER	DATE OF MEETING	MINUTE NUMBER	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
B/001/18	08.06.18	41/18 Quality Committee – Chair Report	Quarterly Quality Strategy update report to be appended to future Quality Committee reports presented to the Board.	SR	October 2018	Quarterly report appended to the Quality Committee Chair's report presented to the October Board meeting. **Action closed.**
B/003/18	06.09.18	84/18 Patient Experience Story	Meet with Mr White outside of the Board meeting to have an in-depth discussion regarding his patient experience and how his complaint was dealt with. In relation to what lessons can be learnt around embedding improvements within the organisation.	LM/SSm	October 2018	In progress – we have been in contact with the family and are working with them to share their experience with shopfloor staff. **Action closed.**
B/004/18	06.09.18	84/18 Patient Experience Story	Provide an update report to the Board on Mr White's patient experience story. In relation to the conclusion of the review of this complaint and that this complaint has been appropriately addressed, responded and closed in line with the complaints process.	PS	November 2018	Response was issued within the final agreed date (14 September). SSm & PS are in contact with the family for complete resolution to their complaint. **Action closed.**
B/005/18	06.09.18	85/18 Medical Director's Report	Produce an escalation process for complaints that have significantly exceeded the required response time standard. Along with producing a procedure for embedding within the Divisions around taking forward lessons learnt and human factors training to improve the complaints process and response times.	SSm/ Executive Team	October 2018	A number of actions are in place including: • Escalation points have been identified. • Monthly performance monitoring is in place with the Care Groups around complaint timescales and progress. • A peer review is planned with a neighbouring Trust. • Service Improvement team are working with the team to ensure we

ACTION NUMBER	DATE OF MEETING	MINUTE NUMBER	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
						have lean impactful processes. This piece of improvement work will be completed during October and November. **Action closed.**
B/006/18	06.09.18	89.2/18 Full Corporate/ Highest Mitigated Strategic Risks Report	Retain the risk Corporate Risk Register (CRR) 47: Inability to prevent deterioration in the number of healthcare associated infection metrics, on the CRR. This risk will also be included on the Urgent Care & Long Term Conditions (UC&LTCs) divisional risk register.	SSm	October 2018	Risk remains on the corporate risk register. **Action closed.**

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**CHAIR'S REPORT**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX A: JOINT VISITS ACTION LOG (TO FOLLOW)**

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;
- Update the Board on the activities of the Council of Governors;
- To bring any other significant items to note to the Board's attention.

Care Quality Commission (CQC)

Following an inspection by the CQC of the Trust's hospitals in Ashford, Canterbury and Margate in May and June this year, examples of outstanding practice were recognised at the East Kent Hospitals as well as acknowledging that there is more work to be done. This is the fourth inspection since 2014 and the first since the Trust was taken out of quality special measures in February 2017.

The CQC published their report on 5 September of this inspection and identified that the Trust still 'Requires Improvement'. The report highlighted outstanding practice in some areas, but more work needs to be done to embed improvements and manage pressure on the Trust's services. It was recognised that the Trust is on a journey of improvement and is working to build on the progress that has already been achieved.

The Trust's rating of 'Requires Improvement' followed a detailed inspection of four areas at three of the Trust's five hospitals: urgent and emergency services; surgery; maternity; and end of life care; as well as the 'well-led' aspect of the Trust.

Areas of outstanding practice were identified and these included:

- How the Trust uses technology to improve the patient experience. Patients are able to use mobile phone applications to access information about pregnancy and the maternity department, and to also get additional support and guidance about surgery before and after their operation.
- The provision of a specialist intravenous access team, who take blood samples and insert cannulas under ultrasound guidance. This provides patients with a better patient experience as it minimises the number of attempts that need to be made to 'find a vein'. The Trust is the first in the Country to implement this innovative service in the Emergency Departments (EDs).
- Equipment in the resuscitation area within the EDs is very well organised with colour coded drawers and clearly labelled equipment in glass-fronted cabinets. This means staff can quickly find the correct equipment they need.
- The maternity service has 'a unique and ambitious approach to education' and the faculty of multi-professional learning provides training that 'exceeded that of other

maternity units'. The service has top of the range simulators for staff training and is the only maternity unit in England to have undertaken quality assurance in clinicians' essential life support skills.

The CQC commented on the significant steps that had been made in the maternity department around driving forward learning, improving patient outcomes and inspiring innovation. The Trust introduced a maternity transformation programme, called 'birthing excellence success through teamwork' (BESTT), to reduce the number of stillbirths, admissions to neonatal intensive care, and skin tears during delivery by the end of next year.

The significant challenges that the Trust is addressing is reflected in the report, these are around the waiting times for surgery and for emergency admissions, as well as the significant impact that high numbers of patients can have on the Trust's ability to deliver some services, particularly in the Trust's EDs.

The Trust is addressing these issues and a total investment of £13.5m has been allocated to increase staffing and services ahead of the winter period. Projects to support improvements include creating more beds for patients needing admission from the EDs at William Harvey Hospital (WHH) and Queen Elizabeth The Queen Mother Hospital (QEQMH), reducing waits and creating more space in the EDs.

The Trust has developed plans to improve surgery waiting times and protect planned orthopaedic operations. This will be achieved by moving some orthopaedic services to the Kent and Canterbury Hospital (K&CH) this year to avoid having to cancel patients' surgery in the busy winter months. This will also provide the Trust with the opportunity to carry out more general and gynaecology surgery at WHH and QEQMH to further reduce the number of people waiting over a year for an operation.

The Trust has received national funding to extend the EDs at QEQMH and WHH in the New Year to build new observation areas that will create more space in the EDs during very busy periods and ensure that patients needing observation can be cared for in a more appropriate environment than a busy ED.

Key findings of the report included:

All hospitals rated 'good' for 'caring', with staff providing emotional support to patients and caring for patients with compassion, and ensuring patients' privacy and dignity by using discreet symbols to communicate personal or sensitive information about medical history, disabilities or end of life status.

Outstanding practice in a number of areas, including use of technology, maternity, specialist IV access teams, resuscitation areas, post-discharge checks for surgical patients and communications practice.

Commitment to improving staff experience at the Trust, with Board members 'recognising the need to focus on and improve the culture of the organisation and developing processes to support staff and promote their positive well-being'.

A need to improve staffing levels in some areas, particularly surgical ward nursing teams and emergency care doctors.

A need to embed quality monitoring, systems and processes, including ensuring the Trust consistently learns from mistakes and makes more use of data to improve the quality of care.

Delays to public consultation regarding the provision of health services across the system has 'impacted many aspects of running the Trust including investment, staffing and culture'.

The CQC provided individual ratings to each of the Trust's three hospitals inspected, in addition to the overall Trust rating, which are noted below:

WHH, Ashford – remains rated 'requires improvement' overall, with surgical services at William Harvey Hospital upgraded to 'good' overall and critical care and outpatients diagnostic imaging rated 'good' overall.

QEQMH, Margate - rated 'requires improvement' overall, with medical care, critical care and outpatient and diagnostic imaging all 'good'.

K&CH, Canterbury – remains rated 'requires improvement' overall, with services for children and young people, critical care and end of life care rated 'good' overall.

The ratings for the Trust's two hospitals in **Dover, Buckland Hospital,** and **Folkestone, Royal Victoria Hospital**, were rated 'good' in 2015 and not re-inspected this year.

Following publication of the report, staff briefings were held across all the hospital sites. The Trust has developed an improvement plan that is required to be submitted to the CQC by 1 October. The plan will address the recommendations contained in the report for improvement to be taken forward along with 'Must Do's'. A workshop was also held with all stakeholders and relevant staff on 17 September and the outputs from this workshop will be evaluated. The overarching aim is to implement a quality improvement programme that will achieve a CQC rating of 'Good'. This will be achieved using the methodology of Listening into Action and by addressing the root causes of the issues raised in the report. The Trust will seek to ensure a consistently strong patient safety culture that is owned and lived by all staff in the organisation. This will enable the Trust to evidence improved experience for patients, safe care and learning implemented in practice.

The Trust has introduced clinical leadership into new Clinical Care Groups in which all senior responsible officers are clinicians. The improvement plan will be monitored at an operational level using the 4Action system, this will ensure an audit trail of the work completed. Monthly Care Group meetings will be held to hold responsible officers to account on progress of actions. Monthly reports will be presented to the Transformation Improvement Group.

The Trust has introduced six-monthly 'Routine Quality Reviews' to support improvements as well as designing new tools against the CQC's five domains. These include guidance on ratings so that each ward or service receives an internal rating at the end of the visit, ensuring on-going actions and improvements are being made and new areas of improvement set and completed.

Regular engagement meetings are held between the Trust and the CQC.

Care Group Operational Structure

The Trust has restructured its operational structure to provide a new clinical structure to support the organisation to be clinically led, management enabled and patient centred. This structure will support improving the health and wellbeing of our local population along with a development programme across operations.

The new Care Group structure comprises:

- Urgent and Emergency Care
- General and Specialist Medicine
- Surgery – Head and Neck, Dermatology and Breast
- Surgery and Anaesthetics
- Women's and Children
- Cancer
- Clinical Support Services

Care Group Clinical Directors are accountable for the Care Group and are supported by Care Group Operations Directors and Care Group Heads of Nursing.

This new structure will be in place from 1 October 2018.

Listening into Action (LiA)

As part of the great place to work initiative the Trust has introduced LiA methodology in response to the results of last year's staff survey. This is around the organisation listening to its staff and their views, as well as staff listening to each other. Everyone at EHKUFT should be able to take an idea about improving their work, their department, their environment, make it come to life and to know that whatever job they do, they can make a difference.

This methodology has been successfully introduced in other Trusts to enable staff to be listened to and improve the quality of care and service they provide. Staff have expressed that the Trust needs to change if it is going to continue to realise its ambition of becoming a top 20 Trust in the next four years.

The LiA methodology is about real action and this will be at the heart of the organisation's work to improve how it feels to be cared for and to work at EKHUFT.

In conjunction with LiA, staff have been invited to take part in the LiA Pulse Check. This is a survey for all staff to tell the Trust how it feels to work at EKHUFT, plus how they think the Trust can make a difference to the experience of its patients. The results of the survey will lead to change and action to help the Trust make the right decisions and to invest where it needs to, and for departments to respond in the right way to their staff issues.

Joint site visits

There have now been seven visits; the Buckland Hospital and Royal Victoria Hospital sites have been visited in their entirety with two visits each to Kent and Canterbury Hospital (K&CH) and William Harvey Hospital (WHH) and one to Queen Elizabeth the Queen Mother Hospital (QEQM). Seven visits are being planned for October and November: two at K&CH and QEQM and three at WHH. A template has been developed for reporting the outcome of the visits and actions are taken forward on receipt. An e-mail is sent to each of the team's visited which will refer to any actions identified during the visit and how these will be taken forward. Feedback from staff who have hosted the team has been very positive. A report will be submitted to both the Board and the Council of Governors on a quarterly basis. At Appendix A is the action log from the visits which have taken place.

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

Chairman	7 September – Tour of the William Harvey Hospital (WHH): to meet with staff in the areas noted below: • A&E, Minor Injury Unit, Clinical Decision Unit, Cambridge Wards, Kings Wards, Kennington Ward; • Meetings with the Clinical Site Management Team, Gynaecology staff and the Patient Experience Team and Volunteers. 10 September – Annual Members Meeting 17 September – Visit to the Fracture Clinic, WHH. 18 September – Visit to Nuclear Medicine, Kent & Canterbury Hospital (K&CH) 21 September - Consultant Diabetes and Endocrinology Interview Panel at WHH

The Executive Directors regularly visit the Trust hospital sites carrying out visits and walkabouts to the wards and departments as well as attending staff meetings and briefings. Noted below is a brief outline of these visits by the Executive Directors.

Chief Executive	4 September - Ward Clerk and Manager Assistant Length of Stay Sprint, Cambridge Ward, William Harvey Hospital (WHH) 7 September – Ward Buddying, Cambridge L Ward, WHH 14 September – Ward Buddying, Day Surgery, Queen Elizabeth the Queen Mother Hospital (QEQMH) 18 September – Ward Buddying, Clarke Ward, Kent & Canterbury Hospital (K&CH) 2 October – Achieving and Celebrating Excellence (ACE) Certificate Presentations, Children's Assessment Centre, K&CH 2 October – ACE Certificate Presentations, Speech and Language Therapy, Outpatients, K&CH 2 October – Visit to Cancer Services and Supportive Therapies, K&CH
Director of Strategic Development and Capital Planning/ Deputy Chief Executive	29 August – Ward Buddying Session at Oxford Ward, William Harvey Hospital (WHH) 3 September – Ward Buddying Session at Kingston Ward, Kent & Canterbury Hospital (K&CH) 4 September – 2gether Support Solutions Staff Briefings, Queen Elizabeth the Queen Mother Hospital (QEQMH) 5 September – 2gether Support Solutions Staff Briefings, K&CH 7 September – 2gether Support Solutions Staff Briefings, Royal Victoria Hospital Folkestone (RVHF) and WHH 17 September – Staff Forums, QEQMH, K&CH and WHH
Medical Director	3 September – Medical Professionalism Talk to Paediatric and Gastroenterology Trainees 4 September – Queen Elizabeth the Queen Mother Hospital (QEQMH) and Kent & Canterbury Hospital Staff Briefings regarding the Care Quality Commission (CQC) visit report 4 September – Meeting with Child Health Consultants 7 September – Nutrition Round, Queen Elizabeth the Queen Mother Hospital (QEQMH) 10 September – World Sepsis Day and presentation of Sepsis Screening Certificates to Wards at Kent & Canterbury Hospital 12 September – World Sepsis Day and presentation of Sepsis Screening Certificates to Wards at Kent & Canterbury Hospital 21 September – Panel Member of Schwartz Round, QEQMH 28 September – Nutrition Round, QEQMH
Chief Nurse and Director of Quality	3 September – William Harvey Hospital (WHH) Emergency Department (ED) Staff Briefing regarding the Care Quality Commission (CQC) visit report 4 September – Queen Elizabeth the Queen Mother Hospital (QEQMH) Staff Briefing regarding the Care Quality Commission (CQC) visit report 4 September – Queen Elizabeth the Queen Mother Hospital (QEQMH) ED Staff Briefing regarding the Care Quality Commission (CQC) visit report 4 September – WHH Staff Briefing regarding the Care Quality Commission (CQC) visit report 6 September – Walk the Floor at the Renal Unit and Children's Assessment Unit, Buckland Hospital Dover (BHD) 7 September – Walk the Floor across all Wards and Departments,

	WHH 10 September – Research Event 'Transforming the Future', WHH 13 September – Presentation of Sepsis Screening Certificates QII Hub, WHH 14 September – Visit to ED, QEQM 17 September – Trust Induction 17 September – Improvement Plan Away Afternoon 21 September – Senior Leadership Forum, video conference across K&CH, QEQM and WHH 21 September – Panel Member of Schwartz Round, QEQMH 1 October – Collaborative Patient Safety Visit in the Birchington Ward, Gynaecology Admission Unit, Early Pregnancy Unit, and Colposcopy, QEQMH 2 October – ACE Certificates Presentations, Children's Assessment Centre, K&CH 2 October – ACE Certificates Presentations, Speech & Language Therapy, K&CH
Director of Finance and Performance	21 August – Royal Victoria Hospital Folkestone (RVHF) Team Talk 3 September – Ward Buddying session at Richard Stevens Ward at William Harvey Hospital (WHH) 4 September – RVHF Staff Briefing regarding the Care Quality Commission (CQC) visit report 13 September – RVHF Team Talk
Chief Operating Officer	Weekly Walk the Floor in Emergency Department (ED), William Harvey Hospital (WHH) Weekly Walk the Floor in ED, Queen Elizabeth the Queen Mother Hospital (QEQMH) Weekly Walk the Floor across all Wards and Departments, WHH Weekly Walk the Floor across all Wards and Departments, QEQM Weekly Walk the Floor across all Wards and Departments, Kent & Canterbury Hospital (K&CH) Monthly Walk the Floor across all areas, Buckland Hospital Dover (BHD) Monthly Walk the Floor across all areas, Royal Victoria Hospital Folkestone (RVHF)

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

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

RECOMMENDATIONS AND ACTION REQUIRED: The Board is asked to discuss and note the report.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: TERMS OF REFERENCE (TRANSFORMATION AND IMPROVEMENT GROUP)**

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
- Transformation and Improvement Group
- 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.

To approve the Terms of Reference of the Transformation and Improvement Group.

CHIEF EXECUTIVE'S REPORT

1 CEO / Trust Activity

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

1.1 I am pleased to advise the Board that the Allscripts Patient Administration System (PAS) implementation is proceeding relatively well. The old system was taken down on Friday 7 September 2018 at which point the entire Trust reverted to paper based down time Standard Operating Procedures. The new Allscripts PAS was brought online on Tuesday 11 September 2018, a day later than planned. There have been a variety of normal issues to resolve – interfacing, system speed, location issues and some numbering issues to do with records of different numbering length. Some of the issues required the system to be taken down again with some fixes applied. This is all normal for a major implementation. There are no significant reporting issues at present. We continue to work through the open issues and to seek out new issues to resolve and work around. I would like to thank Andy Barker, Director of IT, Liz Shutler, Director of Strategic Development and Capital Planning and Lee Martin, Chief Operating Officer, for the highly focussed and committed leadership of this major piece of work. Many senior staff, middle managers, matrons, nursing sisters, laboratory and radiology staff and dozens of clerical staff worked through a 72 hour period with a great emphasis on team work, support and rapid spread of information. Many colleagues worked through the night and the following days to get the system safe and working. It has been an epic programme that has been very well implemented due to good planning and very good support in and to all departments.

1.2 Locally, the Sustainability and Transformation Partnership (STP) announced its recommendations for hyper acute stroke services. These were Ashford, Maidstone and Dartford. The formal decision will be taken by the joint committee of the Clinical Commissioning Groups (CCGs) in January and the Trusts will be expected to implement the recommendation within two years of the decision. Dr David Hargroves, Consultant Health Care of Older People (HCOOP) and Trust Clinical Lead for Stroke Medicine, Liz Shutler, Director of Strategic Development and Capital Planning and I visited all sites and services to personally explain the outcome to the staff.

1.3 NHSE has also sought advice regarding whether to consolidate vascular services ahead of the East Kent strategy decision. NHSE with advice from the vascular society, has taken the view that there would be material patient advantage to the consolidation of the two Kent based vascular services and will make a recommendation to the joint committee recommending that an intermediate decision is made to consolidate services into a single arterial centre with the likely base being Canterbury. This decision will also be made in January but there is no clarity on an implementation timescale at this stage.

1.4 I am pleased to advise the Board that I have attended the NHS Employers Policy Board and an NHS Confederation System Architecture round table with NHSE's director of Strategy. These are opportunities to both hear and influence early stages of policy and approaches, as a significant employer and a large Trust, as the NHS starts its consultation on a ten year plan. Integrated care organisations, new payments systems, regulatory rationalisation, employee Terms and Conditions were all discussed.

1.5 I reported to the Board last month that the Trust had successfully secured £6.42m in national funding for new observation wards at our emergency departments at William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital. The wards will create more space during very busy periods so that patients needing observation can be cared for in a more appropriate environment than a busy emergency department.

The new wards are one part of the Trust's preparations to be 'winter ready' and improve the experience for patients in east Kent's hospitals, as well as giving staff a better environment to work in. This funding is excellent news for east Kent patients. It means people who need an extended period of observation will no longer have to stay in the emergency departments during this time, so we will be able to provide the care they need in a much more suitable environment while at the same time releasing much-needed physical space in our emergency departments.

2 Transformation and Improvement Group (TIG)

2.1 The Trust's Transformation Board has been reviewed and will now incorporate all improvement work, including the financial improvement of the Trust. As a result, the Trust has disbanded the Financial Improvement Committee.

2.2 The new Group will report directly to the CEO and not the Board. The Board is asked to approve the Terms of Reference attached at appendix 1.

3 2gether Support Solutions

3.1 This section is to update the Board on the establishment of 2gether Support Solutions, a limited company with social enterprise principles and wholly owned subsidiary of East Kent Hospitals University NHS Foundation Trust.

3.2 The Board will be aware that 2gether Support Solutions has been created to deliver key support services in relation to Facilities Management, medical equipment and procurement, allowing greater long term strategic control and flexibility in these services.

3.2 Phase one, which went live on the 1 August 2018, saw the successful transfer of services previously delivered by our strategic facilities partner Serco. A core set of patient focused services (cleaning, portering, catering, helpdesk, switchboard and security) transferred to 2gether Support Solutions. Additionally in phase one, Procurement Services including the materials and supplies team, transferred. The transfer went well, with only a few staff facing payroll issues following the movement into 2gether. These issues were mainly as a result of incorrect or out of date information being passed from the transferring company.

3.3 Phase two, which went live on the 1 October 2018, concluded the transfer of remaining staff into 2gether. This included Estates, Medical Equipment Management and in house facilities services such as laundry and logistics. The conclusion of this stage of the project will allow the new company to deliver a cohesive and integrated support function to the Trust, allowing it to focus on patient care and its strategic priorities.

3.4 The Board will be aware that some members of the Estate Team voted for industrial action against the proposal to be transferred into 2gether Support Solutions. This action has now concluded and the staff involved are part of 2gether Support Solutions. Staff taking industrial action continued to support the Trust in relation to emergency issues arising during the period involved.

3.5 2gether Support Solutions will now work to deliver its annual business plans in line with its 25 year contract from the Trust and will provide regular performance reports as required by the Trust as its shareholder.

4 Trust Seal Activity

4.1 There has been no Trust Seal Activity since my last report to the Board.

5 Publications and Policy Developments of Note

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

Susan Acott
Chief Executive

APPENDIX 1

LATEST PUBLICATIONS / RESOURCES

Latest NHSI Publications

Care hours per patient day guides

NHSI's updated guide will help trusts deploy nursing and healthcare assistants more productively, so the right staff are delivering the right care to the right patients. This guide will also assist directors of nursing to identify areas of improvement within your current rostering.

Demand and capacity high complexity model

The high complexity model is intended for services that have more complex pathways e.g. chronic (more than one year) services in acute, mental health or community services, where patients may return for several follow up appointments at intervals which may change depending on how their condition progresses.

Grow your own bank

St Helens and Knowsley Teaching Hospitals NHS Trust shares its experience and process of developing a skilled and experienced temporary workforce.

Elective Care Essentials Programme

In July, 18 operational managers from acute trusts nationwide completed the Elective Care Essentials Programme pilot. Feedback has been excellent and roll-out is starting with cohorts commencing in October and January.

East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE

Transformation and Improvement Group

1. CONSTITUTION

This committee is constituted by the Chief Executive Officer

2. PURPOSE

The objective of this Group is to provide a means for the key components of the Quality, Safety, Financial and Productivity agendas in the Trust can support the Trust in its objectives of delivery of quality and access targets whilst maintaining the organisation in a stable financial position.

3. OBJECTIVES

3.1 Quality & Safety Domain

To seek and request assurance, from each individual Quality and Safety Improvement Project Leadership Team, on the performance of the programme of improvement. This will be done by each group reporting a simple highlight report that identifies status to plan and escalates red slippages (Issues), identifies what might slip in the future and where needed request support (Risks) and performance to agreed KPI (Benefits)

3.2 Financial Performance Domain

To seek and request assurance, from each individual Care Group and Corporate Leadership Teams, on the performance in the progress and delivery of the cost improvement programmes. This will be done by each group reporting a simple highlight report that identifies delivery to plan and escalates red slippages (Issues), identifies what might slip in the future and where needed request support (Risks) and outlines propsed schemes that will make up shortfall/slippage (substitutions)

Also, the performance of each care group and corporate departments in the delivery of financial activities specifically defined to support the trust in exiting financial special measures as agreed with NHS Improvement.

3.3 Productivity Domain

To seek and request assurance, from each individual Productivity and Service Improvement Project Leadership Team, on the performance of the programme of improvement. This will be done by each group reporting a simple highlight report that identifies status to plan and escalates red slippages (Issues), identifies what might slip in the future and where needed request support (Risks) and performance to agreed Key Performance Indicator (Benefits). In addition these cross cutting programme should identify where additional schemes for the Trust cost improvement programme can be identified and delivered.

3.4 People Domain

To seek and request assurance, from Corporate Executives and Senior Managers, on people development and recruitment Improvement Projects. This will be done by each group reporting a simple highlight report that identifies status to plan and escalates red slippages (Issues), identifies what might slip in the future and where needed request support (Risks) and performance to agreed KPI (Benefits).

In addition these cross cutting programme should identify where additional schemes for the Trust cost improvement programme can be identified and delivered.

4. PRINCIPLES

The principles of the Transformation and Improvement Group are:

4.1 Give a balanced view and support on improvements that can provide high quality productive healthcare

4.2 Provide respectful challenge to leadership teams on performance across all four domains

4.3 Establish and maintain clarity on Trust objectives and the means by which they are to be achieved by the care groups

4.4 To act as a support mechanism for leadership team to escalate risks, issues or items that may require support or resolution by the group

4.5 All Projects should endeavour to deliver benefits in either/both of Quality and Productivity benefits and then relate that improvement to deliver financial benefits

5. MEMBERSHIP AND ATTENDANCE

Members

Core membership

Chief Executive Officer or Deputy Chief Executive Officer (A) – Role Chair
Chief Operating Officer or Deputy Chief Operating Officer (nominated) (A) – Role Deputy Chair
Financial Director or Deputy Finance Director (A)

Medical Director or Deputy (A)
Chief Nurse or Deputy (A)
Director of Communication or Deputy (B)
Head of Transformation (A)
Company Secretary or Assistant (B)
Deputy Head of Transformation (B)
Director of Human Resources or Deputy Director of Human Resources (B)
Director of Information Technology (B)
Programme Director of T3 (B)
Head of PMO (B)
Director of Performance (B)
Director of Information (B)

Care Group representatives:
Care Group Clinical Director (C)
Care Group Operations Director (C)
Care Group Head of Nursing (C)

Project Representatives:
Project Clinical Lead (C)
Project Manager (C)
Service Improvement Support (C)

Attendees

Managing Director 2gther Support Services (D)
Managers working on Projects not in a role above
Nurses working on Projects not in a role above

Quorum

5.1 The quorum for the Transformation and Improvement Group is as follows:

Three representatives from members in Group A

Two representatives from members in Group B

One representative from each of Group C*

**Group C representatives that are nominated to attend do so with the appropriate authority to act on behalf of the care group*

Attendance by Members'

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

Attendance by Officers'

5.3 Other staff may be co-opted to attend meetings as considered appropriate by the Committee on an ad-hoc basis. This will be at the discretion and invitation of the Chair or Deputy Chair.

6. FREQUENCY

6.1. The Group shall meet monthly. The meeting will be held on the 3rd Friday of the month
The Chair may call additional meetings to ensure business is undertaken in a timely way.
There will be occasions where it is appropriate for the Chair to cancel the meeting but at least 75% of meetings a year should occur

7. AUTHORITY

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

The Group can have decisions making powers according to the delegated limits of its membership

7.2. The Group is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Group may not delegate executive powers (unless expressly authorised by the Board of Directors) and remains accountable for the work of any such group.

8. SERVICING ARRANGEMENTS

8.1. The Group will be serviced by the Transformation Team and the Chief Executive's Office.

8.2. Papers will be sent prior to meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

9. ACCOUNTABILITY AND REPORTING

9.1. The Group is accountable to the Chief Executive Officer. (TBC)

9.2. A summary will be reported to Board once they have been approved by the Chair along with exception reports as agreed by the membership of this Committee / Group.

10. MONITORING EFFECTIVENESS AND REVIEW

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

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

10.3. The terms of reference will be reviewed and approved by the [committee that the group reports to] on an annual basis.

=ENDS=

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**PATIENT EXPERIENCE STORY**
BOARD SPONSOR:	**CHIEF NURSE & DIRECTOR OF QUALITY**
PAPER AUTHOR:	**HEAD OF CHILD HEALTH SERVICES**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month the Board of Directors are invited to hear the experiences of one family whose daughter was born and admitted to the Neonatal Intensive Care Unit (NICU) at the William Harvey Hospital (WHH). Parents were happy with the level of care provided to their daughter, however, the experience of having to be separated from her was traumatic; in particular for Mrs M.

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

- The positive feedback regarding the care provided to the baby whilst on NICU;
- The positive experience of gaining feedback from Mrs M and the joint working with staff to improve parent facilities.

Thanks are extended to Mrs M 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

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

RECOMMENDATIONS AND ACTION REQUIRED:
The Board of Directors are invited to note the key themes of these experiences and the actions taken that helped this family.

Board of Directors
Patient Experience Story
October 2018

Introduction

This month the Board of Directors are invited to hear the experiences of one family whose baby was cared for within the Neonatal Intensive Care Unit (NICU) at the William Harvey Hospital (WHH). Whilst the parents recognised the appropriate care provided to their daughter, having to leave her at the hospital each evening had a profound impact on them as parents. The story highlights the benefits of feedback and how working together with parents has led to an improvement in facilities for parents. This is critical in terms of parents being able to take part in caring for their babies on NICU and in particular in relation to forming an early bond with their baby and establishing breast feeding.

The Story (in the words of the baby's mother)

On 1 September 2014, our daughter was born prematurely. It was a complete shock and something that we were totally unprepared for. As soon as she was born she was taken to the NICU at WHH, and instead of being able to spend those first few precious hours with her, my husband and I were without our baby.

We entered a world that was completely unknown to us and which was totally overwhelming. Baby A spent her first week in the neonatal intensive care unit before being moved to the special care unit for a further three weeks.

Once I had been discharged from hospital four days after her birth, there was nowhere for me to stay at the hospital. There were just two bedrooms on the unit that were used for 'rooming in'. We had to go home every night, leaving our baby with people who at that time were strangers. We couldn't have asked for a better team of doctors and nurses to look after her, and I knew she was where she needed to be, but even so, leaving her every night was the hardest thing I have ever had to do. It caused me a physical pain that I will never forget. If someone had told me I could leave my right arm there instead of my daughter, I think I would have done it! I knew she was where she needed to be but leaving her every night was the hardest thing I have ever had to do.

This is why the 'Bliss' campaign for more parents to be able to stay with their babies in hospital really struck a chord with me. With Bliss' support, I wrote to our local MP, Helen Whately about the facilities at Ashford and a few weeks later I got a phone call from Dr Vasu inviting me into the hospital to discuss how parent facilities could be improved. Accommodation was the major issue for me but we also discussed parking charges for parents with babies on the unit long term (this has now been dramatically reduced).

After several meetings and negotiations we secured a two bedroom apartment on site at the hospital. This has been completely refurbished and kitted out by the hospital charity and kind donations from local businesses. In April this year I ran the Brighton marathon and raised almost £2,300 which will go towards the project.

We are still a way off all parents being able to stay with their babies, but this is a huge and positive step in the right direction. The opening of the apartment took place on 17 July, and I was absolutely delighted to be asked to officially open it.

On a personal level, being involved in a campaign and project like this has been really cathartic. It has given our experience of neonatal care a purpose, and I fully intend to continue to work with the unit on future projects.

Summary

This story has poignantly described the pain and impact of being separated from a new born baby, and one that required additional care and support had on the parents. The comfort of being able to secure accommodation on site is described. The baby's mother has given her story written verbatim above, and will expand in person at the Board of Directors meeting. We would also like to extend our thanks for attending and for the fundraising Mrs M undertook.

REPORT TO:	**BOARD OF DIRECTORS (BOD)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**MEDICAL DIRECTOR'S REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

This report encompasses the following two areas:

1. Infection Prevention and Control (IP&C)

   This continues to be an area where more work and focus is required. In this report the Healthcare Associated Infection (HCAI) data is presented in terms of the rate of each HCAI per 100,000 bed days with regional and national comparisons to enable some comparability of performance. However, it should be noted that these data are crude rates and are not corrected for demography and co-morbid conditions.
   Also briefly detailed in the report are two Tuberculosis infection incidents.

2. Mortality Update – What rebasing Hospital Standardised Mortality Rate (HSMR) means

   This month the HSMR has been rebased and the Board will notice that the ratio has significantly increased. An explanation as to why the Board can be assured is detailed in the report.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks: 1. Patient safety risks from poor safety culture (infection prevention and control and never event incidents) Actions: 1. Continued communication campaign surrounding bare below the elbows and hand hygiene Trust wide, together with communication around good anti-microbial stewardship.
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
RESOURCE IMPLICATIONS:	None

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Quality Committee

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

RECOMMENDATIONS AND ACTION REQUIRED:

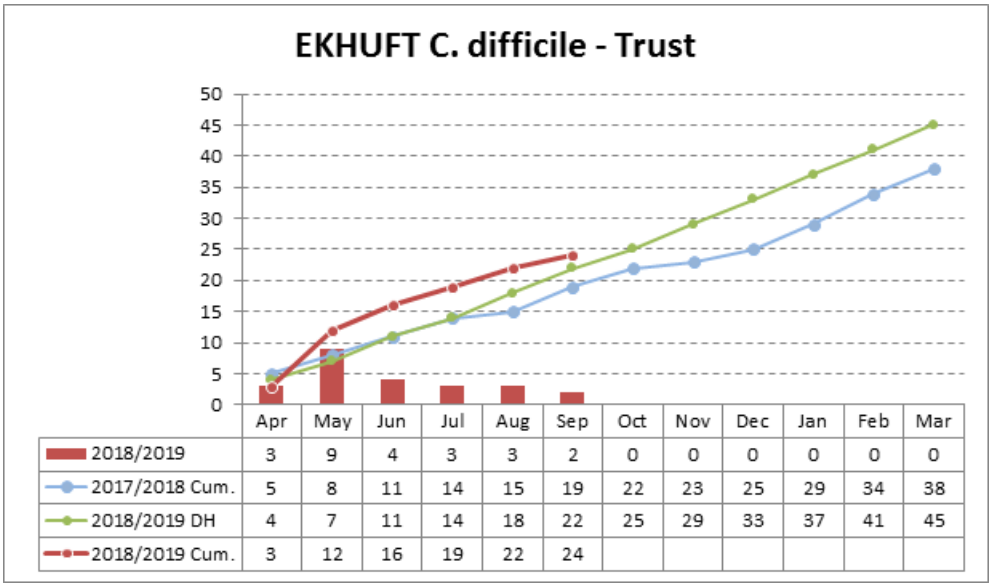
The Board is asked to discuss and note the report.

1. Infection Prevention and Control (IP&C)

1.1 C. difficile infection (CDI)

Since the initiation of CDI surveillance in April 2007, there has been an overall decrease in counts and associated incidence rate of both all reported and hospital-onset cases of Clostridium difficile infection (CDI). Between January to March 2012 and April to June 2018, the incident rate of all reported cases (hospital onset and community onset) reduced by 16% from 27.9 and 23.5/100,000 bed days. Over the same period the incident rate of hospital onset CDI (i.e. Trust apportioned) decreased by 31% from 18.2 to 12.6 cases per 100,000 bed-days.

The beginning of this New Year, in which our Department of Health (DH) trajectory is 45 cases, was hugely disappointing with 16 cases in the first quarter. The year-to-date total (as of 26 September 2018) is now 24 cases but the trajectory is beginning to suggest that this is being turned around.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/2019	3	9	4	3	3	2	0	0	0	0	0	0
2017/2018 Cum.	5	8	11	14	15	19	22	23	25	29	34	38
2018/2019 DH	4	7	11	14	18	22	25	29	33	37	41	45
2018/2019 Cum.	3	12	16	19	22	24						

All of the cases to date have been in either the Urgent Care & Long Term Conditions Division (15 cases) or Surgical Division (9 cases).

The Trust year to date hospital onset rate is 7.04 compared to a regional range of 0.66-11.61, mean 5.27/100,000 bed days. For all C.difficile (hospital onset and community onset) our rate is 20.81 compared to a regional range of 5.59-31.40, mean 18.79/100,000 bed days.

1.2 Methicillin-resistant Staphylococcus aureus (MRSA)

From April 2018, all post 48 hour MRSA bacteraemias have been automatically assigned to the Trust and all pre 48 hour cases to the Clinical Commissioning Group (CCG).

Nationally the incidence rate of all reported MRSA cases has remained broadly stable at around 1.5 to 1.7 cases/100,000 population between January to March 2014 and April to June 2018. The incident rate of hospital-onset MRSA bacteraemia has fluctuated but also remained broadly stable. The incidence rate for April to June 2018 is 15% lower than the incidence rate in January to March 2014 and is 0.86/100,000 bed-days.

Our current rate per 100,000 bed days is 0.91, this compares with the national rate of 0.86 and a regional rate (year to date) of 0.70/100,000 bed days.

1.3 Meticillin Sensitive Staphylococcus aureus (MSSA)

Since the mandatory reporting of MSSA bacteraemia began in January 2011, there has been a general trend of increasing counts and incidence rates, largely driven by an increase in community onset cases. All reported cases of MSSA bacteraemia increased by 36% from 2,199 to 2,992 between January to March 2011 and April to June 2018. This was accompanied by a 32% increase in incidence rate (per 100,000 population) from 16.8 to 21.8.

Over the same period (January 2011 to June 2018), counts and incidence rates of community-onset cases increased by 48% and 41%, respectively, from 1,464 to 2,172 cases, and 11.2 to 15.8 cases per 100,000 population. Over the same period, both counts and incidence rates of hospital-onset cases increased by 12% (735 to 820 cases) and 14% (8.4 to 9.5 cases per 100,000 bed-days).

When comparing the most recent quarter with the same period last year (April to June 2017 and April to June 2018), the incidence rate of hospital-onset MSSA bacteraemia increased by 1% (from 9.46 to 9.53 cases per 100,000 bed-days).

Our current hospital onset MSSA bacteraemia rate is 3.06, below the regional average of 4.47 (range 1.46-7.77) and below the national rate of 9.53/100,000 bed days respectively.

1.4 E.coli

Between July to September 2011 and April to June 2018, incidence rates of all reported cases of E. coli bacteraemia increased by 26% from 61.8 to 77.9 cases per 100,000 population (total cases recorded: 8,275-10,700). Similarly, over the same period, incidence rates of community-onset cases increased by 36% from 46.9 to 63.9 (total cases recorded: 6,279-8,785).

The counts and the incidence rate of hospital-onset cases decreased by 3% between April to June 2017 and April to June 2018, from 1,974 to 1,915 cases, and from 22.9 to 22.3 cases/100,000 bed-days, respectively.

Our current rate of Trust apportioned E.coli bacteraemia is 10.4/100,000 bed days. This compares with a regional average of 10.27 and a range of 4.68-19.37/100,000 bed days. For all E.coli bacteraemias (hospital onset and community onset) our rate is 74.35/100,000 bed days compared to a regional average of 63.67, range 20.07-98.38/100,000 bed days.

1.5 Infection control incidents

1.5.1 Tuberculosis (TB)

TB rates are now at the lowest recorded level ever in England, following concerted efforts to address a two-decade-long rise in cases that started in the mid-1980s. However, the rate of TB among the most deprived 10% of the population is seven times higher than among the least deprived 10% and 13% of people with TB have at least one social risk factor for the illness (homelessness, a history of substance misuse, or time spent in prison).

There have been 2 separate cases of Tuberculosis in adults reported during the last month. One homeless patient with open pulmonary TB was known to the community and Trust TB teams but had defaulted from follow up and sadly suffered an out of hospital cardiac arrest. The other patient is awaiting

confirmation of infection with Mycobacterium tuberculosis. This patient is of low infectivity and all relevant public health measures have been instituted.

1.6 Actions taken

The following actions have been taken as a result of the above:

- Continued communication campaign surrounding bare below the elbows and hand hygiene Trust wide.
- Tightening of the anti-microbial policy and a renewed communication campaign at induction re: compliance with the Trust's antimicrobial prescribing policy.

2. Mortality Update – What rebasing HSMR means

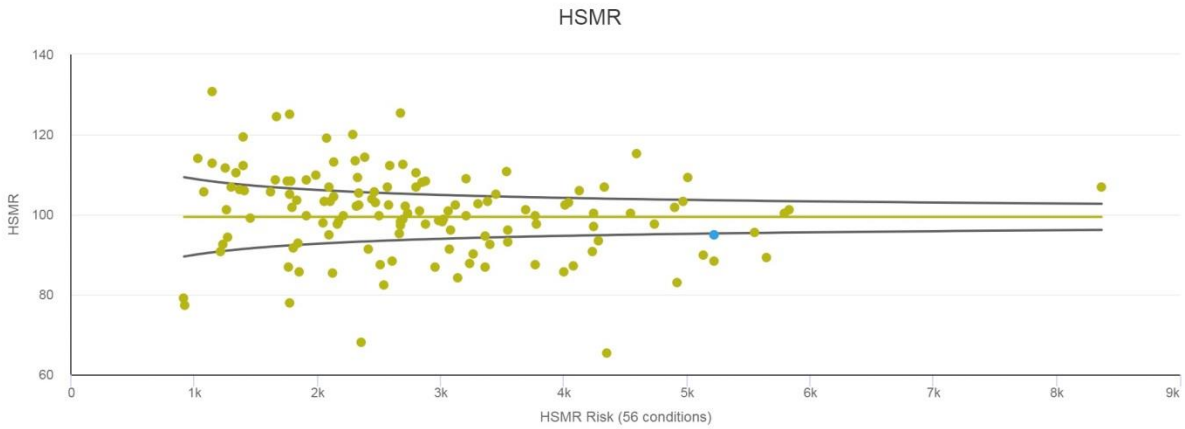
2.1 Understanding HSMR

The Hospital Standardised Mortality Ratio (HSMR) = the ratio of the number of deaths in hospital within a given time period, to the number that might be expected if the hospital had the same death rates as some reference population (e.g. the hospitalised population of England). When using mortality ratios, it is usual practice to set the HSMR in the standard population at the value of 100. This simply means that there is an exact match between the observed deaths and the expected deaths - hence it is the 'standard'. Using 100 also makes it easier to express local trust HSMRs in terms of a percentage difference to this standard. By adjusting for age, gender, diagnoses and other factors any remaining difference between a trust's expected number of deaths and actual number of deaths may be attributed to things within the hospital's control, such as quality of care. This leads to a possible erroneous conclusion that low HSMR is synonymous with good quality of care. There is a problem though and that is the statistical model used to calculate expected deaths is based on historical data and overestimates the number of deaths in the national population compared to that which is observed, because in-hospital mortality rates have fallen. Therefore in the national population the HSMR (the ratio of observed to expected deaths) will have fallen. Since trust HSMRs are relative to the national figure, they will fall too, reflecting the fall in mortality rates. Failure to take this into account can mislead people into thinking that HSMRs have improved when they have not.

2.2 Rebasing HSMR

Due to a number of changes that are seen over a period of time, including improvements in clinical practice and clinical coding and changes in population demographics, the average "base" of 100 will change over time as described above. It is therefore good practice to re-base the statistical model of a mortality ratio at regular intervals to re-set the average to 100. This will inevitably change an organisation's ratio; by how much and in which direction is influenced by a number of factors. The most common change is for the number to go back up to a higher level and that is precisely what has happened with our HSMR.

The hospital standardised mortality ratio (HSMR) for the latest 2 year period (July 2016 to June 2018) was 94.9 but continues to be low in comparison to other Hospital Episode Statistics (HES) Acute Peers as shown in the funnel plot below.



Now that HSMR has been rebased the upper and lower control limits can be reset and the usual triggers will be used for investigation, namely:

- higher than the upper control limit on a single occasion.
- higher than 100 on six or more successive occasions.
- six or more consecutive increases, regardless of the start level (a rising trend).

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE QUALITY COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX A: INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2017/18** **APPENDIX B: QUARTERLY QUALITY STRATEGY REPORT - QUARTER 1** **APPENDIX C: COMPLAINTS UPDATE**

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 July 2018 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 25 SEPTEMBER 2018

1. The following went well over the period:

1.1 The Committee received and discussed the report from the Patient Safety Board.

1.1.1 The Committee noted the continued improvements in medicine safety.

1.1.2 There remained issues with double prescribing and poor performance in relation to the Medication Safety Thermometer. The drug charts have been reviewed and amended as a result to address these issues, which is a multidisciplinary team issue across the medical, nursing and pharmacy staff. This issue will be improved with the implementation of electronic prescribing.

1.1.3 There are currently 82 open Serious Incidents (SIs), of which 21 are breaching. There were 11 new cases reported in August.

1.1.4 Duty of candour compliance for cases reported in July has improved.

1.1.5 There has been an increase in the reporting of pressure ulcers, due to Kent Community Health NHS Foundation Trust feeding back to the Trust cases picked up in community following discharge from East Kent Hospitals.

1.1.6 The Trust is struggling to maintain the Venous Thromboembolism (VTE) risk assessment compliance and is currently at 93.2% (target >95%). The main area of concern is in Urgent Care & Long Term Conditions (UC&LTCs) at William Harvey Hospital (WHH). Action plans will be presented as exception reports in future by each division outlining the challenging areas and the actions to address poor performance.

1.2 The Committee received and discussed a highlight report on the National Constitutional Standards for Emergency Department (ED), Referral to Treatment (RTT), Cancer and Diagnostics.

1.2.1 The Committee noted the update and that there had been slippage against the ED 4 hour wait performance trajectory but was assured of the actions in place to address this and that progress to improve performance was moving in the right direction. August performance was 80.0%; against the NHS Improvement trajectory of 85.4%.

1.2.2 In relation to RTT, performance in August was slightly down at 79.06% being 1.95% behind the improvement trajectory. There had been improvements in the number of patients waiting over 52 weeks for first treatment and this has decreased to 125, which is moving positively towards being on track.

1.2.3 Performance in cancer has improved and for August to 66.53% against the improvement trajectory of 57.87%. The total number of patients on an active cancer pathway is 2,689, of which 25 patients waiting 104 days or more for treatment or potential diagnosis.

1.2.4 The standard for diagnostics had not been met for August 2018 with compliance at 98.03%. There were 298 patients who had waited over 6 weeks for their diagnostic procedure.

1.2.5 The improvement plans continue to be regularly monitored at key meetings ensuring alignment of priorities to achieve sustained improvement.

2. Concerns highlighted over the reporting period:

2.1 The Committee received and discussed the principal mitigated quality risks.

2.1.1 The Committee was unable to take sufficient assurance around progress against mitigating the risks as limited updates had been provided in the report.

2.1.2 The Committee was reassured that there is a great deal of work being taken forward but that this is not being recorded to provide the necessary evidence for governance purposes and the required assurance.

2.1.3 The organisational restructuring around the implementation of Care Groups is designed to address and strengthen the issues around governance and improve the processes. Governance Leads will have a clear focus around supporting their areas and ensuring the register is regularly updated with progress.

2.1.4 The Committee emphasised the importance of the Trust managing its risks to ensure it achieves its improvement plans.

2.1.5 There were no new risks, no risks proposed for closure and none recommended for merging.

3. Other topics discussed:

3.1 The Committee received and discussed a Clinical Quality and Patient Safety Report, which included the patient safety metrics, monthly complaints and compliments, along with compliance against the hand hygiene audit.

3.1.1 The Friends and Family Test (FFT) inpatient satisfaction rate remains positive at 96%.

3.1.2 The ratio of compliments to complaints is positive with a high number of recorded compliments to every single complaint.

3.1.3 Complaint response times met the Trust's standard being responded to within the timescales agreed with the client. This is the seventh month running of achieving this standard.

3.1.4 In relation to Healthcare Associated Infection (HCAI), there have been no Methicillin Resistant Staphylococcus Aureus (MRSA) cases

reported in August. Clostridium difficile remains above trajectory and is a concern, driven by internal anti-microbial stewardship issues and the external community reservoir of C.difficile. Electronically reported hand hygiene (% of ward staff compliant with hand hygiene standards) is red for the second consecutive month in August 2018. On investigation of the data within the Integrated Performance Report (IPR), it has been learnt that there is an interface issue which current activity will resolve.

3.1.5 The Trust falls rate remains green (4.78 per thousand bed days) compared with 4.87 in July and this is the fourth consecutive month reporting below Trust limit.

3.1.6 No new never events were reported in month.

3.1.7 Overall Harm Free Care (HFC) related to the Harms patients are admitted with as well as those they acquire in the Trust's care. The Safety Thermometer continues to register green for new harms in August (for the eighth consecutive month), and reported an improvement compared to the previous month.

3.1.8 Overall Patient Experience calculated from the average of the 5 key questions within the local inpatient survey, reported red in August and recovery actions are being taken forward.

3.1.9 Mixed sex accommodation (MSA) remains within control limits, but breaches are still occurring in the Clinical Decision Units (CDUs) and in some of the escalation areas. Recovery actions are in place to address and eliminate breaches.

3.1.10 The Divisions continue to report some long waits for complaints and clear recovery actions have been identified.

3.1.11 Trust Mortality: The Hospital Standardised mortality index has been re-based and as a result has risen by about 10 points. This is **not** a deterioration in the Trust's mortality and it is important to note that crude mortality (both elective and non-elective) has remained within control limits for the last 7 months.

3.1.12 The risk associated mortality index (RAMI) also remains unchanged over the last 7 months.

3.1.13 Clostridium difficile infections (CDIs) reported red for the fourth consecutive month (n= 23) against trajectory (n=22).

3.1.14 Venous Thromboembolism (VTE) risk assessment: Despite an improved position reported over the year 2017/18, Trust performance for VTE risk assessment remains red at 93.1% in August against a national target of 95%. Recovery actions are in place to ensure a sustained performance.

3.1.15 Pressure ulcer (PU) rate for category 2 PU exceeded the Trust limit in July registering amber 0.25 in August.

3.1.16 The A&E four hour standard remains a priority for the Trust Emergency Department (ED), and was 80.04% in August compared with 80.80, 81.12%, 79.18 % in May, June and July respectively.

3.2 The Committee received and discussed the report from the Patient Experience Group (PEG).

3.2.1 The Group received an update on the ED survey action plan, providing assurance that progress was being made against the plan.

3.2.2 There was discussion regarding the performance of the complaints process following the compelling Patient Story at the Board of Directors meeting on 6 September. There has been focussed work on addressing complaints that breach 45 days. Reassurance was received of the actions in place to address the complaints process and performance.

3.2.3 A report was received and discussed following the discharge survey carried out by Healthwatch. Themes were around consistency of

processes and ensuring adequate support was in place when the person arrived at home. There was positive feedback from patients around communication, not feeling rushed and being involved in the process.

3.2.4 The results of the annual tissue viability audit were received and included positive messages. There is a requirement for improvement actions and these will be taken forward.

3.3 The Committee received and noted a report from The National Institute of Clinical Excellence (NICE)/Clinical Audit and Effectiveness Committee (CAEC).

3.3.1 It was noted that this Committee has not yet been fully embedded in the organisation. Attendance at the last meeting had been poor and it is expected that this will be addressed and resolved once the new care group structure is in place from October.

3.4 The Committee received and noted a Care Quality Commission (CQC) update report. Providing an update on the CQC engagement work, progress against actions, along with a briefing on the outcome of the final CQC report.

3.4.1 The Trust is required to submit a list of actions and 'must do's' to the CQC incorporated in a two year plan.

3.4.2 The plan will be around the development of the Trust staff of a culture of safety and improving the patient experience.

3.5 The Committee received and discussed an update report regarding complaints.

3.5.1 This included an update on the Patient Story presented at the Board of Directors meeting on 6 September. Copy of the report attached for information (Appendix C). The key component was the delay in the Trust completing the complaint investigation and sending a timely and thorough response to the family.

3.5.2 The improvement work already in place in relation to the complaints process is being built upon along with immediate actions being taken, which include:

- A review of the Trust wide complaints process to improve the delays in providing a response to complaints;
- An external peer review of the Trust's complaints processes;
- Benchmarking against local and national Trusts around complaints management and improving the quality of responses;
- An internal review of the specific case presented at the 6 September Board of Directors meeting, and the delays encountered is in progress;
- The complaints process has been strengthened with earlier escalation when delays occur so that more senior intervention takes place;
- Internal support for the complaints team has been strengthened;
- The development of a proposal to redesign the corporate and the new Care Group governance teams to strengthen oversight;
- A stronger focus demonstrating what the Trust does with feedback through greater visibility of "you said" "we did" will further support important cultural change across the organisation. Greater engagement of medical colleagues and stronger clinical leadership and accountability for the complaints process lie at the heart of delivering the required improvement.

3.5.3 The Learning and Development team are looking at the provision of customer care training for Trust staff.

3.5.4 The Trust is committed to responding to the issues patients are raising.

3.6 The Committee received and approved the Infection Prevention and Control Annual Report 2017/18 at its August 2018 meeting and is attached for approval by the Board (Appendix A).

3.7 The Committee received and noted a report on the Central Alert System (CAS) and compliance with Patient Safety Alerts (PSA).

- 3.7.1 The Committee received assurance of the system in place around cascading the alerts issued.
- 3.7.2 Noted the alerts that had been issued.
- 3.7.3 The Patient Safety Board receives the PSA at each meeting following the date of issue.

3.8 The Committee received and discussed a report on learning from incidents.

- 3.8.1 The Committee had a robust and positive discussion on learning from incidents.
- 3.8.2 It was important as an organisation in moving forward that it demonstrated how it was improving based on learning, and how the organisational restructure and governance review relates to improving through learning from incidents.
- 3.8.3 The restructure and implementation of Care Groups will increase assurance that learning is being covered appropriately throughout the organisation to ensure continued learning, and that evidence of learning is recorded to provide the required governance and assurance.
- 3.8.4 The Committee recognised the significance of learning and in order for the Trust to improve its performance it needed to get better through learning from incidents.

3.9 The Committee noted the Quarter 1 Quality Strategy Report, which is attached (Appendix B) for the Board to note. This describes progress against the 2018/19 quality priorities.

3.10 The Committee received and discussed reports from the Divisional Governance Boards along with the confirmed minutes.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to:

i) discuss and accept the report for approval from the Quality Committee;
ii) note the Quarterly Quality Strategy Report;
iii) note the complaints update;
iv) approve the Infection Prevention and Control Annual Report 2017/18.

East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

APRIL 2017 – MARCH 2018

Lead and Author	Valerie Harmon/Paul Stevens/Sri Reddy
Approving body	Patient Safety Board
Date Approved	

Contents

East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT

April 2017 – March 2018

This Report has been produced by Dr Paul Stevens, Director Infection Prevention and Control, Valerie Harmon, Deputy Director Infection Prevention and Control and Dr Srinivasulu Reddy, Infection Control Doctor, on behalf of the Infection Prevention and Control Team.

1. INTRODUCTION

The Director of Infection Prevention and Control (DIPC) is required to produce an Annual Report on the state of healthcare associated infection (HCAI) in the organisation for which s/he is responsible and release it publicly according to the *Code of Practice on the prevention and control of infections and related guidance* (The Health and Social Care Act 2008). The Annual Report is produced for the Chief Executive and Trust Board of Directors and describes the activity of the Infection Prevention and Control Team (IPCT) during the year, including progress made against the work plan and objectives identified in the Infection Prevention and Control Annual Programme. It also includes Divisional performance against Infection Prevention and Control Key Performance Indicator Targets (KPIs). Divisional compliance with regard to mandatory training and hand hygiene/"bare below the elbows" and commode cleanliness is reported monthly (see Appendix 1).

1.1 Annual Programme and Achievement of Infection Prevention and Control

The Infection Prevention and Control (IPC) Annual Programme (2017/18) was designed to achieve compliance with the standards identified in the *Code of Practice*, and the achievement of National and local infection related objectives:

1. MRSA bacteraemia objective for 2017/18

    - NHS objective of no avoidable bacteraemia cases

2. *C. difficile* objective for 2017/18

- NHS England objective of 46 post 3 day cases

These results are discussed in more detail in the section on surveillance of infection.

Infection Prevention and Control Key Performance Indicator Targets are reviewed on an annual basis and presented at the IPCC in the 1st Quarter.

1.2 The Infection Prevention and Control Team (links with other Trust committees and working groups are listed in Appendix 2)

The IPCT are the medical and nursing specialists responsible for undertaking the work described in the Infection Prevention and Control Annual Programme.

East Kent Hospitals University NHS Foundation Trust (EKHUFT) IPCT consists of 5 Consultant Microbiologists. One of 5 Consultant Microbiologists has an additional role as Infection Control Doctor supporting and providing expert advice to the Infection Prevention and Control Nursing Team.

The team structure incorporates the Director, the Deputy Director and the Decontamination Lead managing and overseeing the IPC Team activity.

The IPC nursing staff comprises of 3 Band 7 staff, 3 band 6 staff and 3 band 4 staff across the major sites of the Trust.

The development of the new IPC Team has meant that available resources are maintaining the focus on clinical reactivity (reviewing patients with alert organisms/conditions; ensuring that risks of HCAI can be reduced). However, there has been significant improvement in the visibility of the team and are now able to begin addressing expected levels and sessions for training and education activities for staff, completing IPC Environmental audits and Clinical Practice Standards for all wards and departments across the Trust.

Infection Control Software to Support IPCT Activity (VitalPAC IPC Manager)

A key feature of IPC Manager within the VitalPAC application, is the recording and tracking of all episodes of diarrhoea and/or vomiting on wards where the staff have entered symptomatic patients onto VitalPAC. Whilst significantly improving the pro-active management of infection prevention and control the introduction of IPC Manager has had a large impact on the way in which the IPC Clinical Nurse Specialists work, the current applications are under review to determine more efficacious reporting from the nurses at point of concerns and has involved developing the capacity to record several types of specimen as defined by the Bristol Stool Chart.

1.3 Infection Prevention and Control Committee

The EKHUFT Infection Prevention and Control Committee (IPCC) is a multidisciplinary Trust committee with outside representation from Public Health England (PHE) and Care Commissioning Group (CCG). The IPCC oversees the activity of the IPCT and supervises the implementation of the Infection Prevention and Control Annual Programme. The IPCC met bi-monthly during 2017-18 and this will be continued through 2018-19, with greater emphasis on Divisional representation and engagement.

1.4 The Care Quality Commission

EKHUFT continues to improve the compliance to the essential Care Quality Commission quality and safety standards as they apply to infection prevention and control.

2. EDUCATION AND TRAINING

Introduction

The *Code of Practice* requires that all staff undertake mandatory infection prevention and control training on a regular basis. The specific requirement is:

> ‘that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patients care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection’.

This need is met through provision of a mandatory e-learning package based on Department of Health evidence-based infection control guidelines. In total, 4688 staff completed this training during 2017-18. This is an increase on last year’s figure (3400).

Additional training sessions provided by the IPCT during 2017/18 include:

- All junior doctors receive a short induction session provided by the IPCT. This includes a presentation on infection prevention and control practices, including the education on hand hygiene and the prevention/management of inoculation injuries.
- As part of induction, all Foundation Year 1 (F1) junior doctors also undergo mandatory training and assessment of competence on the insertion of peripheral venous cannulae and phlebotomy skills, including the taking of blood cultures (provided by the Vascular Access Team).
- Participation in the F1 Junior Doctor programme includes 'The Principles of Infection Prevention and Control', antibiotic prescribing and emphasises the role of the microbiology laboratory in diagnosis of infection.
- Ad hoc sessions for Divisions/Departments as requested.
- Education on the management of urinary catheters as part of the induction programme for Healthcare Assistants.
- Practical hand hygiene training for IPC Link Practitioners, Trust wide (training is then undertaken by Link Practitioners for all clinical staff working in their area, annually).
- Site-based teaching for Band 4 Assistant Practitioners as requested.

Full Trust wide Infection Prevention and Control Education and Training figures, are available on application to the IPCT.

3. INFECTION PREVENTION AND CONTROL LINK PRACTITIONER SYSTEM

Infection Prevention and Control Link Practitioners by Site

QEQMH	WHH/BHD/RVHF	K&C
73	112	64

Quarterly site-based IPC LP meetings continued throughout 2017/18.

4. AUDIT

The IPC Clinical Nurse Specialists have undertaken the following audits (with appropriate support from IPC LPs and external agencies, as appropriate):

Audit	Completed	Achievement
Antimicrobial prescribing		Please see Antimicrobial Stewardship Report provided by the Antimicrobial pharmacist
Infection Prevention and Control Audits of Environmental and Clinical Practice	Ongoing	Regular audits (every 12-18 months) of the clinical environments are being resumed now that the team are nearly back to full complement. The completed audit report is sent to the Ward/Department Manager, who is responsible for both formulating and implementing an action plan. The results of these Audits are being reported monthly in the Infection

		Prevention and Control Monthly Report.
Environmental audits (assessment of compliance with the *Code of Practice* with regard to the ward environment)	Every 3 months	All bed holding matrons have been trained in the use of the ward/departmental Hygiene Code Environmental Audit tool to enable them to subsequently complete these audits three monthly on each ward with a requirement to report to their relevant Divisional committees

Compliance with the Management of Invasive Devices

Monitoring of compliance with the management of invasive devices, e.g. peripheral cannula, central vascular catheter and urinary catheter, insertion and continuing care, is being reviewed to ensure this is managed effectively, the results of which will be reported to the IPCC as a standing agenda item.

5. HAND HYGIENE

The focus on improving hand hygiene compliance has continued during 2017-18 with increased attention on improving compliance with the annual practical hand hygiene assessment of staff who have contact with patients as well as contract staff (Divisional KPI). This is undertaken by the IPC Link Practitioners and reported in the Infection Prevention and Control Monthly Report to Divisions. Compliance with hand hygiene, including bare below the elbows, is audited and reported via EKBI QlikView and reported in the Infection Prevention and Control Monthly Report to Divisions and the IPCC.

6. HOSPITAL HYGIENE

The IPCT have continued to monitor standards of cleanliness within the Trust and promote good practice in conjunction with the Hospital and Facilities Managers through participation in the following activities:

- Patient-led Assessment of the Care Environment (PLACE).
- Advising contractors/contract management on cleaning and domestic issues.
- Day to day advice/intervention/escalation to facilities management as appropriate, with regard to cleaning issues.

7. OTHER WORK

- The IPCT continue to be involved in the planning aspects of Trust wide building and development projects in relation to infection prevention and control.

8. WATER QUALITY AND SAFETY (INCLUDING LEGIONELLA AND PSEUDOMONAS)
(Controlling the risk associated with water supply and air conditioning systems)

8.1 A patient admitted to Minster ward at QEQM Hospital acquired Legionella during his hospital stay. This incident was thoroughly investigated and remedial measures were instituted to reduce risk of Legionella transmission from hospital water systems. An independent expert review was undertaken which has led to changes in water safety management at EKHUFT. The Water Safety Group meets on a bi-monthly basis and Estates water safety meetings are held on fortnightly basis at each hospital site.

9. INCIDENTS/OUTBREAKS OF HOSPITAL INFECTION

9.1 Norovirus Diarrhoea 2017/18

Reporting of cases of norovirus during 2017-18 showed a continued reduction and the ward closures have been managed and kept to a minimum partly due to staff awareness and actions taken in a timely and appropriate manner, as well as the ongoing use of the daily review of all patients reported on VitalPAC with one or more episodes of diarrhoea and/or vomiting, and the use of hydrogen peroxide vapour (HPV) for the high-level disinfection of single rooms, bays and wards as appropriate.

Table 1 shows the numbers of affected patients per site per year since 2013/14.

Table 1: Patients with confirmed Norovirus infection by year

Site	*2013/14*	*2014/15*	*2015/16*	*2016/17*	*2017/18*
WHH	0	44	20	11	3
QEQMH	59	11	3	10	13
K&C	0	53	21	18	2

Ad hoc education sessions were held on the wards once again by the site-based IPC Clinical Nurse Specialists. “Norovirus banners” were displayed at the hospital entrances across the Trust, advising members of the public not to visit the Trust if they had any symptoms that were suggestive of Norovirus infection, and an automated “awareness” message was installed onto the telephone system by the Telecommunications Department, when there was an increase in Norovirus activity affecting QEQM.

The prevention and control of Norovirus remains an ongoing challenge for IPCTs across the country due to its changing epidemiology, short incubation period, sudden onset, rapid spread, and the fact that it circulates within the community throughout the year; therefore continued surveillance is necessary. Admission-avoidance of symptomatic patients is key within the ECC/ Emergency Departments, along with the rapid isolation of symptomatic patients on the wards and notification to the IPCT.

9.2 Contact tracing/look-back exercises

MRSA Outbreak NICU WHH March 2018

A cluster of six babies acquired MRSA whilst on William Harvey Hospital neonatal intensive care unit during February - March 2018. Staff and parent screening identified 1 staff member and the parent of one baby carrying the same strain as other babies. Weekly screening, deep cleaning of the unit and other corrective measures were undertaken to interrupt transmission on the unit. There were no further cases and none of the MRSA colonised babies developed serious infections such as bacteraemia or complications.

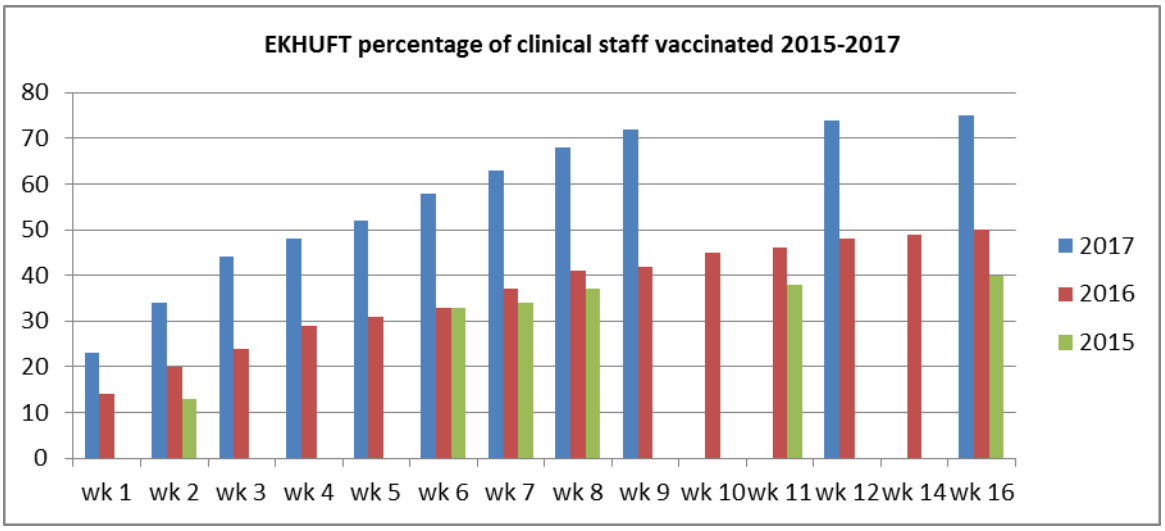
10. SURVEILLANCE AND EPIDEMIOLOGY

10.1 Influenza 2017/18

Experience in East Kent reflected the national picture with less pressure on ICU beds compared with recent seasons.

Year	All staff Vaccinated	% uptake Total staff 7,500	Clinical Workforce	Drs		Nurses/ Midwives		Other Professional Qualified		Clinical Support Staff		No Direct Patient Contact	
2015	2939	38.6%	39.6%	356	39.5%	731	32.3 %	445	76.3%	740	37%	667	33%
2016	3530	48%	50%	434	50%	890	40%	472	57%	916	60%	718	41%
2017	4853	66.5%	75%	661	82.3%	1425	65.7 %	749	73.6%	1242	86%	776	41.6 %

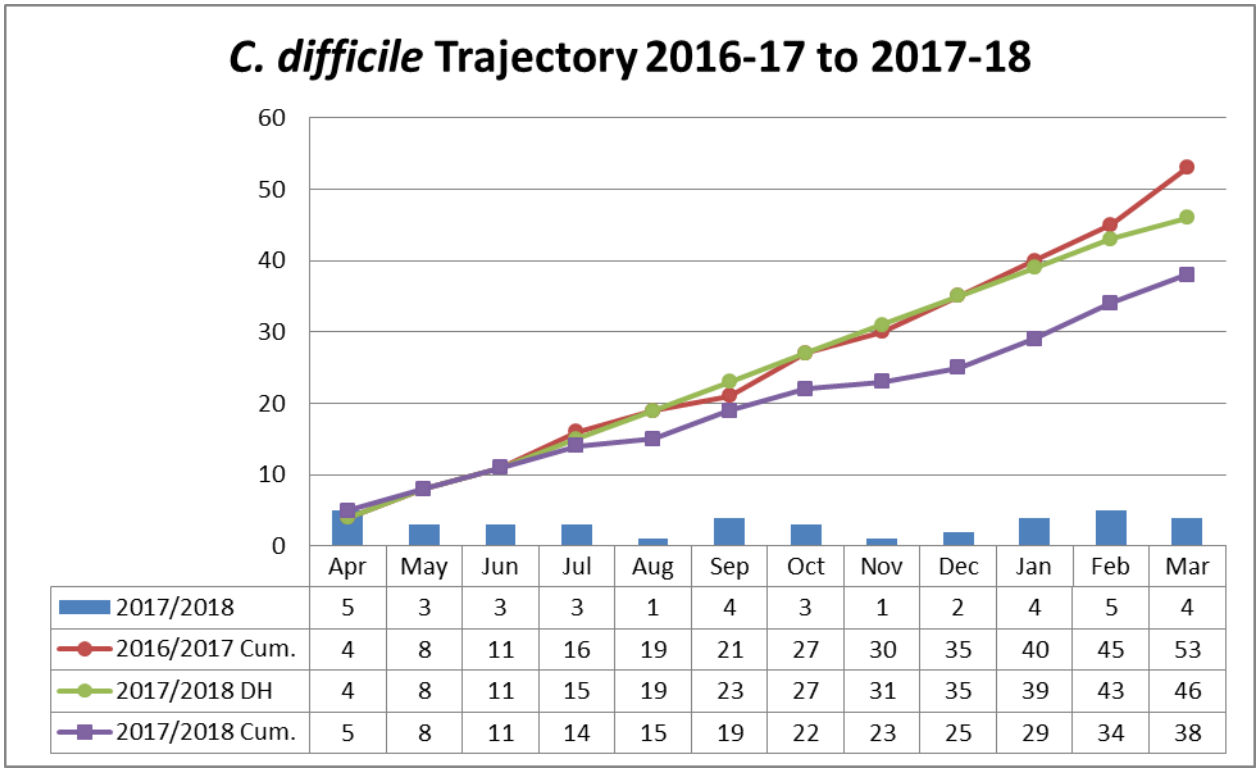
The overall level of influenza vaccine uptake by staff was 66.5%, which was a big increase on last years' figure. The targeted campaign with positive communications driven by the senior team, as well as multiple options for accessing vaccination has yielded significant improvements to the vaccination uptake rate. This is clearly demonstrated graphically below.



10.2 *Clostridium difficile*

There were 38 cases of *C. difficile* infection during 2017-18; the NHS England objective set for 2017-18 was 46 cases. The annual target was met. The cumulative total of *C. difficile* cases compared with 2016-17 is displayed in Table 2 below.

Table 2: EKHUFT *C. difficile* Trajectory 2016-17 to 2017-18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/2018	5	3	3	3	1	4	3	1	2	4	5	4
2016/2017 Cum.	4	8	11	16	19	21	27	30	35	40	45	53
2017/2018 DH	4	8	11	15	19	23	27	31	35	39	43	46
2017/2018 Cum.	5	8	11	14	15	19	22	23	25	29	34	38

Root cause analysis of C. difficile cases showed non-compliance with Trust Diarrhoea assessment tool. Several of these cases could have been avoided if staff nurses had performed correct risk assessment for sending stool specimens and noted previous history of C. difficile disease.

The number of cases attributed to each Division for the periods 2017-18 are to be noted as this is the period of concern.

Table 3

	2015-2016		2016 – 2017*		2017-2018**	
	Avoidable	**Unavoidable**	**Avoidable**	**Unavoidable**	**Avoidable**	**Unavoidable**
Surgical Services	1	18	1	8	2	1
UCLTC	4	19	3	12	6	29
Specialist Services	1	4	0	2	0	14
Total	**6**	**41**	**4**	**22**	**8**	**44**

*2 cases were unclassified
**1 case was not applicable

Periods of Increased Incidence (PII)

There were nine periods of increased incidence during 2017-18. These consisted of six cases at QEQM, two cases at K&CH and one case at WHH.

There were four PII meetings held for wards with two or more hospital acquired C. difficile/GDH antigen positive cases within a 28 day period. The learning outcomes were as follows:

- All staff are required to be competent in the use of the Diarrhoea Assessment Tool (DAT) and stool sample collection, ensuring all new staff receive adequate training.

- Ensure the antibiotic prescription is reviewed in relation to the required length of time and ensure any identification of an organism and its sensitivities are addressed appropriately.

- Ensure appropriate use of PPE by all members of staff.

- Ensure hand hygiene and commode cleaning compliance scores are above 90% (95% in high risk areas).

There were five PII meetings held for wards with two or more hospital acquired MRSA colonisation within a 28 day period. The learning outcomes for these PIIs were as follows:

- All staff should be 'bare below the elbows' as detailed in the Uniform policy.

- The numbers of appropriately trained staff should meet the safety requirements of the patient acuity of the ward.

- All staff are required to complete bi-annual mandatory Infection Control e-learning training.

- To ensure there are open communication channels between ward staff and Serco to share information with regards to infection control precautions to be followed and cleaning of ward bays occupied by infectious patients and isolation rooms etc.

- Staff are to use Clinell wipes to clean stethoscopes.

- Staff are required to check the MRSA status of all patients on admission to the ward and to be aware of current and previously MRSA positive patients.

- Ensure all Hand Hygiene, Commode and Bare Below the Elbows audits are carried out weekly and the results promptly uploaded to QlikView.

- Ensure that all permanent and agency staff are familiar with the updated MRSA policy, including screening and management of MRSA patients.

- All ward-based medical and nursing staff are required to have their hand hygiene assessed annually.

- MRSA leaflets are to be displayed on wards and given to patients and relatives as appropriate.

- All staff administering decolonisation/suppression treatment are required to complete the Competency Assessment with their ward based IPC Link Practitioner or a member of the IPCT.

Lapses of Care

All cases of *C. difficile* are assessed as part of the root cause analysis (RCA) process to determine whether the case was linked to a lapse in the quality of care provided. A lapse in care would be indicated by evidence that policies and procedures consistent with national guidance and standards were not followed.

These are classified 0 – 3. Classification 1 indicates that there was a lapse of care, but different management would not have made a difference to the outcome. Classifications 2 and 3 indicate that different management *might* have, or would *reasonably have been expected* to have, made a difference to the outcome.

A provisional decision regarding whether or not there have been any lapses of care are made at the RCA meeting, and then reviewed separately with the CCGs.

10.3 *Staphylococcus aureus* Infections (MRSA and MSSA)

Mandatory surveillance by the Department of Health now includes both Methicillin Sensitive *Staphylococcus aureus* (MSSA) blood stream infections as well as Methicillin Resistant *Staphylococcus aureus* (MRSA) infections.

10.3.1 Methicillin Resistant *Staphylococcus aureus* (MRSA)

There is no specific NHS England Trust objective for MRSA bacteraemia other than observance of the principle of "zero avoidable cases".

Figure 2: MRSA bacteraemia cases depicted from 2013 - 2018

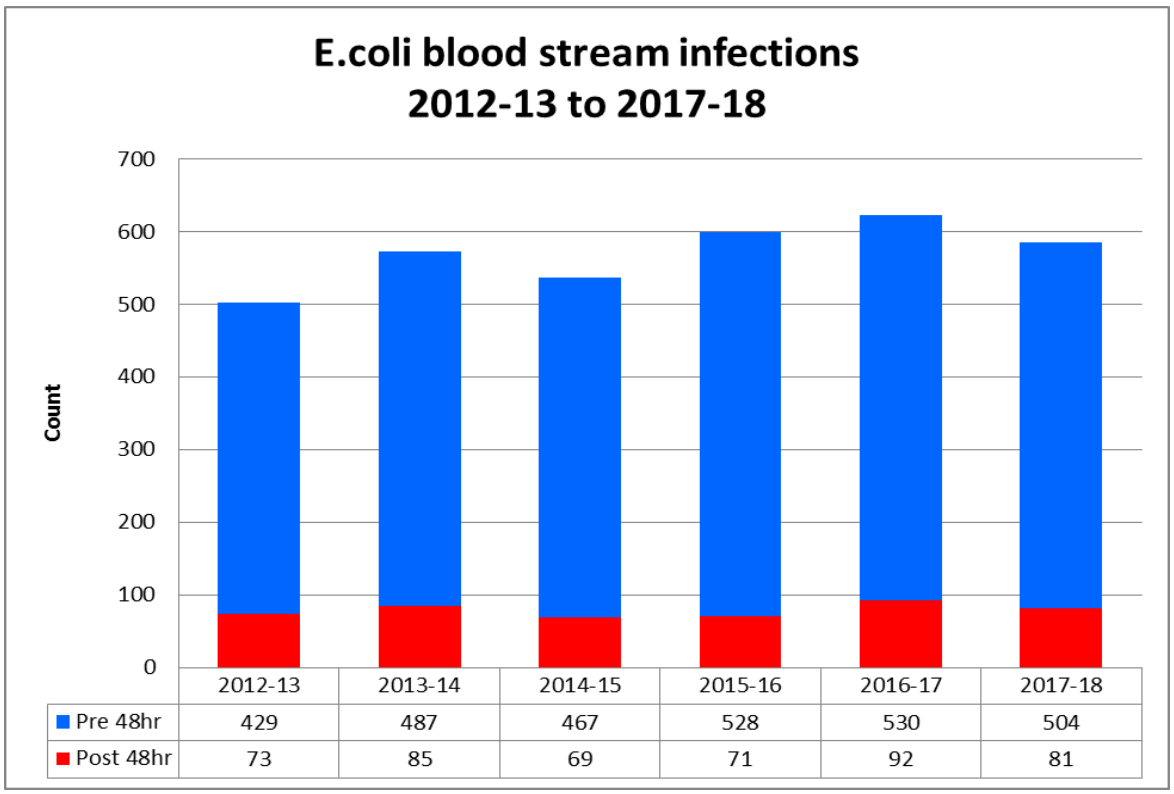
	2013-14	2014-15	2015-16	2016-17	2017-18
Trust assigned MRSA cases	9	1	2	9	7
Trust MRSA rate/100K bed-days	2.7	0.3	0.6	2.52	0.59
NHS rate/100K bed-days	4.2	0.9	0.9	0.91	0.9

The overall rate of Trust assigned MRSA bacteraemia cases for 2017-18 was 0.59/100K bed days compared with the NHS average of 0.9/100K bed days.

10.4 *E. coli* Blood Stream Infections Surveillance

Escherichia coli (*E. coli*) remains the most frequent cause of septicaemia identified across the NHS. Most cases are community acquired infections and case numbers have been increasing year on year.

Chart 1: *E. coli* blood stream infections



Post 48 hour cases (in red above) represent the proportion of cases with potential onset of infection after admission to hospital.

During 2016-17, EKHUFT reported an increase in *E. coli* blood stream infections, as depicted in the table above and the figures for 2017-18, show that the cases identified continues to increase.

The majority of cases are thought to be linked to urinary tract infections, bile duct sepsis and other gastrointestinal sources. It is likely that the high rate locally is due to demographic factors, notably the higher proportion of population in the age group > 75 years who account for most *E. coli* infections. Analysis of the *E. coli* rate per head of population demonstrates that the local rate of *E. coli* infection is within the range of variation seen nationally.

Examination of geographical variation in *E. coli* rates reported by Public Health England reveals that the overall East Kent rate of 80.8/100K population is high for the South of England but lower than the average population rates found in many parts of the North. The reason for this regional variation is not known.

The most frequent clinical diagnosis associated with *E. coli* bacteraemia continues to be urinary tract infection. In order to reduce preventable urinary catheter associated infection, EKHUFT implemented the HOUDINI protocol which was an initiative designed to improve the management of urinary catheters and reduce the number of unnecessary catheter placements.

The current situation (2017-18) bears out this analysis and monitoring and auditing of the compliances with HOUDINI is to be addressed commencing April 2018.

10.5 Carbapenemase Producing Organisms (CRO's)

Since CRO's have become more established, asymptomatic gut carriage is far more frequent than clinical infection and such carriers can spread CRO's to other patients particularly if they have been rendered susceptible to colonisation by prior antimicrobial therapy.

In response to this threat the IPCT introduced CRO rectal screening (as recommended by the PHE Acute Trust Toolkit) for all admissions meeting the following conditions:

- Recent hospital stay in UK outside Kent
- Recent hospital stay overseas
- Hospital care in an institution where CRO's are prevalent
- Previous carriage or infection by CRO's.

Since introducing this policy a number of asymptomatic carriers of CRO's have been detected but no symptomatic infections have been encountered.

The screening process did identify a case which culminated in a period of increased incidence (PII) – the ongoing issues relate to isolating appropriately and staff reviewing patient history.

11. ANTIMICROBIAL STEWARDSHIP GROUP

Antimicrobial stewardship interventions have been proven to improve individual patient outcomes, reduce the overall burden of antibiotic resistance and reduce costs. If everyone, from commissioners, prescribers, those who administer to and care for our patients, specialists and clinical pharmacists work together to employ effective antibiotic stewardship, we can improve patient care, more effectively combat antibiotic resistance, reduce rates of C. difficile and MRSA bacteraemia and ultimately save lives.

This is in addition to the costs of not doing so in terms of financial penalties associated with missed CQUIN, C. difficile and MRSA triggers.

Antimicrobial stewardship continued to present challenges for the Trust in 2017/18 compounded by shortages of both consultant staff and clinical pharmacy staff. For much of the year microbiologists were more than 40% below establishment.

Pharmacists; the team was transformed, following the departure of previous team in Dec-16/Jan17, with 2 8a WTE posts replacing the 3 previous posts (0.6 WTE 8b, 1.5WTE 7 - funded by pharmacy), these new posts:

- 8a Advanced Anti-Microbial Pharmacist at WHH-taking on all the Lead pharmacist responsibilities who started 27/11/2017
- 8a Advanced Pharmacist specialising in ITU with antimicrobial stewardship at QEQM-taking the lead on sepsis for the trust & use of Antimicrobials in critical care who started 1/8/17

Work to facilitate the 'decentralising' the Pharmacy AMS service by ensuring all clinical pharmacists are engaged and have the skills to support effective antimicrobial stewardship at the front line and reduce the dependency on the antimicrobial stewardship pharmacists for routine queries allowing them to focus on referrals for more complicated patients as well as supporting the MDT that oversees and delivers the antimicrobial stewardship plan for the Trust.

The result is a more engaged network of 40+ clinical pharmacists with the aim that they become skilled in antimicrobial stewardship working at ward level and in the dispensary supporting effective antimicrobial stewardship which has previously been the realm of just 3.

The Antimicrobial stewardship group was reformed with amended Terms of Reference (ToR) in September 2017 to support the challenges as well as renew the focus required in this critical area with key roles defined:

a) Ensure that evidence-based local antimicrobial guidelines are in place and reviewed regularly or when new evidence is published
b) Ensure regular auditing of antimicrobial stewardship and good prescribing practice
c) Report a regular formal review of the organisation's retrospective antibiotic consumption data
d) Oversee any AMS related CQUINs
e) Support a health economy perspective on effective antimicrobial stewardship practice including review of benchmarking data via the DEFINE application
f) Identify actions to address non-compliance with local guidelines, general antimicrobial stewardship issues and other prescribing issues
g) Advise on AMS support in relevant evolving clinical systems such as EPMA
h) Support and develop the AMS MDT clinical round
i) To produce an annual report on the activities of the Antimicrobial Stewardship Group and feedback outcomes to the IPC, DTC and other relevant meetings
j) To facilitate regular education and training on antimicrobial use for all staff involved in prescribing, administration and monitoring of antimicrobials.
k) To liaise with the Microbiology Department to help map out resistance patterns and implement measures to prevent the propagation of resistant organisms

The challenges coincided with the 2nd year of the National CQUIN (value £900k) which the Trust had failed two of the triggers the previous year (decreasing use of carbapenems and

piperacillin/tazobactam) and predicted to miss both the overall consumption of antibiotic and carbapenem reductions in 2018/19 as the benchmark remained 2013/14 not the previous year.

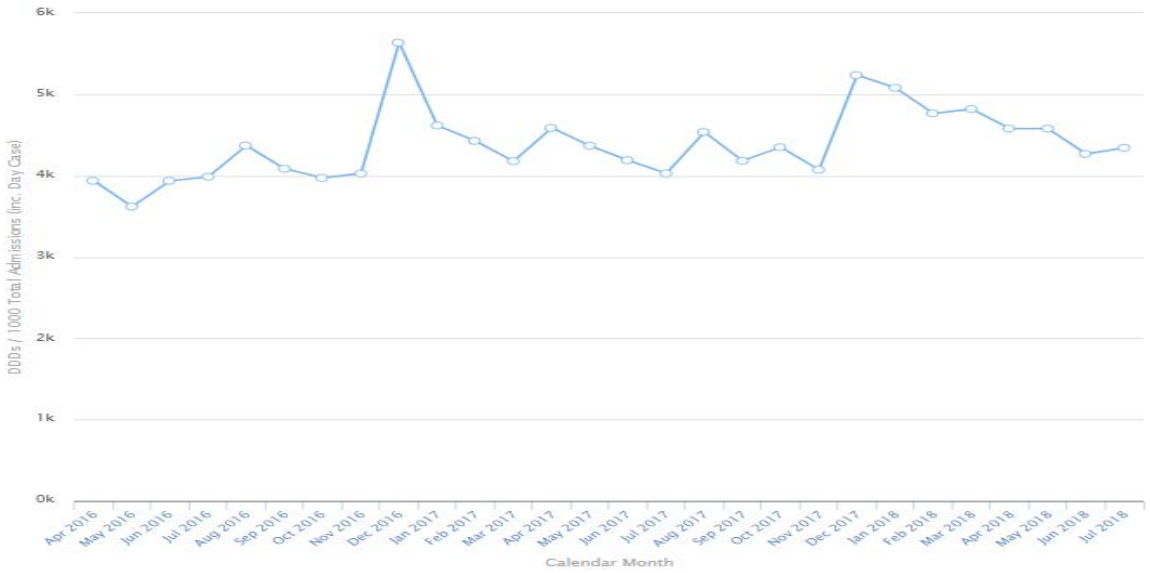
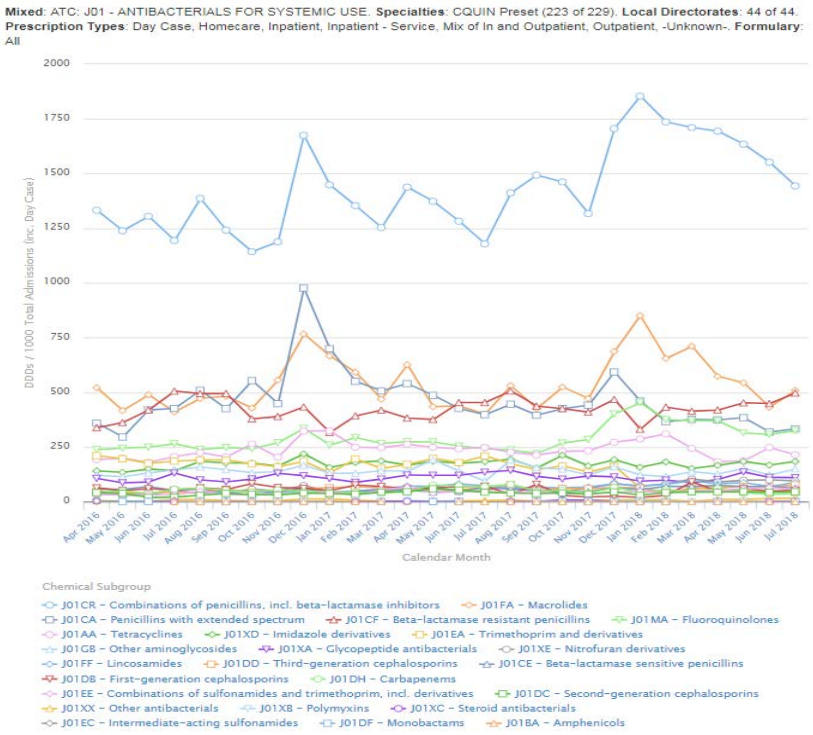


Fig 1 use of antimicrobial drugs April 2016-July 2018 as DDD/1000admission

The use of antimicrobials has seen a pattern develop over the last 2 years (see above) with spikes in use per 1000 occupied bed days occurring through Nov-Jan and the drivers seems to be the use of broad spectrum antimicrobials, principally in Acute medicine.



The current increase in antimicrobial usage that we are seeing across the Trust coupled with the on-going challenges to the organisation around bed capacity and flow impact on the use of medicines, not least antimicrobials and thus the importance of an effective MDT supporting this key area of patient safety cannot be under estimated.

Achievements of the ASG to date (August 2018)

- The AMR CQUIN part 2c for the review of antibiotics within 72 hours was achieved for 2017/18 due to ward level pharmacist effort to get antibiotics reviewed and junior doctor training on documentation of reviews.
- Challenges regarding antibiotic shortages in 2017/18 were dealt with and communicated effectively.
- Education and training provided to ward pharmacists to ensure effective antimicrobial stewardship across the trust at ward level
- Education and training of junior doctors on appropriate antimicrobial prescribing and stewardship
- Engagement of over 100 multi-disciplinary antibiotic guardians who made pledges to promote safe and effective use of antimicrobials across the trust at ward level
- Establishment of AMS rounds at 2 sites. They are currently ad hoc but plans are in place to make a regular occurrence and embed as part of normal ward practice
- Embedded in the sepsis collaborative and contribute to the initiatives related to the sepsis CQUIN
- Involvement in investigations relating to antibiotic use that has resulted in HCAIs or adverse events
- Baseline prescribing audit undertaken. Results collaborated to identify areas to focus on with regards to poor prescribing of antimicrobials.
- Gram negative resistance data collated and analysed, giving basis for review of the trust antimicrobial guidelines and the advice that is given around antimicrobial prescribing.
- Reduction in use of carbapenem usage from 57.91 DDDs/1000 total admissions in 2017/18 to 42.73 DDDs/1000 total admissions to date in 2018. CQUIN Target for 2018/19 is 45.78 DDDs/1000 admissions, meaning the trust currently stands at 6.6% below target. This has been due to a new approach in dosing of meropenem and the impact of stewardship rounds.

Plan for the coming 12 months:

1. Agreement of an audit calendar, including the following:
    a. ‘Take Five’ to be conducted by the directorates and fed back to ASG on a monthly basis.
    b. Prescribing compliance audits on a 6 monthly basis

2. Education and training on antimicrobial stewardship
    a. On-going with junior doctors and pharmacists
    b. Training with the new Registrars in October 2018
    c. Plan an approach for training of nurses and RMOs
    d. Re-emphasising the key AMS strategies and goals with senior staff
    e. Add e-learning modules on antimicrobial stewardship to the annual updates for all clinical staff
    f. Design and implement a checklist for all new pharmacy staff

3. Engagement of antibiotic guardians, including nursing staff and creating a forum for feedback as to the challenges for AMS on the wards.

4. Implementation of an updated drug chart in line with changes made to the Public Health England standards of reviewing antibiotics. This will help to meet certain criteria on the AMR CQUIN part 2c.

5. Promote quality improvement for prompt IV to oral switch of antimicrobials to the clinical directorates.

6. Establishment of an AMS ward round timetable to ensure consistent support to the wards.

7. Feedback of antimicrobial stewardship issues to the clinical directorates on a regular basis.

8. Review of trust antimicrobial guidelines, focusing on increasing the use of narrower spectrum antibiotics in conjunction with trust resistance data and CQUIN AWaRe groupings.

9. Launch paediatric antimicrobial guidelines

10. Expand the AMS team, to increase visibility on the wards and undertake AMS tasks such as ward based audits and provide support to the ASG initiatives.

11. Review antimicrobial consumption data every month and identify areas for improvement.

12. Complete antimicrobial stewardship self-assessment tool, to ensure we are meeting the national standards required for effective AMS.

13. Establish antifungal stewardship within the trust

12. TRAUMA AND ORTHOPAEDIC SURGERY

Surveillance of surgical site infection (SSI) following orthopaedic surgery has been included in the mandatory healthcare-associated infection surveillance system in England since April 2004 although EKHUFT has been participating in this scheme since 1998. The National Surveillance Scheme enables hospitals in England to undertake surveillance of healthcare associated infection, compare their results and national aggregated data, and use the information to improve patient outcomes.

All NHS Trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months surveillance in at least one of the three orthopaedic categories:

- Total hip replacements
- Knee replacements
- Hip hemiarthroplasties

EKHUFT undertake continuous surveillance in all 3 categories (rather than limiting participation to the mandatory single quarter per year).

SSI data for orthopaedic procedures for year 2017-18 reports infection rates for orthopaedic joint replacement surgery remains below the average for Trusts participating in the scheme.

Hip Replacements

William Harvey Hospital

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	128	1	0.8%	0	0.0%	1	0.8%
2017 Q2	120	0	0.0%	0	0.0%	0	0.0%
2017 Q3	127	1	0.8%	0	0.0%	1	0.8%
2017 Q4	122	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

QEQM Hospital

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	131	0	0.0%	0	0.0%	0	0.0%
2017 Q2	84	0	0.0%	0	0.0%	0	0.0%
2017 Q3	103	0	0.0%	0	0.0%	0	0.0%
2017 Q4	131	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Knee Replacements

William Harvey Hospital

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	109	0	0.0%	0	0.0%	0	0.0%
2017 Q2	109	0	0.0%	0	0.0%	0	0.0%
2017 Q3	135	0	0.0%	0	0.0%	0	0.0%
2017 Q4	132	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

QEQM Hospital

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	125	1	0.8%	0	0.0%	1	0.8%
2017 Q2	125	0	0.0%	0	0.0%	0	0.0%
2017 Q3	129	0	0.0%	0	0.0%	0	0.0%
2017 Q4	133	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Repair Neck of Femur fracture

William Harvey Hospital

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	94	1	1.1%	0	0.0%	1	1.1%
2017 Q2	98	0	0.0%	0	0.0%	0	0.0%
2017 Q3	97	2	2.1%	0	0.0%	2	2.1%
2017 Q4	146	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

QEQM Hospital

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	113	0	0.0%	0	0.0%	0	0.0%
2017 Q2	121	0	0.0%	0	0.0%	0	0.0%
2017 Q3	106	2	1.9%	0	0.0%	2	1.9%
2017 Q4	120	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

13. CONCLUSION

The Infection Prevention and Control Annual Programme for 2017/18 has been completed and there has been an increased level of visibly from the newly recruited team.

The team development and the integrating of the staff members across the sites has been very successful. Each team has started compiling baseline information about their demographic and are beginning to address audit requirements along with educational opportunities with the various ward staff.

MRSA and *C. difficile* infection rates remain the concerns for staff and IPC Team. These concerns and areas of non-compliance have been part of the action plans developed for renewed communication with ward staff, to reflect on the themes and to take the learning from these to the wards, to staff forums – to reiterate the infection prevention and control standards to ensure patient safety and quality of care.

On-going policy review and the embedding of infection prevention and control standards remain a challenge – the adherence to the Hand hygiene and the bare below the elbow requirements have received a varied and often low compliance rate – these areas are still a major priority to follow up and embed with all staff groups.

The lessons learned and the emphases for priority in the forthcoming year have been identified as:

- MRSA implementation and adherence to the policy, screening programme and appropriate isolation
- C. difficile implementation and adherence to the policy, correct use and understanding of the DAT tool and appropriate isolation
- The embedding of the AMR strategy and ensuring appropriate A/B prescribing
- The review and feedback of the perceptions of the IPC team and how they interact appropriately with staff across the Trust.

Return to Contents

Appendix 1: Mandatory Training Compliance and Hand Hygiene/BBE/Commode Cleanliness Reports

Apr-18

Infection Control

		3 Years
Clinical Support Services	**Total**	**97%**
	Clinical Support Divisional Management	100%
	Outpatient Services	99%
	Pathology	96%
	Pharmacy	99%
	Radiological Sciences	96%
	Therapies	95%
Corporate	**Total**	**95%**
	Clinical Quality, Patient Safety and Operations	93%
	Finance & Performance Management	96%
	Human Resources	98%
	PGME/Library	98%
	Research & Development	95%
	Trust Board	89%
Specialist Services	**Total**	**91%**
	Cancer, Clinical Haematology & Haemophilia	92%
	Child Health	92%
	Dermatology	80%
	Renal Medicine	94%
	Specialist Services Divisional Management	88%
	Womens Health	90%
Strategic Development & Capital Planning	**Total**	**98%**
	Facilities	97%
	Hospital Management K&C	100%
	Hospital Management QEQM	100%
	Hospital Management WHH	100%
	Information Technology	98%
	Procurement	98%
	Strategic Development	100%
	Strategic Estates	100%
Surgical Services	**Total**	**93%**
	Anaesthetics	95%
	General Surgery	88%
	Head & Neck	90%
	Surgical Services Divisional Management	95%
	Trauma & Orthopaedics	95%
	Vascular, Inter Radiology & Urology	85%
Urgent Care & Long Term Conditions	**Total**	**88%**
	Accident & Emergency	88%
	Acute Medicine	83%
	HCOOP	94%
	Specialty Medicine	93%
	UC&LTC Divisional Support	95%
Trust Average		93%

EKBI Business Intelligence Beautiful Information®

East Kent Hospitals University NHS
NHS Foundation Trust

April 2018

Infection Control Audit Performance

Bare Below The Elbows Audit

	Clinical	Specialist	Surgical	Urgent & Long Term
AHP Staff	100.0 %	100.0 %	100.0 %	100.0 %
Medical Staff	100.0 %	94.8 %	96.2 %	94.7 %
Nursing Staff	100.0 %	99.3 %	98.3 %	99.6 %
Support Staff	100.0 %	100.0 %	100.0 %	98.7 %

Commode Audit

	Clinical	Specialist	Surgical	Urgent & Long Term
Commode	64.3 %	96.2 %	89.7 %	84.1 %

Hand Hygiene Audit

	Clinical	Specialist	Surgical	Urgent & Long Term
AHP Staff	89.8 %	89.1 %	100.0 %	91.8 %
Medical Staff	93.4 %	91.5 %	96.2 %	69.9 %
Nursing Staff	93.2 %	96.3 %	98.4 %	98.3 %
Support Staff	94.2 %	89.1 %	99.2 %	98.5 %

Putting patients first

Appendix 2: Infection Prevention and Control Team Committee/Group Membership

The Infection Prevention and Control Team Committee/Group Membership (IPCT members contributed to the following committees in 2017-18)

- Clinical Advisory Board
- Drugs and Therapeutics Committee
  - And Antibiotic Sub-Group
- Infection Prevention and Control Committee
- Trust wide Matrons Forum
- Infection Prevention and Control Team meetings
- Patient Safety Board
- Medical Devices Group
- Health and Safety Committee
- CSSD Divisional Risk and Governance Committee
- Surgical Division Clinical Governance Board
- Soft FM Partnership Board
- Endoscopy User Groups
- Heads of Nursing meetings
- UCLTC Quality and Assurance Board
- Endoscopy Decontamination Steering Group
- Procurement Assurance Group
- Portering Task and Finish Group
- Chief Nurse fortnightly catch up
- Trust Board
- Mortuary Task and Finish Group
- Bed and Mattress Task and Finish Group
- Senior Quality Leadership Forum
- Strategic Investment Group
- Pillows Project – Working Group
- Microbiology and Infection Control meeting
- EKHUFT Quality meetings

External

- Kent-wide Infection Control Committee
- Kent Director of Infection Prevention and Control Forum
- Eastern and Coastal Kent NHS Primary Care Trust Infection Prevention and Control Committee
- Eastern and Coastal Kent NHS Primary Care Trust Infection Prevention and Control Project Group
- NHS South East Coast Directors of Infection and Control Committee
- HCAI Assurance Panel
- Kent and Medway HCAI Improvement Working Group
- Kent and Medway Infection Prevention and Control Forum
- HCAI Operational Group

Return to Contents

QUALITY STRATEGY: QUARTER 1 REPORTING

BACKGROUND AND EXECUTIVE SUMMARY

The following paper describes Trust quarter 1 progress against the 2018/19 Quality priorities.

The quality priorities were refreshed in April 2018. The new priorities were developed by in consultation with our staff, patients, stakeholders and Trust Board. They are built on progress achieved through the previous three year strategy (2015 - 2018) and additionally respond to new and emerging priorities.

The priorities we have selected, include development of pathways/holistic models of care that will equip us to better deliver evidence based care to some of our most vulnerable patient groups (i.e. patients with mental health problems and dementia).

We aim to build staff capability and (through a professionally blended staffing model) staff capacity as well, to deliver these new ways of working. The scope of this work means that for several of our priorities, progress is focused on securing stakeholder engagement and identifying the detailed plan / milestones that we will later use to measure project success.

Each priority has a project lead. Milestones and required action will be described within bespoke action plans that report to Trust Steering groups such as the Patient Safety Board, Patient Experience Group and Medication Safety Group for example. This and subsequent reports will provide a high level over view of progress across all the priorities.

Recognising that this first quarter focuses on setting out early plans and identifying stakeholders, there has been solid progress towards our metrics in Q1. Improvement is noted in relation to falls; and omitted medication albeit that further work is required to meet and exceed trajectory. Strong collective leadership is required to achieve progress in relation to National Safety Standards for Invasive Procedures (NATSiPPS), Never Events, and Venous Thromboembolism (VTE) specifically.

Quality Strategy 2018-21 Quarter 1 report

1. Background:

The Trust's quality goals and annual objectives are aligned with the Quality Strategy. The strategy aims to make explicit what the quality improvement goals for the Trust are over 3 years, how we are going to achieve those goals, and what needs to be in place to enable the goals to be achieved. The Quality Strategy was agreed at the Board of Directors during April 2018.

The Quality Strategy has five main annual priority areas, which mirrored the Trust Annual Objectives and the EKHUFT Shared Purpose Framework. These are :

Priority 1	**Person-centred care** – deliver excellent care whereby staff involve and treat people with kindness, dignity and respect
Priority 2	**Safe care** – by improving safety and reducing harm
Priority 3	**Effective Responsive care** - deliver care, treatment and support that achieves good outcomes and is based on best available evidence;
Priority 4	**Build our academic potential** – By 2021 we will have improved our potential as a University Trust
Priority 5	**Effective Workplace Cultures -** By 2021 we will have a workforce that demonstrates a) an inter relationship between holistic safety, being person centred and team effectiveness (SCQIRE project principles) and that we b) live and breathe this culture every day.

Our Quality Strategy reflects the Trust priorities (4Ps) and those of the Care Quality Commission (CQC). The priorities of both are threaded through our improvement work, to ensure that at all levels of our services are:

- Well led
- Safe
- Effective
- Caring
- Responsive.

Key:	
Complete	
On track	
On track some areas sub optimal	
Behind schedule	

This following report describes progress against Trust quality strategy annual priorities:

Patient centred care:	Baseline	Target	Rating	Progress notes
1. Deliver on our CQC Improvement Plan;		Actions on track as per plan		A CQC inspection took place during Q1. The previous high level plan has been reviewed and action s closed or transferred to the new plan. Immediate actions were taken during the inspection phase when issues arose. Discussion during Q1 took place to refocus on integrating the management of financial, operational and quality metrics. Work being undertaken led by the Transformation Board. In the meantime actions continue to be overseen by the Improvement Board led by the Chief Nurse.
2. Deliver Getting to Good Transformation workstream				Trust wide Transformation Board meeting established – priorities for action identified, action plan in place. Quality review linked to the transformation work stream as an enabler. On track.
3. Working in partnership with our service users deliver and develop services;				

A) Identify and implement strategic action plan within 2018/19. We will agree a programme of work using evidenced based methodologies that proactively involve patients and users and we will listen and act on their feedback to develop improved services. Action to include:				
• Map current involvement in improving, monitoring and developing our services and co construct best practice model by March 2019.				During Q1 we have consulted with stakeholders, staff and patients to map current patient involvement and to capture existing and new approaches. We are using the outcome of above to develop a Trust patient engagement framework by March 2019. We are developing a model that will deliver over the next three year. The implementation plan which supports this builds on existing stoma and orthopaedic, haemophilia / haemodialysis, MSK EKHUFT models. Detailed milestone / measures of success / evaluation approach and SMART objectives are being identified to ensure and track progress. On track.
• Implementation of MDT peer review Trust wide		80% ward areas visited within year		Programme relaunched through matrons and ward managers meetings –focus on grass roots review, inclusion of governors (non-clinical member) and use of emotional touch points. Report to the Patient Experience Group Q2. Evaluation of impact and effectiveness of these visits undertaken in real time with a summary evaluations planned at years end, March 2019. Action plan in place. On Track.
B) We will identify best practice models to receive and respond to patient feedback. We will strengthen the way we use patient and user input to improve and guide our services. Action to include:				
• Implement the PIE project to one ward at WHH, evaluate and assess roll out. To include patient and carer feedback		Implement the PIE project to one ward at WHH		Implementation approach in early stages development – meeting scheduled – stakeholders being identified.

• Undertake review of and strengthen PALS, complaints and PET function to maximise the effectiveness of this important route for patient feedback.		Complete review of service by Q4. Evaluate effectiveness against performance metrics. Identify success metrics and include service users.		Internal review completed by the Complaints team local actions (staff training, additional staff capacity and monitoring and reporting) in place pending broader review. Service improvement support for broader review has been delayed / available from October 2018 . Performance Monitoring of timeliness and responsiveness to the Quality committee. And Board in place. Service user and peer review will inform the service review. Service review on track for completion Q3.
• Strengthen visibility of Trust action arising from feedback		Implement 'You said, We did' on 2 pilot wards by December 2018.		Pilot wards identified. Plan in place to pilot corporate standard for notice boards. Engagement Discussion through ward managers "smile session" and matrons meetings. On Track.
		Improve performance in 4 areas identified by annual in patient survey		Action plan agreed at Q1 Heads of Nursing meeting and Carer and Complaints steering Group; professional engagement secured through site based Matrons meetings. Monthly reporting of progress secured through IPR. Hub sessions scheduled at QEQM October / requested at WHH and K&CH to promote "ownership" from broader font line staff. On track.
4. Implement national guidance / best practice to deliver great care to our patients with dementia and become dementia friendly in all aspects of our service. Action to include:	By 2021 we will achieve Dementia Friendly organisation status across all 5 hospitals			
• Confirm pilot for implementation of relationship based standards for people with Dementia		Identify standards and confirm implementation plan for pilot by March 2019		Meeting scheduled to confirm plan to: • Identify best practice model /co create with stakeholders • Identify standards and confirm implementation plan and milestones by March 2019 Commence implementation March 2019 and evaluation March 2019 – 20.
		Secure 2 Darzi fellows to focus on technology and the model of care for people with dementia by July 2019		Not yet developed. To be discussed at October meeting of the steering group.

• Train and draw upon volunteers to obtain feedback on relationship based care (see toolkit)		Commence training of 6 volunteers using the picker model by March 2019.		Steering group scheduled September - action plan and progress to be reported to the Patient Experience Group, Q3. Identification of individuals required. Detailed project plan in development.
5. We will deliver effective person centred care to meet the needs of our of all patients. Recognising the role of an acute hospital, we will promote effective care delivery to patients with mental health needs and Learning Disabilities - we will assess ourselves against relevant best practice guidelines (including but not limited to NCPOD) and identify and respond to required action.		Establish baseline, plan and milestones by March 2019.		MDT task and finish group planned October 2018 to scope project and required action. Timeline for audit against NCPOD to be confirmed.
		Identify Trust wide MDT training programme by March 2019		Training resource identified – work on-going. Planned programme development to be driven by October steering group .
6. Enable patients to become more independent and self-caring, we will:				
A) Identify and confirm roll out plan		Achieve Meal time matters roll out across 3 pilot wards at QEQM , K&CH WHH by March 2019.		Pilot wards identified. Implementation plan progress slower than planned – pace and approach reviewed by Nutrition steering group to pick up pace and deliver to timescale.
		Achieve minimum of 80% corporate meal time standards by March 2019.		Measurement methodology to include peer review – full methodology being confirmed. Feasibility of using observation (undertaken by volunteers /including the third age university), is additionally being explored.

		Develop and commence Trust wide implementation of meal time matters by March 2019.		Trust wide plan in place – regularly reviewed and updated by the Nutrition Steering Group to reflect progress and implementation ambition. Full implementation of meal time matters scheduled 2021.
B) Scope and confirm plan to improve patient access to information (internet / people) so that they can better access practical support and information				
Undertake evaluation of internet and ward based information available Produce accessible information for these areas and confirm strategy for ensuring continued review / quality assurance.		Identify patient user groups for 4 priority groups by March 2019		Patient engagement groups established Q1 for diabetes and Pressure Ulcers Groups. • Related information leaflet development underway. Groups for A & E and Youth forum in development Q3. • Related information leaflet in development. Reporting established to the overarching Patient experience group with specific action reported to the Complaints and pressure ulcer steering groups. On track.
		By September 2019 produce a Patient information sheet for 4 common drugs used by older patients (drugs used commonly within residential and nursing home care)..		Early discussion with Trust lead, Community trust and CCG Q3 in progress.
Person centred care by 2019				
1. Improve FFT satisfaction for inpatients:				

• Target Inpatients		95%		Achieved 97% June
• Target Outpatients		90%		Achieved 91 % June
• Target Maternity		98%		Achieved 99% June
• Target ED		85%		Achieved 85% June
2. We will improve patient experience		Monthly survey against national benchmark		Achieved 97%
		Annual inpatient survey against national benchmark		Reported annually – awaiting results at the end of Q1. Action plan will be developed on receipt.
3. 90% of complaints concerns will be responded to within the timeframe agreed with the client		90%		Achieved 92 % June 2018. The performance for the urgent care and surgical divisions continues to have the largest impact on this metric due to the higher number of complaints received by these divisions. While complaints performance has been rising incrementally in the months leading up to the end of year, we recognise that this needs to be sustained and plans are in place overseen by the complaints and patient feedback steering group.
Safe Care:				
1. Reduction in falls:				
• Maintain the falls rate to be less than the national average;	National rate 2017/18 6.4 per 1000 bed days	Maintain the falls rate below the National average		5.0 reported May 2018. On track. EKHUFT is participating in the NHSI Falls collaborative. Improvement action is reported to the falls steering group and a high level of improvement plan remains in place. Divisional and ward engagement remains crucial to delivery. Improvement action is reported to the Falls Steering Group and a high level of improvement plan remains in place. Divisional and ward engagement remains crucial to delivery.

• Achieve a decrease in the rate of falls compared with EKHUFT 2017 /18 rate	2017/18 EKHUFT falls rate 5.4 per 1000 bed days	Achieve a decrease in the rate of falls compared with 2017 /18 (5.4 per 1000 bed days)		
• Compliance with all 7 main indicators (included in the Falls risk assessment)	Improve 100% from baseline (baseline 10%)	Improve compliance in relation to all 7 main indicators (included within the falls risk assessment) by 100%		Baseline of 10% for all 7 indicators demonstrated in the 2017 National Inpatient Falls Audit – action plan in place overseen by Falls Steering Group. Collaborative work on 2 wards at WHH and K&CH. Trust wide action led by FallsStop programme. On Track. Improvement action is reported to the falls steering group and a high level of improvement plan remains in place. Divisional and ward engagement remains crucial to delivery. Improvement action is reported to the Falls Steering Group and a high level of improvement plan remains in place. Divisional and ward engagement remains crucial to delivery.
• Increase the measurement of lying and standing Blood pressures	Site baseline 2018 **24% K&CH** **38% WHH** **40% QEQM** Ward baseline being determined as part of the project	Show improvement on two intervention (pilot) wards - achieve 60%		Two wards and control ward identified as part of the NHSI collaborative – EKHUFT performance already exceeds national average of 19% , and we remain focused on improving this within year. Action plan in place. over seen by the falls steering group. On track.

• Complete medication reviews to reduce falls risk		Improve from 2017 audit baseline Discussion takes place within board rounds regarding medication for minimum of 50%		This work is being taken forward as a Falls Collaborative project – progress is on track. Baseline is being established for both metrics. Harbledown ward is identified as the pilot ward. Implementation progress is slower on the second pilot ward, Cambridge j, due to a ward relocation and changes in the staff team. Sufficient progress noted to remain on track.
2. Reduction in category 2 pressure ulcer rates:		Achieve below 0.15 trajectory		Trust performance **all** PUs 0.22 in June against 0.15 trajectory. Not achieved. Improvement action is reported to the pressure ulcer steering group. Action taken to respond to underlying reasons for avoidable category 2 pressures is reflected within the Trust wide action plan. : . action focuses on developing ward based tissue viability capability, supported by rigorous recording. Trust performance IN quarter 1 hovered around or under the trajectory and sustainability of improvement is an important factor in our intended recovery action. Current Action includes: Further Care Home training o Manage Moisture in May and sneak a peek campaign o TV link study day 14th May 2018 o Patient Tissue Viability Focus Group focusing on improving the documentation and care of wounds within East Kent o Joint TV,EME and MEL meetings held monthly o x3 TVNs attended Accelerate leg ulcer course o Joint QII HUB event with Dementia nurse at QEQM o Further analysis of on admission pressure ulcers to enable targeted work to be completed o Joint working with community stakeholders further strengthens preventative action.
• Secure a 25% increase in risk assessment within 6 hours of admission;	76 % 2018 baseline	To achieve 10 % increase in risk assessments		The audit was undertaken 2 February 2018 patients assessed within 6 hours was 82% . Targeted improvement action is reflected within the Trust action plan. This includes development of link practitioner capability and programme of educational sessions undertaken within the emergency department(s) to improve the documentation of early risk assessment. Progress is additionally being reported to the overseeing Trust Pressure Ulcer Steering Group and reported , reporting to the Patient Experience Group.

3. Delivery of the Sepsis Commissioning for Quality and Innovation CQUIN;		Achieve CQUIN target of 90%		90% eligible patients screened in ED and Acute Inpatient - Full achievement Q1 Continued good performance on screening in EDs – 93% overall reported in July. Achieved CQUIN target 9 consecutive months. 90% eligible patients received antibiotics within 1 hour of diagnosis each quarter ED – delivery of antibiotics within an hour of diagnosis in 100%. Achieved CQUIN target for last 5 months. Improvement in performance against tougher performance target (antibiotics within an hour of admission) - WHH continues to perform reasonably well. QEQM has a different triage model and struggles more. Delay in antibiotics is always because of a delay in medical review in ED (longest delay 4hours).Performance at QEQM this month is 78% overall. Wards: The wards which had been improving rapidly, plateaued July however there is continued good performance at QEQM and K&C. The WHH at only 65% remains our most challenging site. • Surgical wards in general are performing better than medical wards at WHH. CCU and Bartholemew have worked hard to improve their performance over last couple of months. This metric remains subject to targeted action through the Sepsis Collaborative. Action undertaken to promote achievement include: • clinical induction programme now includes sepsis • Introduction of Bedside Emergency Assessment Course for Healthcare assistants (BEACH). Ward screening has been steadily improving since, similarly EDs have achieved the target for antibiotics within an hour of diagnosis for the last two months. • 13th September is world sepsis day and that week we will be hosting events in hubs on all 3 sites (K&CH Monday 10th, QEQM Wednesday 12th, WHH Thursday 13th). We will be handing out certificates to good performing wards and celebrating their success.
		Reduction on total antibiotic usage of 2% per 1000 admissions against 2017/18 target.		Q1 local data indicates that none of the targets will be achieved - total antibiotic consumption 13.9% above target, Carbapenem 3.2% above target and AWaRe Access Group Consumption 22% below target. Recovery action includes Ward clinical pharmacists to support daily review of drug chart to ensure timely review of antibiotic usage – additionally supported by the above Sepsis actions.

4.	Embed National Safety Standards for Invasive Procedures (NATSiPPs) and achieve compliance to the patient safety alert	N/A			A NATSiPPS police has been developed but progress remains slow. Embedding is contingent upon the development of LocSSIPs by the individual specialities and roll out of human factors across the Trust which has commenced but not yet concluded. Recovery action is led by the Patient Safety Board.
5.	Reduce omitted medicine doses to be at least as good as the national average:	National average	Reduce omitted medicine doses to be at least as good as the national average; across the Trust (65%)		Progress has been made. 15 wards were included in the collection of Medication Safety Thermometer data in August. From these: 7 wards had <10% of patients with a missed dose of medication % of patients with missed dose average per division in August UCLTC division 19.3% Surgical division 23% Specialist division 5% Progress is monitored and reported to the medication safety group and Patient Safety Board
6.	Maintain Venous Thromboembolism (VTE) assessment above 95%;		VTE risk assessment aiming to be above 95% for 7 consecutive months.		Performance has slipped from 94.59% reported in March but remains stubbornly below target during quarter 1. • 94% April; • May 94%; • 94% June. There is a difference between sites. K&CH was 97%; QEQM 94.3%; WHH 91%. The main issues arise from urgent care at WHH. Risk assessment at ED is a particular problem. Locum consultant cover is anticipated to be an underlying issue at WHH. Actions plans have been requested from the specialties that are not reaching target, included within their exception report to Patient Safety board. Escalated to the executive leads Chief nurse and Medical Director. Performance is additionally scrutinised through at quality committee and EPR.
7.	Maintain Hospital Standardised Mortality Ratio (HSMR) below 85 & maintain Summary Hospital-level Mortality Indicator (SHMI) below 100;		**85**		The Trust Hospital Standardised Mortality Ratio (HSMR) for the rolling year 2017/2018 In June we reported Hospital Standardised Mortality Ratio (HSMR) is in the 25th percentile of Acute Trust Peers and in the latest dataset period (June 2017 to May 2018) was 85.6% Measured against our peers (other similar trusts) HSMR remains in the lowest quartile. This means that our performance remains on track. The latest summary hospital mortality index (SHMI) reported on NHS digital is from the January 2017 to December 2017 period and was 1.02 (0.90-1.12, 95% over dispersion control limits). A SHMI of 1.02 is categorised 'as expected'.

8. Eliminate Never Events;		To have nil never events in 2018/19		We had 1 never event in Q1 which was a retained vaginal pack. The report is complete and identified a number of actions regarding the recording of accountable items on dry/wipe boards. These actions will form part of the Trust wide action plan. We have rolled out a programme of Human Factors training for staff within the Trust and trained further Human Factors trainers, reflecting this commitment within our Patient Safety Strategic Drivers. Action including a never Event workshop and deep dive is underway to identify and address the underlying causes of error. This metric remains the focus of high level of monitoring and follow up to secure required recovery.
Effective Responsive Care				
1. Deliver our constitutional access standards RTT, ED & Cancer standards				Performance is reported within the IPR and divisions (care groups) are challenged through the Executive Performance Review (EPR) process. Recovery action remains in place.
3. Clinical outcomes achieved within the top quartile for benchmarked Trusts;				Awaited
5. Evidence strong MDT decision making to promote safe and effective patient management and discharge, effectiveness measured through establishment of clearly documented management plan reflecting consistently attended, appropriately attended (resilient) ward board rounds		Board rounds established within urgent care divisions on all wards by March 2019		Piloted at QEQM medical wards supported by service improvement team. Checklist developed and utilised to support consistency. Executive support and challenge additionally introduced through buddying scheme in Q1. Trust wide implementation in progress overseen by the ED improvement workstream.
6. Implement national guidelines in relation to:				
• assessing and responding to pain (MDT/registered and non-registered);		By March 2019 Identify and commence implementation plan and training and training implementation plan		QII hub sessions held not yet formalised within supportive cohesive trust wide plan. Planning meeting(s) scheduled.

• ensure the safe and effective oxygen administration and prescribing;		By March 2019 Identify and commence implementation and training plan		QII hub sessions held not yet formalised within supportive cohesive trust wide plan. Planning meeting(s) scheduled.
7. Identify Quality Improvement (QI) principles to improve how we use our resources to create and safe and effective physical working environment.		Using principles of lean identify and commence site based plan by March 2019		Ward managers and matron meeting s used to identify stakeholders – launched "great spring" clean campaign to de clutter ward environments April 2018 and link with Trust news (communication strategy). Peer review programme being used to encourage supportive behavioural change, to increase staff awareness and ownership of their clinical environment. Link with estates PEIC funds supports ward refurbishment initiatives, additionally supported by funds identified through "listening into action" where staff identify that an action can lead to improved patient experience or productivity. Matrons and ward manager stakeholders engaged – wider MDT engagement is the next focus, as we build this project from "grass roots". On track.
Build our academic potential	Strengthen engagement with our academic partners			
1. To promote the accessibility of evidence based Continuing Professional Development (CPD) across our diverse work force, we will:		Information management resources integration into the K&CH; WHH and QEQM hub programmes by March 2019.		Information management, early engagement with QII hub QEQM. Further wave of engagement is planned across all hubs Q3.
• strengthen our QII hubs to provide greater access to evidence based resources (providing both information and access to specialist personnel) with a strong focus on supporting professional progression and revalidation; • – integrate the tools and resources as a standard tool kit. To include TIPS resources; Improvement Methodology, Critical Companions;		Deliver the plan on time		Review of hub model (to include the non-acute sites) planned. Hubs are active and developmental work continues with Folkestone and Dover. Resources are being brought together as part of the Leadership Academy. This work is linked to the Trust transformation work stream and high level improvement plan. Further population of the portal is continuing.

• Position the Trust as a centre of excellence for research and innovation in all areas not just clinical research, but also quality, safety and transformation research and establish a renowned track record of practice development achievement with the England Centre of Practice Development;		By March 2019 we will develop a health community research strategy (linked to EKHUFT strategy) around quality, safety and transformation		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.
• Develop research capability and resource across the health economy		Train 10 research champions by September 2019		
		Identify career framework for honorary joint posts at consultant level –all professional groups – confirm proposal March 2019		
		Scope out potential for Clinical Research Facility on at least one EKHUFT site		
		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		

		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		
• Work on the establishment of the Medical School		Submit bid and follow up for a CLARC		Q1 saw the finalisation of this priority. Further progress will be reported within Q2 report.
2. Become a knowledge rich organisation that informs our decision making at every level by evidence blended with local knowledge, expertise and patient experience;		Support 3 staff members to submit bids for Research for Patient Benefit		Q1 saw the finalisation of this priority in discussion with key stakeholders. Planning meeting(s) are scheduled to support progression.
Effective workplace culture				
1. Develop a plan to work towards adopting a model of appreciative inquiry, to consider briefings, debriefs, huddles.		Develop and commence plan by March 2019.		Plan in early development – further report within Q2 report – this will be strengthened through the new CQC Improvement plan development.

3. Increase teams achieving 'Accrediting and Celebrating Excellence (ACE)' award		Accredit at least 5 further workplace teams against as 2017 baseline of n=3.		ACE accreditation –The Achieving and Celebrating Excellence (ACE) initiative enabled three teams to be accredited in 2017/18. It is important to acknowledge that these include participants working together across a number of boundaries in different departments and therefore reflect contributions so far from 10 areas. This cross boundary working is an unforeseen benefit of including the ACE initiative. The submission process for future evidence is being simplified to enable the submission of evidence to be less onerous. On track.
4. Increase the number of critical companions who have skills to support front line staff		Develop the skills of 30 further staff to enable them to be an effective companion and facilitator in any setting		Critical companions provide a valuable opportunity to support staff. More than 35 participated in the two Clinical Leadership Programmes 2016/17, supporting them to develop their skills in critical companionship. The portal enabling staff to search for a critical companion across a range of perspectives is in its prototype in readiness for the new integrated clinical leadership programme which focuses on skills in enabling others through critical companionship as well transformational and collective leadership. This model will enable our staff to focus on important areas like improving quality, learning, development, safety, knowledge translation, research, clinical leadership, innovation and being a champion.
5. Embed a patient safety culture		Assess culture using safety tool Develop / commence implementation of related action plan by March 2019		The electronic reporting tool has been developed with BI. Baseline data from recent staff survey will provide the baseline data. Testing has been undertaken with TIPS participants and iterations to provide site, professional group and grade segmentation in reporting. The tool is available on the BI suite of quality metrics and is in line with the roll out plan for implementation.
6. Identify and implement a programme of Human Factors training for staff;				Programme in place. Principles increasingly embedded in incident investigation approach and RCA. HF training continues and the Business plan to continue with the TIPS programme is nearing completion.

Detailed action plans have been requested for those metrics that have not achieved required progress. Strong collective leadership is required to achieve progress in relation to NATSiPPS, Never Events, developing a Trust wide Safety culture and VTE specifically.

Leadership from Divisional Heads of Nursing and Medical leads remains critical to ensure that divisional staff are appropriately sighted on and engaged with the work required to achieve all the quality metrics.

A communication and engagement plan is being developed to maximise the visibility of the strategy to our front line staff. We are using site based clinical meetings including but not limited to the matrons and ward managers meeting to support this. we will continue to use our QII hubs and patient and staff feedback to provide qualitative information that will aid implementation of our metrics.

As we move forward to a new reporting year, progress will continue to be overseen by the Chief Nurse & Director of Quality and Medical Director and reported to Patient Safety Board, Clinical Executive Management Board and Quality Committee.

COMPLAINTS UPDATE -

INCLUDING UPDATE ON PATIENT STORY AT BOARD OF DIRECTORS 6 SEPTEMBER 2018

BACKGROUND AND EXECUTIVE SUMMARY

The Board of Directors welcomed a patient and his son to the meeting held on 5 September 2018. A key component of the story was the delay in the Trust completing the complaint investigation and sending the family a timely and thorough response. The story was compelling and the Board asked for assurance around improvements and actions to prevent such delays happening again. Since this story and building on the improvement work already in place the following immediate actions have been taken:

- The Trust wide complaints process is being reviewed to improve the delays in providing a response to complaints;
- An external peer review has been requested of our complaints processes;
- We have approached NHS Improvement (NHSI) for a national exemplar to support this further. Benchmarking against local and national Trusts around complaints management and improving the quality of our responses is underway. This review will be undertaken during October 2018;
- An internal review of this specific case and the delays encountered is in progress;
- The complaints process has been strengthened with earlier escalation when delays occur so that more senior intervention can take place;
- The panel that meets monthly with the Divisions, who investigate and formulate the responses, has been strengthened with a focus on unblocking issues that cause delays. This will reduce the length of time a complaint is open;
- Internal support for the complaints team has been strengthened – management of staff vacancy and leave are reviewed proactively to anticipate and mitigate risk;
- We have escalated to secure the support from service improvement team to review our Patient Advice & Liaison Service (PALS) to prevent us from falling into backlog for response to PALS emails;
- We are developing a proposal to redesign the corporate and the new care group governance teams to strengthen oversight. Early draft planned by the end of September;
- A stronger focus demonstrating what we do with feedback through greater visibility of “you said” “we did” will further support important cultural change across our organisation. Greater engagement of medical colleagues and stronger clinical leadership and accountability for the complaints process lie at the heart of delivering the required improvement.

More specific actions where there are issues at Divisional level are described below:

- We have scheduled an urgent meeting with urgent care and surgery respectively – meeting to be attended by the Divisional Medical Lead, Divisional Director and Head of Nursing, Head of Patient Experience Team (PET), Deputy Medical Director and Deputy Chief Nurse. Meetings are scheduled the week commencing 17 September 2018. We intend to unblock and complete all old cases (over 60 days). Any cases that are kept open after 4 weeks of this review meeting will be escalated to the Executive leads and unless there is a compelling reason to keep them open completion will be required.

Longer term we are working with the Learning and Development team to provide customer care training for Trust staff; we are continuing our QII hub events to involve the matrons more directly, introducing 'Feedback Friday' at Queen Elizabeth the Queen Mother Hospital (QEQMH) and "it's good to talk" sessions in the lobby at Kent & Canterbury Hospital (K&CH). We are focused on identifying action in response to feedback and continue our deep dives into common themes.

While we focus on achieving our response targets we remain absolutely committed to responding to the issues our patients are raising.

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR FINANCE AND PERFORMANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE FINANCE AND PERFORMANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: MONTH 5 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.

25 September 2018 Meeting

The Committee reviewed the following matters:

Specialist Services Division – Divisional Presentation:

1. In the month ending August 2018 (Month 5) the following were the main highlights from the Division:
   1.1. The Divisional position at Month 5 was £0.6m behind plan. The Division is behind plan on income; and overspent on pay (against agency costs) and non-pay.
      1.1.1. Underperformance in income is driven by electives in dermatology and gynaecology, non-electives within women's health and renal, as well as outpatients in child health, women's health and renal.
      1.1.2. Activity is above plan for electives in oncology/cancer services, non-electives in paediatrics and also in Neonatal Intensive Care Unit (NICU)/Special Care Baby Unit (SCBU).
      1.1.3. The Divisional Income & Expenditure (I&E) run rate identified its average monthly income as £11k higher than 2017/18, average

monthly pay is £243k higher than 2017/18 and the average monthly non-pay is £40k lower than 2017/18.

1.1.4. The Cost Improvement Programme (CIP) under-delivered by £132k Year to Date (YTD) against plan. The Division highlighted an issue with achieving its pay CIPs target and planned to address this by overachieving against other schemes. There are also a number of business cases that are being progressed to support its CIP along with working with specialities to identify new CIP schemes.

1.1.5. Additional support is needed in the Division around resources for programme management.

1.1.6. The review of the Division's Service Line Reporting (SLR) for 2017/18 had identified improvements in the obstetrics coding CIP scheme for 2018/19, and plans for paediatrics as well as community paediatrics. SLR sessions will be held with the Clinical Leads once the new Care Groups are in place, as it is vital that clinical staff understand the SLR process and data.

1.1.7. The main challenging areas for the Division include: maternity, and gynaecology waiting times backlog. This is being mitigated by focussed work on efficiency/optimising existing capacity, the appointment of additional booking/waiting list staff, and the possible provision of extra clinics. The department will undertake a focussed review of job planning. On dermatology waiting times backlog, the Division is looking at the provision of extra clinics and plans a full review which will help identify a comprehensive set of corrective actions. Cancer 62 day performance remains a challenge. Performance is monitored weekly and there is on-going transformational work with the Multi-Disciplinary Teams (MDTs) to improve the pathway, along with the appointment of an Interim General Manager.

Financial Special Measures (FSM) Update:

2. The Committee received a verbal update on FSM:
   2.1. A meeting was held on 25 September with NHS Improvement (NHSI) to have a system-wide discussion regarding FSM.
   2.2. The Trust is required to produce a three year financial plan.
   2.3. The Trust needs to achieve its Q2 target and closure of its undertakings.
   2.4. The Programme Management Office (PMO) is required to be sufficiently resourced.
   2.5. NHS Improvement (NHSI) has not yet formally defined an FSM exit strategy for the Trust.

CIPs Update

3. The Committee received and discussed an update against CIPs:
   3.1. In Month 5 £1.8m CIPs had been achieved against the plan of £2.2m.
   3.2. The YTD CIPs delivery is £10.4m and is £0.3m ahead of plan, against the 2018/19 £30m target. The current gap against the £30m 2018/19 target is approximately £0.7m. In addition, the current value of 2018/19 schemes not fully worked up (i.e. not RAG rated green) is £3.7m.
   3.3. The current position against the forecast £30m CIP plan, indicates £25.8m (87%) green, and it is aimed that a further £2.3m amber schemes will be converted to green by the end of September.

3.4. The top ten CIP schemes include:

CIP Scheme	RAG Status	Total 2018/19 target
Biosimilar Clinical Commissioning Group Adalimumab	Amber	£120k
Other SLR opportunities in the Specialist Division	Amber	£440k
Obstetrics productivity improvements	Amber	£187,500k
Theatre efficiencies including reducing cancellation	Amber	£875k
Non-recurrent pay in the Surgical Division	Red	£303,236k
Non-recurrent non-pay in the Surgical Division	Red	£279,762k
Water consumption schemes	Red	£110,000k
Managed Service Contract Endoscopy (equipment)	Amber	£105,000k
Efficiencies in Spencer Private Hospital	Red	£583,334k
Endoscopy waiting list coverage	Amber	£133,000k
Total 2018/19 target		£3,136,832m

3.5. Additional schemes are currently being scoped and the Trust aims to achieve the £30m target by year-end.

3.6. A CIPs pipeline has been identified for 2019/20, which is currently c£12m and it is aimed to identify and work up at least £20m CIP schemes to green status by 31 December 2018.

3.7. A report has been requested for the next FPC on revalidating the CIP forecast and identifying mitigating actions for this financial year with additional schemes. This will be presented at the October FPC.

Month 5 Finance Report:

4. The Committee received the Month 5 finance report (attached Appendix 1).

4.1. The following points were noted in relation to the Trust's financial position in Month 5:

4.1.1. The Trust's consolidated deficit in month is £4.4m and the YTD deficit position is £15.6m, which is £0.2m behind plan. The main variances are around higher than planned A&E activity and higher income being driven by the non-elective case mix. As well as very high agency spend that is mainly being driven by Urgent Care and Long Term Conditions (UC&LTCs) due to operational pressures.

4.1.2. The Trust's unconsolidated pay costs in month is £32.5m. This is £0.6m more than in July.

4.1.3. Clinical income in month is ahead of plan by £0.8m and the net YTD position is currently £2.7m ahead of plan, the key drivers of this over performance is within non-electives around A&E and ITU

and is being offset by underperformance in electives in relation to outpatient activity.

4.1.4. The Trust's cash balance as at the end of June was £9.2m, which is £5.8m above plan. The Trust's total cash borrowing is £55.6m.

4.1.5. There is an estimated risk of £9.5m to the year-end position in relation to expert determination on income, CIP delivery and activity related costs. The Trust is currently reviewing its financial risks around mitigating these throughout the year.

Financial and Operational Risks Review

~~5.~~ The Committee received and discussed a report on the financial risks, noting the key risks:

5.1. The principal financial risk to the Trust remains as SRR5 – Failure to achieve financial plans as agreed by NHS Improvement (NHSI) under the FSM regime.

5.2. There have been no changes to the residual risk scores during the period reviewed.

5.3. Risk CRR51 – Patient safety may be compromised as a result of the move of acute medicine, acute geriatric medicine and stroke from the Kent & Canterbury Hospital (K&CH) site, has been closed on the risk register.

5.4. A new financial risk has been added to the risk register, risk number 1446 – this relates to establishing 2gether Support Solutions (2SS), this is because the transaction is technically complex, it is mitigated through use of relevant professionals.

Operational Performance and Activity

6. The following key areas were discussed and noted in relation to the Trust's operational performance and activity:

6.1. A comprehensive improvement plan is in place covering emergency care and good progress has been made over the past month. Deputy Heads of Clinical Operations are now in post, enabling the Head of Clinical Operations to have a focussed review of the current practices in both ED sites. This has identified opportunities for sharing best practice, standardisation and priorities for training and development. New staff will be taking up in month the additional Clinical Site Practitioner (CSP) posts.

6.2. Improvement work continues in the Emergency Departments (EDs) around quality, safety and access. The ED Escalation Pack was successfully launched in August as well as ED streaming. The Urgent Care Centre (UCC) model is progressing at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQMH). The Medical Model at QEQMH has progressed with Minster Ward to become a short stay ward. The GP in reach service continues and the Clinical Commissioning Groups (CCGs) have committed to develop an integrated UCC Model.

6.3. A business case for an ED observation area at WHH and QEQMH has been submitted to address capacity to meet the demand for short stay patients. In association with this a review of the staffing requirements across ED and the new ED observation areas has been completed.

6.4. A frailty model is being progressed both with external partners and internally with clinical teams, this will enable frailty services to be implemented as a priority.

6.5. A workstream is being progressed to reduce the Length of Stay (LoS) and this is focussed on the efficiency of internal processes, including maximising the use of the discharge lounge. A successful 'Peak Flow'

week took place during August, where all staff involved in emergency care pathways were engaged, and focussed on improving flow and discharge. Partners from across the wider health economy were also involved in reducing the number of patients with a length of stay over 20 days.

6.6. The Trust is developing a local health economy winter plan and is working with NHSI and key partners. Internal protocols have been reviewed and rewritten to ensure these are focussed on the response to the Operational Pressures Escalation Levels (OPEL) framework.

6.7. The Trust is actively continuing to work with key partner organisations to improve ambulance handover times, mental health and frailty pathways. The 60 minute ambulance handover performance has significantly improved.

6.8. Performance against the ED 4 hour wait target was 80.0% in August, against the NHSI trajectory of 85.4%. This is an increase in performance compared to the previous month. August was a particularly challenging month due to an increase in the number of attendance and patient acuity due to the continued extremely high temperatures experienced during that month.

6.9. There were no 12 hour trolley waits in ED in August.

6.10. Time to treatment in ED improved from July but remained un-compliant at 48.0% in August.

6.11. August performance against the Referral to Treatment (RTT) standard reduced to 79.06% and is currently 1.95% behind the improvement trajectory.

6.12. The number of patients waiting over 52 weeks for first treatment has decreased to 125 and is within the trajectory submitted to NHSI.

6.13. Cancer performance for August was 66.53% against the improvement trajectory of 57.87%. The total number of patients on an active cancer pathway is 2.689 at the end of the month, of which 25 patients are waiting 104 days or more for treatment or potential diagnosis.

6.14. The diagnostics standard was not met for August, the Trust's compliance is 98.03% and remains a challenge. There were 298 patients at the end of the month who had waited over 6 weeks for their diagnostic procedure.

6.15. The Trust will continue to monitor the improvement plans for ED, RTT and cancer through its key meetings to ensure the alignment of priorities.

6.16. NHSI and NHS England (NHSE) have reviewed the Trust's cancer improvement plan, confirming that these are robust with continued evidence of improvement in performance and patient outcomes.

6.17. The Trust continues its focus around engaging and empowering front line staff across all operational groups and specialities, including focussing on support along with training and development to sustain improvements.

6.18. Potential harm reviews are in place.

Business Case

7. The FPC received, discussed and approved a business case submitted by the Safeguarding Children team.

7.1 Requesting additional funding to increase the Nurse Advisors within the team, to meet the increased safeguarding activity within the organisation and ensure safe services are delivered across EKHUFT. An additional 3 Nurses and 0.6 admin is required.

7.2 This will support improving the training compliance that is still below the national requirements at levels 2, 3 and 4.

7.3 The workload within the team has increased by a further 75% this year on top of a 53% increase in the previous year, and the workload is no longer

able to be absorbed effectively by the team.

7.4 The Committee acknowledged the importance of the provision of this training and the need for the team to have sufficient capacity to be able to provide this training.

Capital Funding

8. The FPC received, discussed and approved a request for the provision of capital funding to support the Dementia Village business case.
   - 8.1. Additional capital funding is required as the business case included a requirement for a loan from Kent County Council (KCC), subject to approval by the Department of Health (DoH). The DoH has not approved this loan at the KCC's rate.
   - 8.2. The construction costs for the Dementia Village following a competitive tender process now exceed the original business case estimate.
   - 8.3. There has been some slippage in the capital budget and there are no items outstanding for capital allocation.
   - 8.4. The Trust is committed to supporting this project.
   - 8.5. The Committee approved the allocation of capital funding.

Service Line Reporting (SLR) – Q1 2018/19

9. The FPC received and noted a quarterly SLR for Q1 2018/19:
   - 9.1 The SLR statements built from patient level costs (PLICs).
   - 9.2 The majority of Trust services are making a positive contribution and performance.
   - 9.3 There are on-going service reviews and updated costing performance packs per service will be produced on areas of focus by the Divisions.

Horizon Scanning

10. The FPC received and noted a six monthly report providing surveillance of external financial issues that may have relevance for the Trust and/or the potential to affect the Trust's business environment.

Strategic Investment Group (SIG)

11. The FPC received and noted a report from the SIG along with the confirmed minutes. This group is an approval and recommendatory group that focuses on corporate priority business cases.

Financial Improvement Committee (FIC)

12. The FPC received and noted a report from the FIC along with the confirmed minutes. It was noted that following a review of the Transformation Programme Board and a change to the governance arrangements, the FIC is being incorporated into the new Transformation and Improvement Group (TIG).

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and approve the FPC report.

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2018/19

August 2018

Director of Finance and Performance Management
Philip Cave

Contents and Appendices

Month 05 (August) 2018/19

Contents

Appendices

Executive Summary
Month 05 (August) 2018/19

Executive Summary

The Trust has generated a consolidated deficit in month of £4.4m and a year to date (YTD) deficit of £15.6m which is £0.2m behind plan. YTD position includes some significant variances. The main variances include:-

- Higher than planned A&E activity and Non Elective case mix driving higher income
- High Other Clinical Income driven by central funding of pay awards. This is offset by higher pay costs.
- High Other Income driven by SACP progress and Serco transfer payment (this was budgeted as a cost reduction so also appears as a cost over run YTD)
- Off set by YTD under performance of complex Elective and Out Patient activity driving low income but also low non rechargeable drugs costs.
- Very high agency spend mainly driven by U&LTC operational pressures

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 5 (August) was £15.3m (consolidated position including our Subsidiaries and after technical adjustments) against a planned deficit of £15m. A reconciliation of the various adjustments is presented below.

	This Month			Year to Date			Annual		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
EKHUFT Income (inc PSF)	47,433	49,671	2,238	240,709	248,672	7,963	583,617	583,617	0
EKHUFT Pay	(30,280)	(32,455)	(2,175)	(152,236)	(158,874)	(6,638)	(365,552)	(365,552)	0
EKHUFT Non-Pay	(21,147)	(21,593)	(446)	(103,910)	(105,451)	(1,541)	(249,052)	(249,052)	0
EKHUFT Financial Position (inc PSF)	**(3,994)**	**(4,376)**	**(383)**	**(15,437)**	**(15,653)**	**(217)**	**(30,987)**	**(30,987)**	**0**
Subsidiaries Financial Position	9	20	12	48	68	21	132	132	0
Consolidated I&E Position (inc PSF)	**(3,985)**	**(4,356)**	**(371)**	**(15,389)**	**(15,585)**	**(196)**	**(30,855)**	**(30,855)**	**0**
Impairments Adjustment	85	88	3	425	280	(145)	1,025	1,025	0
PSF Funding	0	0	0	0	0	0	0	0	0
Consolidated I&E Position (excl PSF)	**(3,900)**	**(4,268)**	**(368)**	**(14,964)**	**(15,305)**	**(341)**	**(29,830)**	**(29,830)**	**0**

Trust unconsolidated pay costs in the month of £32.5m are £0.6m more than July. This increase is driven by non medical pay arrears paid in month (funded in clinical income) off set by the release of a reserve for this years medical pay award based on NHSi guidance. These adjustments give a net increase of £0.9m month on month. After removing the pay award adjustments, staff costs were £0.3m less than last month due to reductions in temporary staffing. Agency spend in month is £1.5m more than plan. Permanent staff costs (including Overtime and waiting list work) are £0.6m more than plan and were £0.2m higher than July (the latter after allowing for pay award adjustments). The main driver for the pay overspend against plan in month remains U&LTC where medical staffing are being used above establishment and recruitment to nursing has been slower than expected.

Clinical income was ahead of plan by £0.8m in month once the impact of central pay award funding (£1.6m) is removed. The net YTD position is now £2.7m ahead of plan. The key drivers to this are over performance in non-electives, A&E and ITU offset by under performance in elective and Outpatient activity.

Against the full year £30m CIPS target, including income, £10.4m has been reported YTD against a target of £10.1m, £0.3m ahead of plan. The main issues in month were that delivery from Agency reduction schemes and Procurement initiatives have fallen behind plan whilst Divisional schemes are over performing. Of the YTD reported position 49% is non recurrent.

The cash balance as at the end of June was £9.2m, £5.8m above plan. The Trust's total cash borrowing is now £55.6m.

The Trust continues to carry and estimated £9.5m of risk to the year end position in relation to expert determination on income, CIP delivery and activity related costs. The Trust is currently re-forecasting and is reviewing the financial risks .The Trust will seek to mitigate these risks as we move through the year.

Income and Expenditure A

Income was ahead of plan in month due largely to Non-Electives, A&E and Other NHS Area (driven by ITU and pay award funding). Non-Electives are over plan by £0.6m in month, largely due to General Medicine and General Surgery activity.
Other non clinical income is £0.1m lower than plan which is driven by training and donated asset income underperforming slightly in month.
Pay is over plan by £2.2m in month and £6.6m YTD (including £2m of agenda for pay award which was funded) . The YTD variance is driven principally by additional costs associated with UC&LTC and Surgery medical staffing however nursing staff agency spend is also above plan in month. In addition TFS are still being used and pay CIPs are under delivering.
Total non pay spend is £0.4m over plan in Month 5 and £1.5m overspent YTD. The YTD position is driven mainly by non clinical supplies (due to the plan including the benefit of the Serco settlement income which is appearing in clinical income) and prior year sewerage and maintenance costs where invoices received have indicated unexpectedly high charges.

Cash G

The Trust's cash balance at the end of June was £9.2m which was £5.8m above plan. The main drivers for the YTD position are as follows:-

- CCG payments are net £0.2m over plan due to payments on account being made early and NHSE over plan £1.5m driven by payment of prior year over performance
- HMRC VAT returns are £2.1m above plan
- Other Income is £5.3m above plan; £2.3m from Serco, STF funding of £1.4m and £1.7m of AfC funding from the DoH
- Loans from DHSC are £3.4m above plan
- Cash payments driven by capital are £6.8m above plan net.

The Trust borrowed £3.7 in month bringing total borrowings to £55.6m. The total expected borrowing by the end of the year will be £89.7m. The increase in expected borrowings from plan is due to adoption of a cautious view on lowering of the CCG contract and 2gether impact but will be revisited in Month 6.

Capital Programme A

The Trust has spent £3.7m on capital to August which is £1m behind plan. The majority of the underspend is driven by slippage on the Dementia Village project and some IT programmes due to long lead times ordering IT goods. The capital plan is currently being reviewed in order that developments such as the pilot elective orthopaedic centre can be considered. The Capital plan for the year remains at £16m.

Cost Improvement Programme A

Net CIPs in month were £0.4m behind plan bringing the YTD position to £0.3m ahead of plan at £10.4m of savings YTD. The main issues in month relate to agency reduction and procurement schemes not delivering as planned and savings not yet generated from 2gether which were recognised in the plan from month 5. YTD 49% of all CIPs are non-recurrent .

Risks to the full year plan remain in relation to finalising all delivery plans and risks remain in relation to 2gether, the ability to release planned agency savings for U&LTC and the delivery of further bed reductions.

Income and Expenditure Summary
Month 05 (August) 2018/19

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	6,239	7,652	1,413	40,457	38,998	(1,460)	103,209
Non-Electives	13,355	13,907	553	68,320	70,875	2,555	161,862
Accident and Emergency	2,185	2,465	280	11,163	12,332	1,169	26,226
Outpatients	7,023	6,337	(685)	33,560	32,618	(941)	81,011
High Cost Drugs	4,727	4,458	(269)	23,331	22,521	(810)	55,662
Private Patients	(62)	13	75	105	147	42	248
Other NHS Clinical Income	10,170	11,169	1,000	44,819	49,048	4,229	109,496
Other Clinical Income	153	151	(1)	768	719	(49)	1,845
Total Clinical Income	**43,789**	**46,153**	**2,364**	**222,522**	**227,257**	**4,735**	**539,558**
Non Clinical Income	3,644	3,518	(126)	18,187	21,415	3,228	44,059
Total Income	**47,433**	**49,671**	**2,238**	**240,709**	**248,672**	**7,963**	**583,617**
Expenditure							
Substantive Staff	(27,728)	(28,335)	(607)	(138,995)	(136,660)	2,335	(326,479)
Bank	(1,111)	(1,171)	(60)	(5,633)	(5,951)	(318)	(19,900)
Agency	(1,441)	(2,949)	(1,508)	(7,608)	(16,263)	(8,655)	(19,431)
Total Pay	**(30,280)**	**(32,455)**	**(2,175)**	**(152,236)**	**(158,874)**	**(6,638)**	**(365,810)**
Non Pay	(18,936)	(19,430)	(494)	(92,879)	(94,632)	(1,753)	(222,146)
Total Expenditure	**(49,216)**	**(51,884)**	**(2,668)**	**(245,115)**	**(253,506)**	**(8,391)**	**(587,956)**
Non-Operating Expenses	(2,211)	(2,163)	47	(11,031)	(10,819)	211	(26,648)
Income and Expenditure Surplus/(Deficit)	**(3,994)**	**(4,376)**	**(383)**	**(15,437)**	**(15,653)**	**(217)**	**(30,987)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	44,480	46,857	2,377	225,977	231,411	5,434	547,857
Non Clinical Income	3,529	3,633	104	17,612	20,978	3,366	42,682
Total Income	**48,009**	**50,490**	**2,481**	**243,589**	**252,389**	**8,800**	**590,539**
Expenditure						-	
Pay	(30,634)	(34,168)	(3,534)	(154,006)	(162,068)	(8,062)	(370,054)
Non Pay	(19,125)	(18,502)	623	(93,824)	(95,006)	(1,182)	(224,416)
Total Expenditure	**(49,759)**	**(52,670)**	**(2,911)**	**(247,830)**	**(257,074)**	**(9,244)**	**(594,470)**
Non-Operating Expenses	(2,235)	(2,176)	59	(11,148)	(10,900)	248	(26,924)
Income and Expenditure Surplus/(Deficit)	**(3,985)**	**(4,356)**	**(371)**	**(15,389)**	**(15,585)**	**(196)**	**(30,855)**

Clinical Income

Income from Commissioners in month was on plan. Non elective activity remains higher than planned, while elective income is showing a large, one off, positive variance due to a phased reduction in plan to cover expected high levels of annual leave. Please note this phased reduction was not applied to Elective activity and therefore the comparison between income and activity is not useful in month. The majority of the adverse variances are contained within Outpatients and Non-PbR The largest increase in income is £1.6m of funding received in month to cover the pay awards which is included under under "Other NHS Clinical Income" and for which there is no clinical income plan.

There remains some uncertainty around the financial impact of 2017-18 Expert Determination challenges on 2018-19 baseline as both commissioners and the Trust work through the implications of the way some of our activity is recorded. The Trust is holding a provision against this risk.

NHSE Contracts are ahead of month by £176k. Rechargeable expenditure such as high cost drugs, devices and haemophilia blood products under performed by £365k 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 adverse to plan in August by £0.1m and favourable to plan ytd by £3.2m. As previously reported, the majority of the favourable variance ytd relates to £2.1m of contract exit income from Serco which was planned as a reduction to contract expenditure and above plan income relating to the PAS project totalling £0.6m.

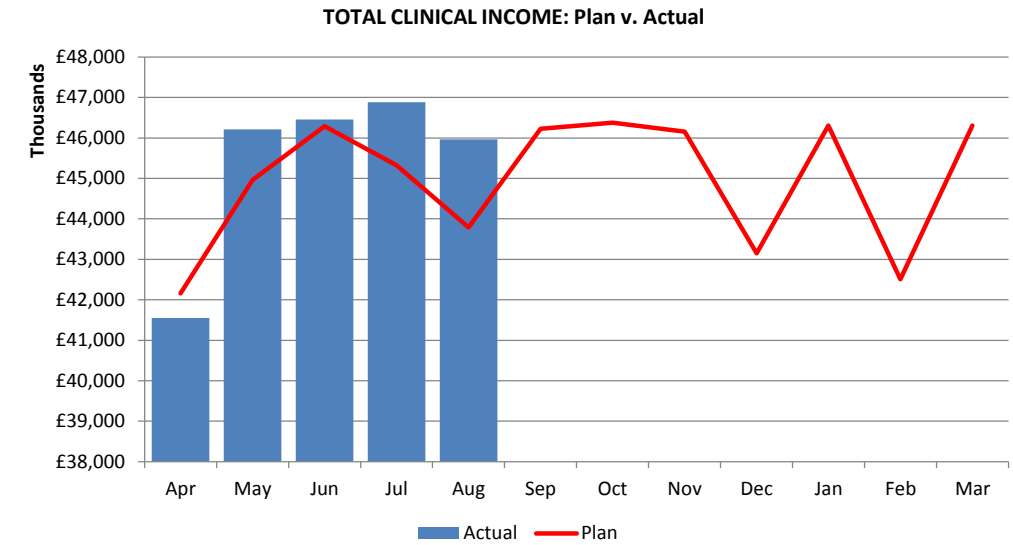
Total expenditure is adverse to plan by £2.7m in August and £8.4m ytd. In month, pay is overspent by £2.2m again mainly driven by medical and nursing agency spend which is £1.2m net adverse to plan although all pay headings are overspent apart from waiting list payments. Non pay is overspent by £0.5m in August mainly relating to slippage on CIP targets.

The expenditure run rate has increased by £0.1m in August when compared to July, with pay spend increasing by £0.6m (mainly driven by pay award back pay) and non pay spend reducing by £0.4m. Non medical pay award arrears of £1.3m were paid in August offset by reduced spend on temporary staffing, medical locums and waiting list costs totalling £0.4m. Medical pay award accruals of £0.3m were released pending October implementation. The reduction in non pay spend relates mainly to drugs and clinical supplies offset by increased security costs in EDs.

Key Highlights
Month 05 (August) 2018/19

CLINICAL INCOME

Clinical income is over plan in August by £2.4m. £1.6m of this over performance is due to unplanned pay award income. Non-Elective income is ahead of plan (£0.6m), and Elective income is also over planned levels by £1.4m due to a one off reduction in phased budget to allow for medical holidays. Outpatients are under performing 0.7m. Non-Elective income remains high due to a 3% increase in activity along with an income increase of 4.1% which indicates that Trust services are treating patients with more complex needs than planned. A&E Income is also ahead of plan in month by 12.8% driven largely by activity. Elective CIPs are held centrally and services are finding it difficult to meet these income targets in month. Higher than planned levels of regular day attenders continue which is generating a lower case mix variance resulting in lower average tariffs within Electives.



ACTIVITY

A&E demand is ahead of plan by 5.9% this month. This over performance follows on from July 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 also performed above plan in month, richer casemix has meant that income is 3.7% above plan. The commissioners have increased the provision of care packages with a view to returning patients home more quickly and as part of their QIPP schemes are investing in preventing patients with Pneumonia from coming to the hospital where they can be treated at home. Outpatient activity in month is behind plan but remains ahead of plan YTD. Elective activity is 10.4% behind plan, however, the phased adjustment made for lower elective income due to high levels of annual leave expected, was not applied to activity so this measure will look unusual in month.

COMMISSIONER ANALYSIS

Activity plans reflected CCG QIPP schemes to the value of £1.4m 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. GP referrals were 2.4% over plan in August. 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.

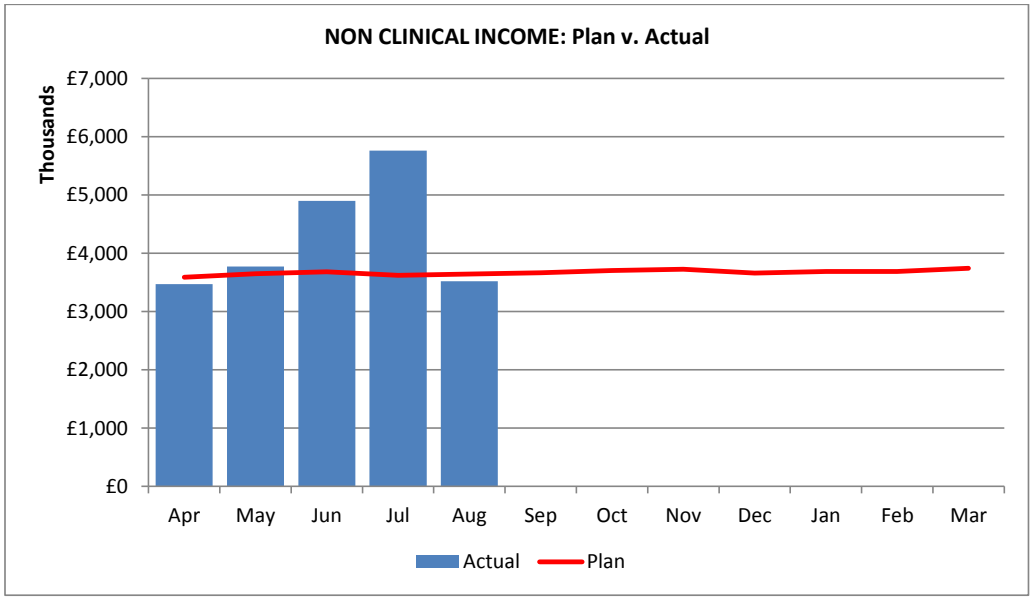
The Trust has agreed an April and May closedown position with East Kent CCGs and both parties have committed to a financial reconciliation and closedown of Q1 by the 1st October 2018.

Key Highlights
Month 05 (August) 2018/19

NON CLINICAL INCOME

Non clinical income is adverse to plan in August by £0.1m and favourable to plan ytd by £3.2m.

The majority of the overperformance ytd relates to income received from Serco following early exit from the contract of £2.1m which was included in the Trust's plan as a reduction to contract expenditure. There is also a favourable performance against plan on income relating to the PAS project totalling £0.6m.

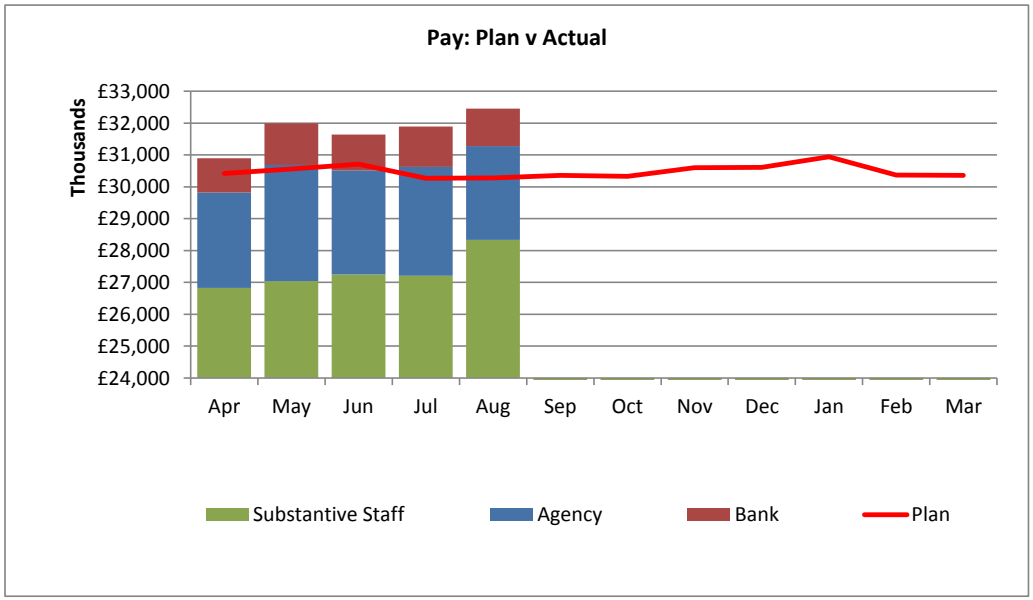


PAY

Pay performance is adverse to plan in August by £2.2m and by £6.6m ytd (4.4%). Pay CIPs are adverse to plan in month by £0.3m and by £1.5m ytd.

Total expenditure on pay in August was £32.5m, £0.6m higher than in July. This includes £1.3m of non medical pay award arrears paid in August relating to April - June but is partially offset by the release of medical pay award accruals for April - July totalling £0.3m and a reduction in expenditure on temporary staffing, medical locums sessions and waiting list payments totalling £0.4m.

All pay headings are overspent overall in August except waiting list payments which are marginally favourable to plan. The main driver for the overspend continues to be expenditure on medical and nursing agency staff which are adverse to plan by £1.2m in August and by £6.8m ytd.



Key Highlights
Month 05 (August) 2018/19

NON-PAY
Non Pay expenditure is adverse to plan in August by £0.5m and by £1.8m ytd.

The main driver for the overspend in August is the planned impact of 2gether Support Solutions in CIP targets which have not yet been delivered totalling £0.4m. Overspends on the purchase of healthcare from external organisations, premises costs and security services totalling £0.3m are offset by an underspend on drugs.

Non pay expenditure in August reduced by £0.4m when compared to July, mainly relating to drugs and clinical supplies.

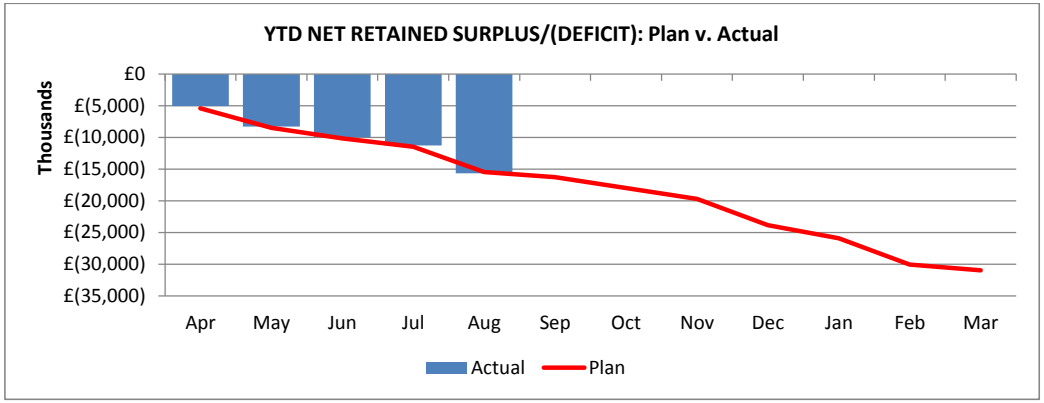
DEBT
Total invoiced debtors have decreased from the opening position of £28.5m by £11.9m to £16.6m. The largest debtors at 31st August were East Kent CCGs £5.2m and East Kent Medical Services £1.7m.

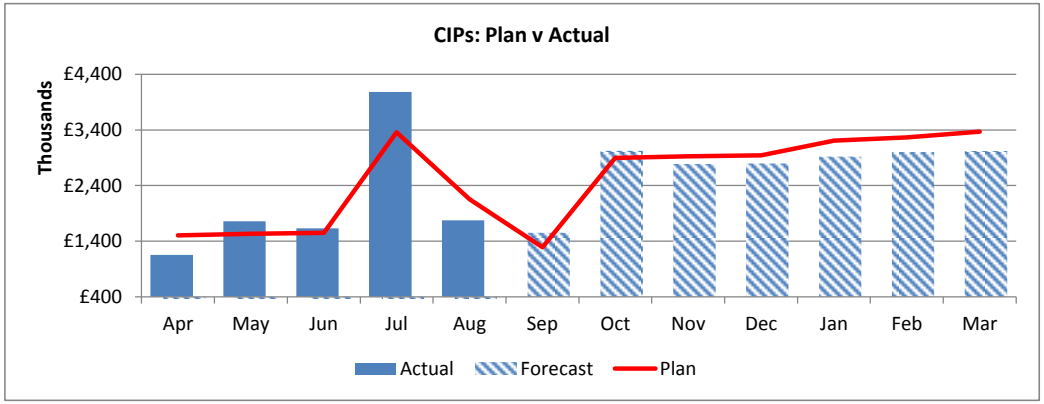
CAPITAL
Total YTD expenditure for Mth 5 2018/19 is £1.0m below the NHSI plan

EBITDA
The Trust is reporting a year to date deficit EBITDA of £4.8m

CASH
The closing cash balance for the Trust as at 31st August was £9.2m.

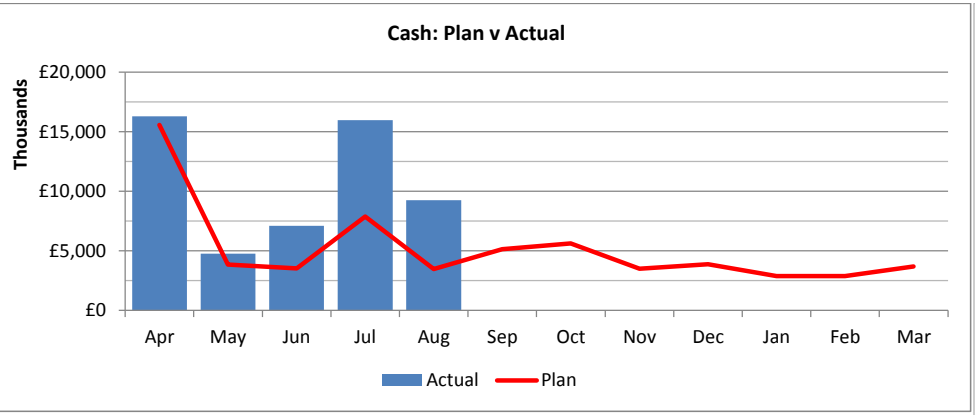
FINANCING
£726k of interest was incurred in respect of the drawings against working capital facilities to 31st March 2018 (£46.2m) and April 2018 (£2.2m), July 2018 (£3.4m) and August (3.7m).





CIPS
The target for the year is £30m. The NHSI Improvement Director is maintaining confirm and challenge meetings. As at the time of reporting, c.87% of schemes were 'green' rated . The major focus is on delivering 18/19 schemes and progressing 'red' and 'amber' schemes to 'green'. Divisions , supported by the PMO, are being asked to work up schemes for 2019/20.

Cash Flow
Month 05 (August) 2018/19



Unconsolidated Cash balance was £9.2m at the end of August 2018, £5.8m above plan.

Total receipts in August 2018 were £3.8m above plan
- Total receipts from East Kent CCGs were £0.9m below plan
- Receipt of £1.5m 17/18 Overperformance from NHSE
- Receipt of £1.7m AfC funding from DoH
- VAT reclaim £1.2m above plan
- Total Payments in August 2018 were £6.1m over plan
- Monthly payroll was £0.3m above plan
- Creditor payments inc Capital were £5.8m above plan

YTD cash receipts are £12.5m above plan
- East Kent CCGs are net £0.2m above plan. Payments against contract are £5.0m below plan due to the reduction of their contract value. This is offset by £5.2m payments made on account in June as advances for 17/18 overperformance.
- NHSE 17/18 overperformance £1.5m above plan
- Receipt of £1.7m AfC funding from DoH
- HMRC VAT returns are £2.1m above plan
- STF receipt was £1.4m above plan
- Loans from DHSC £3.4m above plan
- Other receipts are £2.2m above plan; £2.5m received from Serco offset by other receipts £0.3m below plan
- YTD cash payments are £6.8m above plan
- Payroll is £3.6m below plan
- Creditor Payments including Capital are £10.4m above plan; Payments to 2gether Support Solutions were £1.4m greater than expected as the Trust paid payroll on their behalf

2018/19 Forecast
- The forecast includes restrictions on creditor payment runs throughout the year to ensure that a positive cash balance is maintained
- Changes to the forecast will be required once 2gether Support Solutions is operating fully and the impact on Payroll and Creditors payments is known

Provider Sustainability Funding (Formerly Sustainability and Transformation Funding)

The Trust received £5.6m incentive Provider and Sustainability Funding (PSF) relating to 2017/18 in July 2018.
As a result of the Trust not agreeing to a control total, the Trust is not eligible for any PSF funding in 2018/19.

Working Capital Facility

Loan Schedule	Loan Value £'000	Facility Type	Repayment date	Interest rate	Total Interest if full term £'000
2016/17 Received	22,736	ISRWF	17/05/2021	3.5%	3,688
2017/18 Received	23,492	ISUCL	2020/21	3.5%	2,485
Apr' 2018 (Received)	2,234	ISUCL	2021/22	3.5%	323
July' 2018 (Received)	3,410	ISUCL	2021/22	3.5%	359
Aug' 2018 (Forecast)	3,708	ISUCL	TBA	TBA	TBA
Sept' 2018 (Forecast)	5,103	ISUCL	TBA	TBA	TBA
Nov' 2018 (Forecast)	5,812	ISUCL	TBA	TBA	TBA
Dec' 2018 (Forecast)	6,832	ISUCL	TBA	TBA	TBA
Jan' 2018 (Forecast)	4,161	ISUCL	TBA	TBA	TBA
Feb' 2018 (Forecast)	3,949	ISUCL	TBA	TBA	TBA
March' 2018 (Forecast)	8,271	ISUCL	TBA	TBA	TBA

- Planned 18/19 Loan was £27.4m in line with the plan pre technical deficit but on current forecast this will be exceeded.
- Future Loans have been rephased due to changes in the forecast

Creditor Management
- Creditor management continued to be applied throughout August 18. The Trust is close to the limit in restricting creditor payments and still being able to receive essential goods and services. At the end of August 2018 the Trust was recording 63 creditor days (Calculated as invoiced creditors at 30th August/ Forecast non pay expenditure x 365)

Facility Type Key
- ISRWF Single Currency Interim Revolving Working Capital Support Facility
- ISUCL Uncommitted Single Currency Interim Revenue Support - this facility replaces the ISRWF as the Trust is in Financial special measures and has a variable interest rate

Income and Expenditure Forecast

Month 05 (August) 2018/19

Unconsolidated	Annual			Forecast	Normalised [D.12]	
£000	Plan	Forecast	Var.	Adjustment	Forecast	Var.
Income						
Electives	100,573	100,573	-	-	100,573	-
Non-Electives	161,862	161,862	-	-	161,862	-
Accident and Emergency	26,226	26,226	-	-	26,226	-
Outpatients	81,677	81,677	-	-	81,677	-
High Cost Drugs	55,662	55,662	-	-	55,662	-
Private Patients	113,310	113,310	-	-	113,310	-
Other	248	248	-	-	248	-
Total Clinical Income	**539,558**	**539,558**	**-**	**-**	**539,558**	**-**
Non Clinical Income	44,059	44,059	-	(500)	43,559	(500)
Total Income	**583,617**	**583,617**	**-**	**(500)**	**583,117**	**(500)**
Expenditure	-	-	-	-	-	
Substantive Staff	(332,710)	(328,599)	4,111	-	(328,599)	(4,111)
Bank	(13,411)	(13,411)	-	-	(13,411)	-
Agency	(19,431)	(23,542)	(4,111)	-	(23,542)	4,111
Total Pay	**(365,552)**	**(365,552)**	**-**	**-**	**(365,552)**	**-**
Non Pay	(222,404)	(222,404)	-	-	(222,404)	-
Total Expenditure	**(587,956)**	**(587,956)**	**-**	**-**	**(587,956)**	**-**
Non-Operating Expenses	(26,648)	(26,648)	-	1,525	(25,123)	1,525
Income and Expenditure Surplus/(Deficit)	**(30,987)**	**(30,987)**	**-**	**1,025**	**(29,962)**	**1,025**

Consolidated	Annual			Forecast	Normalised [D.12]	
£000	Plan	Forecast	Var.	Adjustment	Forecast	Var.
Income						
Clinical Income	547,857	552,733	4,876	-	552,733	4,876
Non Clinical Income	42,682	44,835	2,153	(500)	44,335	1,653
Total Income	**590,539**	**597,568**	**7,029**	**(500)**	**597,068**	**6,529**
Expenditure						
Pay	(370,054)	(374,983)	(4,929)	-	(374,983)	(4,929)
Non Pay	(224,416)	(226,516)	(2,100)	-	(226,516)	(2,100)
Total Expenditure	**(594,470)**	**(601,499)**	**(7,029)**	**-**	**(601,499)**	**(7,029)**
Non-Operating Expenses	(26,924)	(26,924)	-	1,525	(25,399)	1,525
Income and Expenditure Surplus/(Deficit)	**(30,855)**	**(30,855)**	**-**	**1,025**	**(29,830)**	**1,025**

The Trust's consolidated year end forecast is set at a deficit control total equivalent (no STF assumed) of £29.8m deficit after all other technical adjustments, which is consistent with the 18-19 Financial Planning Return submitted to NHSI in April. Risks exist of £9.5m which the trust is seeking to mitigate.

CIPS of £37.3m gross / £30.0m net are required to support the delivery of this plan.

Risks and Opportunities
Month 05 (August) 2018/19

Risk/Opp	Area	Description	Narrative	Full Year (Risk)/Opp £000	Probability	Impact £,000
RISK	Clinical Income	Expert Determination	The full impact of the Expert Determination findings is currently being worked through with commissioners. There is some risk that the actual impact of the determination is higher than assumed in our 18-19 plan.	(5,000)	20%	(1,000)
Risk	CIP Delivery	Green Schemes with delivery risk	SubCo and Agency reduction plans in U&LTC currently carry an innate in year delivery risk due to the timing of commencement of schemes	(7,675)	20%	(1,535)
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	(9,000)	50%	(4,500)
Risk	Pay and Non Pay	Costs of Additional Planned activity	The costs of additional planned activity may exceed the marginal costs for this activity allowed in the plan	(5,000)	50%	(2,500)
			Total Risk			(9,535)
			Total Opportunity			
			NET (RISK)/OPPORTUNITY			(9,535)

Some risks have been realised and are now included in the Forecast, only remaining risks are shown in the table.

Clinical Income

Month 05 (August) 2018/19

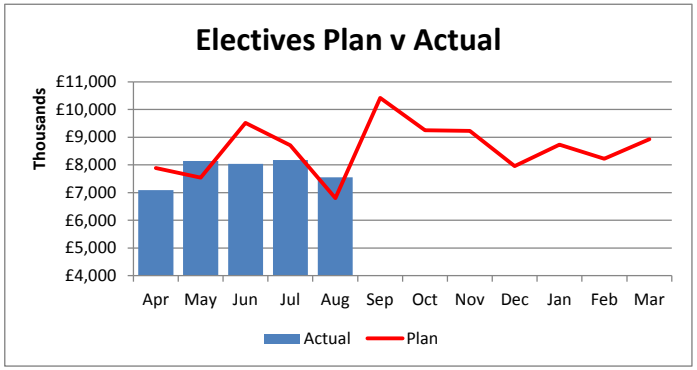
	This Month				Year to Date				Annual
£000	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	6,801	7,558	757	11.1%	40,457	38,998	(1,459)	(3.6%)	103,209
Non-Electives	13,358	13,979	621	4.7%	68,320	70,875	2,555	3.7%	161,862
Accident and Emergency	2,185	2,454	269	12.3%	11,163	12,332	1,169	10.5%	26,226
Outpatients	7,245	6,240	(1,005)	(13.9%)	33,559	32,618	(941)	(2.8%)	81,011
High Cost Drugs	4,727	4,465	(262)	(5.5%)	23,331	22,521	(810)	(3.5%)	55,662
Private Patients	21	13	(8)	(37.0%)	105	147	42	39.6%	248
Other NHS Clinical	9,299	10,908	1,608	17.3%	44,819	48,863	4,044	9.0%	109,496
Other Clinical	153	151	(2)	(1.4%)	767	719	(49)	(6.4%)	1,845
Prior Month Adjustment		200	200	0.0%		()	()	0.0%	
Total	**43,789**	**45,968**	**2,179**	5.0%	**222,522**	**227,072**	**4,550**	2.0%	**539,558**
			Favourable				Favourable		

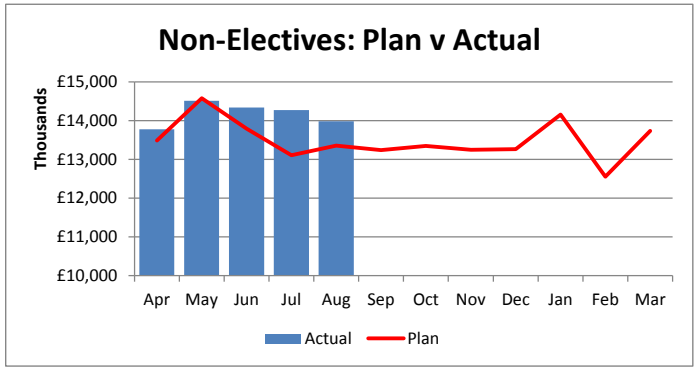
Income has performed over plan in August, due largely to £1.6m unplanned income to fund Agenda for Change pay awards. This income will be offset in expenditure. Electives, Non-Electives, A&E and Other NHS Areas also over performed in month. Non-Electives are over plan by £0.6m in August, largely due to General Medicine and General Surgery activity.

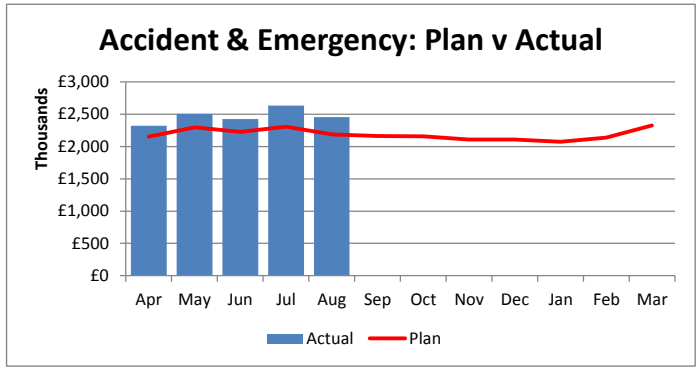
Elective inpatients and Day cases over performed in month as the Elective plan was reduced in August to allow for the impact of holidays. However planned run rates increase in September. To mitigate the risk of non achievement, plans for using Independent Sector organisations for the rest of the year 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.

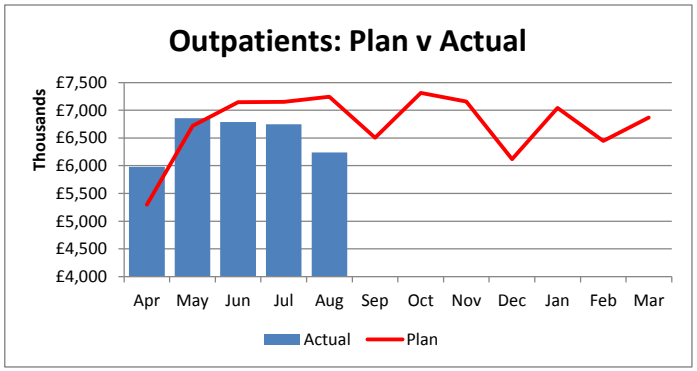
Other NHS Clinical activity is also ahead of plan due to an amount received to cover the increased pay award costs (£1.7m) along with a reduction in the risks position.

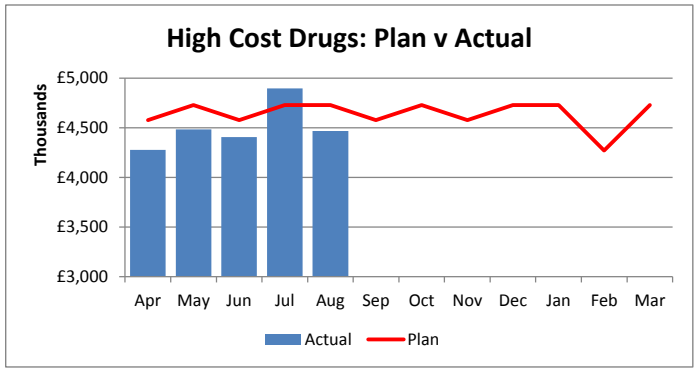
Rechargeable income is under plan in month with Drugs and Devices £365k behind plan. This does not impact the bottom line as there is a corresponding decrease in expenditure.

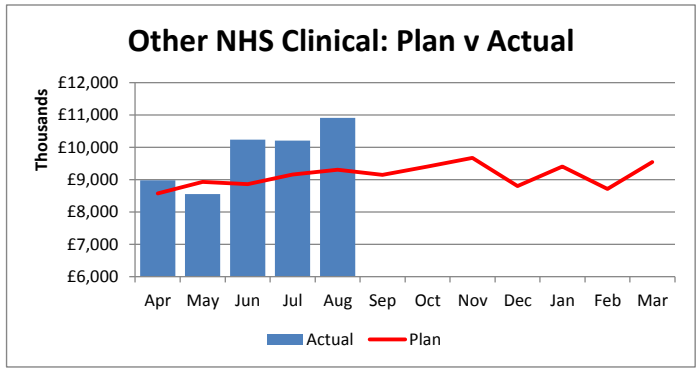












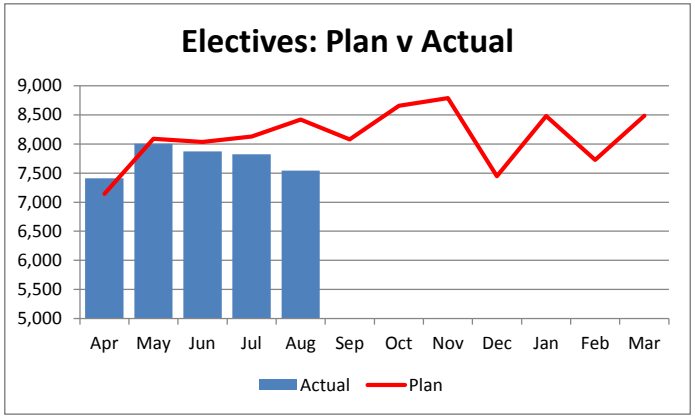
Clinical Activity
Month 05 (August) 2018/19

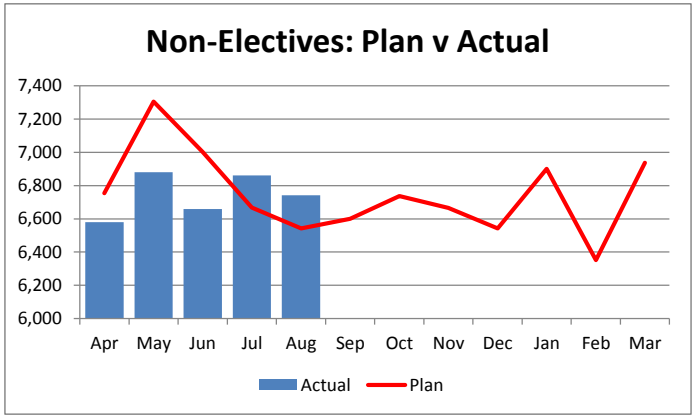
	This Month				Year to Date				Annual
Activity Units	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	8,419	7,545	(874)	(10.4%)	39,814	38,658	(1,156)	(2.9%)	97,481
Non-Electives	6,543	6,741	198	3.0%	34,274	33,721	(553)	(1.6%)	81,010
Accident & Emergency	17,603	18,649	1,046	5.9%	89,878	92,822	2,944	3.3%	211,076
Outpatients	70,989	62,021	(8,968)	(12.6%)	330,635	326,343	(4,292)	(1.3%)	802,956
Other NHS Clinical	464,163	498,730	34,567	7.4%	2,269,005	2,415,312	146,307	6.4%	5,397,116
Total	**103,554**	**94,956**	**(8,598)**	(8.3%)	**494,601**	**491,544**	**(3,057)**	(0.6%)	**1,192,523**
				Adverse				Adverse	

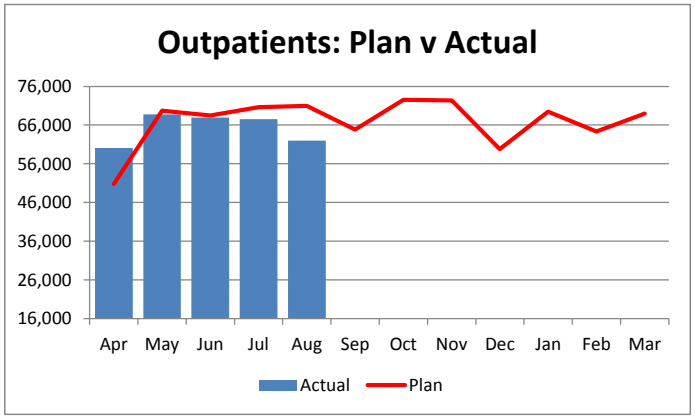
Within Elective activity (10.4% under), Inpatient activity was 14.9% under plan largely due to Urology (by 65), T&O (by 65) and General Medicine (by 53) and Day case activity was 12.8% under plan (Dermatology 145, T&O 156, Pain Management 182 and General Medicine 103). This is offset by over performance in Regular day attenders which has reduced the overall under performance.

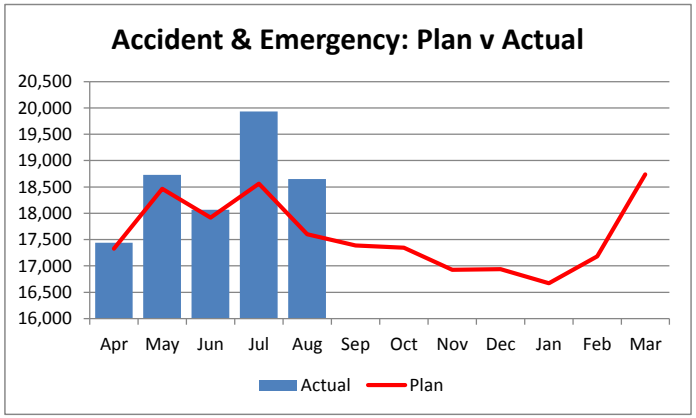
Outpatient activity under performed in month by 12.6% across new and follow up attendances, many areas were behind plan such as: Urology, General Surgery, T&O, ENT, General Medicine, Gynaecology, Respiratory Medicine, Ophthalmology, Rheumatology, Paediatrics, Physiotherapy and Neurology, while the only notable over performing specialty was Cardiology.

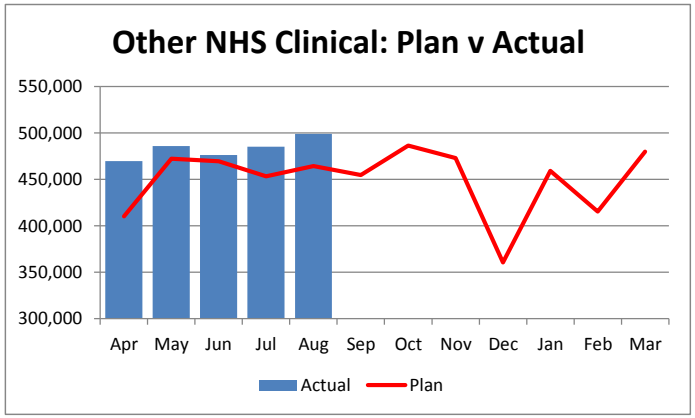
Divisions have signed off their demand and capacity plans and have been funded to resource each speciality to a level that will allow the to meet their plans. Achievement of this will depend upon the ability to recruit to key positions in hard to recruit to areas and an increased use of the independent sector.







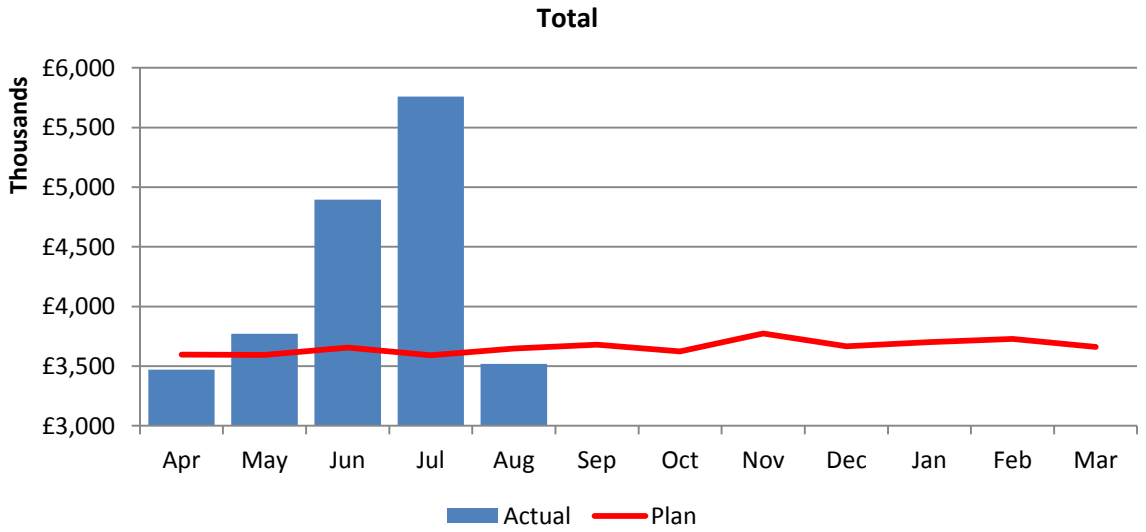




Non Clinical Income

Month 05 (August) 2018/19

Income - Other	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,429	1,398	(31)	7,147	7,957	810	17,150
Research and development	223	209	(14)	1,115	1,127	12	2,673
Education and Training	1,269	1,216	(53)	6,345	6,328	(17)	15,233
Car Parking income	399	389	(10)	1,895	2,037	142	4,766
Staff accommodation rental	178	133	(45)	957	879	(78)	2,494
Property rental (not lease income)	(66)	1	67	6	5	(1)	13
Cash donations / grants for the purchase of capital assets	42		(42)	210	160	(50)	500
Charitable and other contributions to expenditure	12	12	()	60	60	()	145
Other	157	160	3	453	2,862	2,409	1,085
Total	**3,644**	**3,518**	**(126)**	**18,187**	**21,415**	**3,228**	**44,059**
			-3.45%			17.75%	
			Adverse			Favourable	



Non clinical income is adverse to plan in August by £0.1m and favourable to plan ytd by £3.2m.

In month, education and training income and income relating to donated assets are underperforming against plan by a total of £0.1m.

As previously reported the majority of the overperformance ytd relates to income received from Serco following early exit from the contract of £2.1m and a favourable performance against plan on income relating to the PAS project totalling £0.6m.

Pay
Month 05 (August) 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	1,106	1,028	78	(8,122)	(7,937)	184	(40,713)	(39,711)	1,002	(97,532)
Nurses and Midwives	2,402	2,043	359	(7,682)	(7,838)	(156)	(38,507)	(37,890)	617	(92,248)
Scientific, Therapeutic and Technical	1,396	1,343	54	(4,527)	(4,572)	(45)	(22,695)	(21,664)	1,030	(54,367)
Admin and Clerical	1,461	1,277	184	(2,871)	(2,933)	(63)	(14,391)	(13,715)	676	(34,474)
Other Pay	1,591	1,445	146	(3,986)	(4,530)	(544)	(19,981)	(21,027)	(1,046)	(47,859)
Permanent Staff Total	**7,957**	**7,137**	**820**	**(27,188)**	**(27,811)**	**(623)**	**(136,286)**	**(134,007)**	**2,279**	**(326,479)**
Waiting List Payments										
Medical and Dental	0	0	0	(227)	(188)	39	(1,137)	(1,300)	(163)	(2,723)
Waiting List Payments Total	**0**	**0**	**0**	**(227)**	**(188)**	**39**	**(1,137)**	**(1,300)**	**(163)**	**(2,723)**
Medical Locums/Short Sessions										
Medical and Dental	1	0	1	(314)	(336)	(22)	(1,572)	(1,353)	219	(3,766)
Medical Locums/Short Sessions Total	**1**	**0**	**1**	**(314)**	**(336)**	**(22)**	**(1,572)**	**(1,353)**	**219**	**(3,766)**
Substantive	**7,957**	**7,137**	**821**	**(27,728)**	**(28,335)**	**(607)**	**(138,995)**	**(136,660)**	**2,335**	**(332,968)**
Bank										
Medical and Dental	0	13	(13)	(468)	(203)	265	(2,375)	(1,587)	788	(5,654)
Nurses and Midwives	0	65	(65)	(248)	(265)	(17)	(1,256)	(1,599)	(343)	(2,990)
Scientific, Therapeutic and Technical	0	6	(6)	(12)	(21)	(9)	(62)	(104)	(42)	(147)
Admin and Clerical	0	51	(51)	(94)	(153)	(59)	(476)	(692)	(216)	(1,133)
Other Pay	0	219	(219)	(289)	(528)	(239)	(1,465)	(1,969)	(504)	(3,487)
Bank Total	**0**	**354**	**(354)**	**(1,111)**	**(1,171)**	**(60)**	**(5,633)**	**(5,951)**	**(318)**	**(13,411)**
Agency										
Medical and Dental	48	127	(79)	(660)	(1,515)	(855)	(3,487)	(8,343)	(4,856)	(8,906)
Nurses and Midwives	0	139	(139)	(423)	(933)	(510)	(2,233)	(5,219)	(2,986)	(5,704)
Scientific, Therapeutic and Technical	0	38	(38)	(48)	(257)	(209)	(254)	(1,328)	(1,073)	(650)
Admin and Clerical	0	11	(11)	(5)	(28)	(23)	(29)	(122)	(93)	(73)
Other Pay	0	40	(40)	(41)	(164)	(123)	(215)	(952)	(736)	(550)
Agency Total	**48**	**354**	**(306)**	**(1,178)**	**(2,898)**	**(1,720)**	**(6,219)**	**(15,963)**	**(9,745)**	**(15,883)**
Direct Engagement - Agency										
Medical and Dental	0	4	(4)	(263)	(51)	212	(1,389)	(299)	1,090	(3,548)
Direct Engagement - Agency Total	**0**	**4**	**(4)**	**(263)**	**(51)**	**212**	**(1,389)**	**(299)**	**1,090**	**(3,548)**
Agency	**48**	**358**	**(310)**	**(1,441)**	**(2,949)**	**(1,508)**	**(7,608)**	**(16,263)**	**(8,655)**	**(19,431)**
Total	**8,005**	**7,849**	**157**	**(30,280)**	**(32,455)**	**(2,175)**	**(152,236)**	**(158,874)**	**(6,638)**	**(365,810)**
						-7.18%			-4.36%	
						Adverse			Adverse	

Pay performance is adverse to plan in August by £2.2m and by £6.6m ytd (4.4%). Pay CIPs are adverse to plan in month by £0.3m and by £1.5m ytd.

Total expenditure on pay in August was £32.5m, £0.6m higher than in July. This includes £1.3m of non medical pay award arrears paid in August relating to April - June but is offset by the release of medical pay award accruals for April - July totalling £0.3m following announcement from the DoHSC that the medical pay award will be effective from October. Expenditure on temporary staffing, medical locums sessions and waiting list payments fell in total by £0.4m.

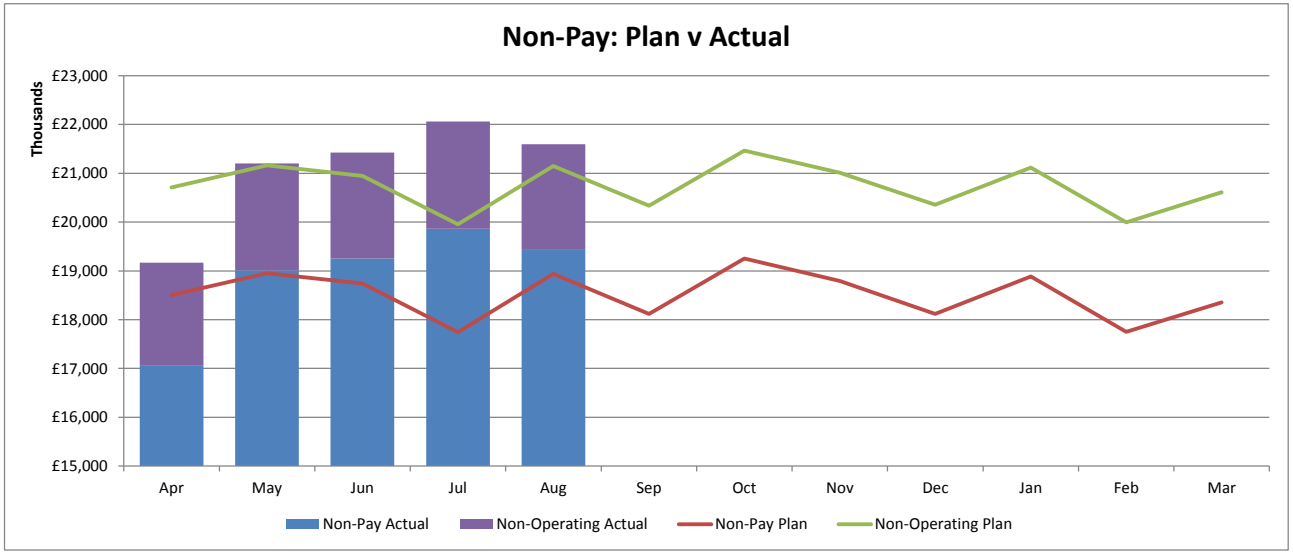
Substantive staff expenditure is adverse to plan by £0.6m August and favourable to plan by £2.3m ytd. Other pay groups account for the majority of the overspend in month driven by HCA's, with minor overspends in nursing, ST&T and A&C offsetting an underspend against plan on medical staff.

Bank staff are marginally adverse to plan by less the £0.1m in month and by £0.3m ytd with underspends on medical staff offsetting overspends on all other staffing groups.

Agency and Direct Engagement performance continues to be adverse to plan by £1.5m in month and £8.7m ytd. Despite a reduction in actual spend of £0.5m in month when compared to July, all staffing groups are adverse to plan. Expenditure on medical staff continues to show the highest overspend with adverse variances again in all clinical divisions except Clinical Support Services which is favourable to plan in month by £0.3m. Nursing and HCA agency usage remains high in UC&LTC though usage of TFS HCAs at premium rates is reducing from September.

Non-Pay
Month 05 (August) 2018/19

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(5,757)	(5,352)	405	(28,486)	(26,814)	1,672	(67,802)
Clinical Supplies and Services	(5,845)	(5,852)	(7)	(28,295)	(28,914)	(619)	(66,208)
Non-Clinical Supplies and Services	(1,756)	(2,229)	(473)	(7,920)	(9,616)	(1,696)	(22,245)
Purchase of Healthcare	(762)	(901)	(139)	(3,810)	(4,059)	(249)	(9,138)
Education & Training	(246)	(182)	64	(1,230)	(819)	411	(2,951)
Consultancy	(72)	(119)	(47)	(360)	(319)	41	(861)
Premises	(1,731)	(1,820)	(89)	(8,656)	(9,915)	(1,259)	(20,552)
Clinical Negligence	(1,859)	(1,853)	6	(9,295)	(9,263)	32	(21,336)
Transport	(323)	(330)	(7)	(1,615)	(1,552)	63	(3,877)
Establishment	(274)	(336)	(62)	(1,384)	(1,615)	(231)	(3,296)
Misc Other Operating Expenses	(311)	(455)	(144)	(1,828)	(1,747)	81	(3,880)
Total Non-Pay Expenditure	**(18,936)**	**(19,430)**	**(494)**	**(92,879)**	**(94,632)**	**(1,753)**	**(222,146)**
Depreciation & Amortisation-Owned Assets	(1,517)	(1,519)	(2)	(7,584)	(7,663)	(79)	(18,201)
Impairment Losses	(42)		42	(208)		208	(500)
Profit/Loss on Asset Disposals	(10)	1	11	(50)	1	51	(120)
PDC Dividend	(501)	(501)	()	(2,505)	(2,505)		(6,013)
Interest Receivable	9	17	8	46	80	35	110
Interest Payable	(150)	(162)	(12)	(726)	(733)	(7)	(1,917)
Other Non-Operating Expenses	(1)		1	(3)		3	(7)
Total Non-Operating Expenditure	**(2,211)**	**(2,163)**	**47**	**(11,031)**	**(10,819)**	**211**	**(26,648)**
Total Expenditure	**(21,147)**	**(21,593)**	**(446)**	**(103,910)**	**(105,451)**	**(1,541)**	**(248,794)**



Non Pay expenditure is adverse to plan in August by £0.5m and by £1.8m (1.9%) ytd.

Drug expenditure is favourable to plan by £0.4m in month and by £1.7m ytd. Pass-through drugs are favourable to plan in month by £0.2m and by £0.8m ytd, offset by an adverse position on clinical income. All other drugs are favourable to plan in month by £0.2m and by £0.9m ytd (CIP schemes account for £0.1m of the favourable variance in month and ytd).

Clinical supplies and services are breakeven against plan in month and adverse to plan ytd by £0.6m. The adverse performance continues to be driven by underperformance on CIP schemes which are adverse to plan in July by £0.2m and by £1.2m ytd, partially offset by slippage on developments.

Expenditure on non clinical supplies and services is adverse to plan in August by £0.5m and by £1.7m ytd. The in month variance relates predominantly to CIP expectations of £0.4m from initiation of 2gether Support Solutions which have not yet been delivered. As previously reported the ytd variance is driven by the planned benefit of the Serco contract exit fee being realised in non clinical income.

The adverse trend on expenditure on the purchase of healthcare from external sources continues and is adverse to plan in August by £0.1m and by £0.2m ytd.

Premises expenditure is adverse to plan in month by £0.1m and by £1.3m ytd, mainly relating to prior year sewerage costs, increased electricity rates, PAS project and PGME IT purchases and waste disposal costs in excess of plan totalling £0.9m.

The overspend on miscellaneous operating expenses of £0.1m in August relates predominantly to increased security provision mainly in EDs.

Non pay actual expenditure in August reduced by £0.4m when compared to July, mainly relating to drugs and clinical supplies.

Non Operating Expenditure YTD is on plan. The Trust has incurred £726k interest charges in respect of the facility utilised in 2016/17 and 2017/18. in 2018/19 £2.2m was drawn in April 2018, £3.4m in July and £3.7m in August.

Cost Improvement Summary

Month 05 (August) 2018/19

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Patient Flow/LOS	-	-	-	-	-	-	1,000	-
Agency	674	347	(327)	2,988	2,215	(773)	5,412	(724)
Workforce *	20	44	24	30	147	117	502	333
Procurement	258	54	(203)	830	298	(532)	1,277	(1,416)
Medicines Value	66	194	128	244	623	378	1,382	510
Division Schemes **	1,021	1,237	216	4,503	5,116	613	15,989	(167)
Sub-total	**2,039**	**1,877**	**(161)**	**8,596**	**8,399**	**(197)**	**25,561**	**(1,464)**
Central	117	(100)	(217)	1,505	2,000	495	3,943	968
Grand Total	**2,156**	**1,777**	**(378)**	**10,101**	**10,399**	**298**	**29,504**	**(496)**

*** Smaller divisional schemes not allocated to a work stream*

Delivered £000

Month	Target	Actual
April	1,502	1,155
May	1,533	1,758
June	1,552	1,629
July	3,357	4,081
August	2,156	1,777
September	1,289	
October	2,895	
November	2,927	
December	2,944	
January	3,208	
February	3,267	
March	3,370	
	30,000	**10,399**
		34.7%

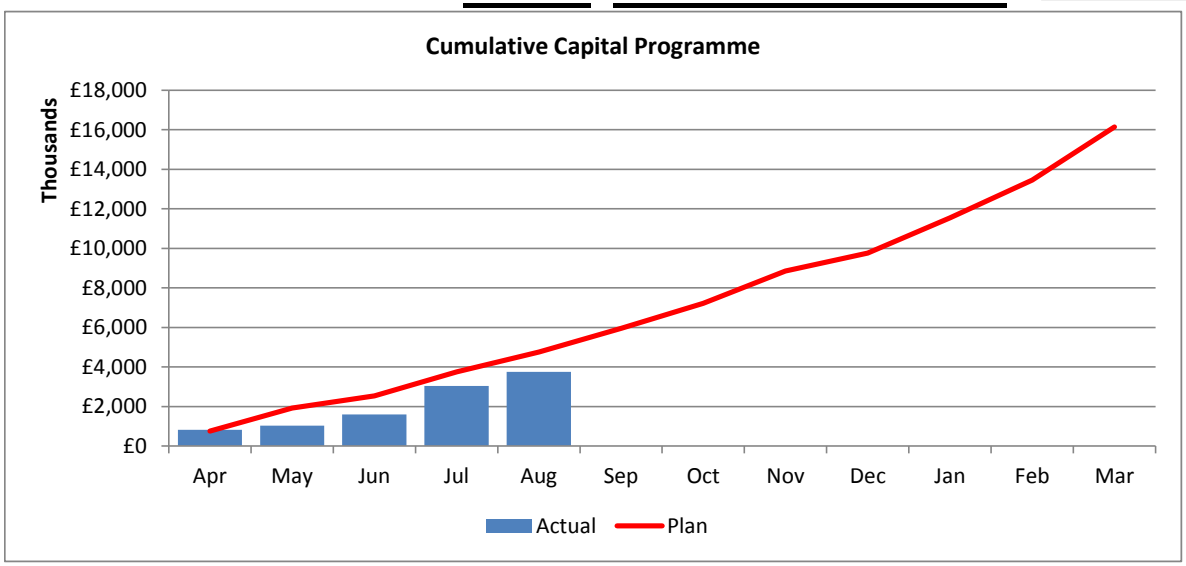
CIPs

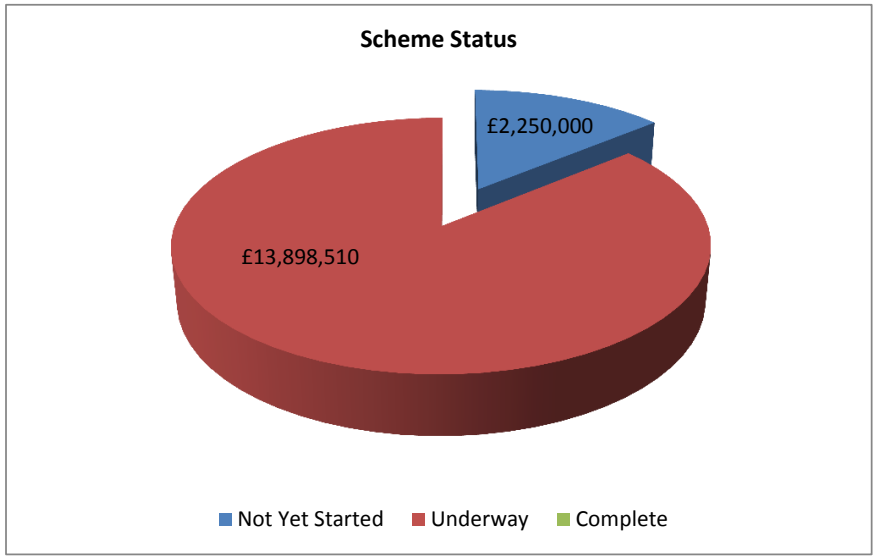
The CIPs Plan of £30.0m is net of the cost of delivery. CIPs achieved in M05 were £1.8m against a plan of £2.2m. Medicines Value and Divisions over performed in month and YTD. Agency and Procurement are below plan in month and YTD. CIPs in August amounted to £1.4m recurrent and £0.4m on a non-recurrent basis. The YTD position is recurrent £5.3m and non-recurrent £5.1m.

Capital Expenditure
Month 05 (August) 2018/19

Capital Programme	Annual	To Date		
£000	Plan	Plan	Actual	Variance
Dementia Village	1,065	707	43	664
Clinical Strategy Plans	200	120	133	(13)
Orthopaedic Modular Theatres			46	(46)
CT/CT SPECT Replacement	2,921	20	23	(3)
Invest To Save Schemes	150	50		50
Medical Devices Group	3,082	620	614	6
Patent Environment Investment Committ	2,200	951	805	146
Information Development Group	2,000	1,010	930	80
Other Equipment Schemes			164	(164)
Other IT Schemes	2,281	1,527	1,280	247
All Other Schemes	150	(251)	(147)	(104)
VAT Reclaim			(142)	142
Unallocated Capital Funds	2,100			
Total	16,149	4,754	3,747	1,007

- Total expenditure at Mth 5 2018/19 is 21% below the NHSI plan. NHSI have notified the Trust that they will require a detailed full-year capital forecast as part of reporting the Month 5 position. This forecast has been prepared and forms the basis of the Trust re-prioritised capital plan.
- The capital forecast outturn position for 2018/19 is to meet plan. The capital plan has been re-prioritised to recognise forecast slippage on the CT SPECT replacement scheme and to accommodate internal funding of the Elective Orthopaedics activity transfer to K&C as part of the Trust's winter plan. The updated plan will be reflected in the Month 6 capital position.
- The capital underspend YTD is predominantly driven by slippage on the Dementia Village scheme (whilst Board approval is sought on additional capital) and Other IT schemes, relating almost entirely to a supplier's expected lead time not being met. This position will recover by the end of the financial year.





Statement of Financial Position

Month 05 (August) 2018/19

£000	Opening	To Date	Movement	
Non-Current Assets	**270,767**	**267,406**	**(3,361)**	▼
Current Assets				
Inventories	8,949	8,930	(19)	▼
Trade and Other Receivables	39,034	38,308	(726)	▼
Assets Held For Sale			-	
Cash and Cash Equivalents	7,157	9,247	2,090	▲
Total Current Assets	**55,139**	**56,485**	**1,346**	▲
Current Liabilities				
Payables	(39,536)	(38,111)	1,425	▼
Accruals and Deferred Income	(26,013)	(31,828)	(5,815)	▲
Provisions	(884)	(852)	31	▼
Net Current Assets	**(11,294)**	**(14,306)**	**(3,013)**	▼
Non Current Liabilities				
Provisions	(3,203)	(3,131)	72	▼
Long Term Debt	(46,228)	(55,580)	(9,352)	▲
Total Assets Employed	**210,042**	**194,389**	**(15,653)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	191,687	191,687	-	
Retained Earnings	(41,167)	(56,820)	(15,653)	▼
Revaluation Reserve	59,523	59,523	-	
Total Taxpayers' Equity	**210,042**	**194,389**	**(15,653)**	▼

Non Current asset values reflect in year additions of £3.9m (including donated assets) less depreciation charges of £7.7m. The balance of movements relates to fluctuations in the level of RTA income recognised for new claims

Trust closing cash balances for August was £9.2m, £5.8m above the revised plan. See cash report for further details.

Trade and other receivables have decreased from the 2018/19 opening position by £0.7m. Invoiced debtors have decreased from the opening position of £28.5m by £11.9m to £16.6m at the end of August.

Accruals and Deferred Income have increased by 5.8m since the opening position. Of the £31.8m balance, £24.1m relates to Accruals and £7.7m is Deferred Income.

The long term debt entry reflects drawings against working capital facilities. The Trust drew £22.7m in 16/17, £23.5m in 17/18, £2.2m in April, £3.4m in July and £3.7m in August.

Retained earnings reflects the year to date deficit.

Working Capital
Month 05 (August) 2018/19

Creditors

Invoiced creditors have decreased by £1.3m from the opening position to £32.2m. 53% relates to current invoices with 9% or £3.0m over 90 days.

Over 90 days NHS creditors have remained static in the month.

YTD the Trust has paid 67.2% of NHS and 46.4% of non NHS invoices by value to 30 days. The average payment terms are now 45 days.

Debtors

Total invoiced debtors have decreased from the opening position of £28.5m by £11.9m to £16.6m.
At 31st August there were 4 debtors owing over £1m.

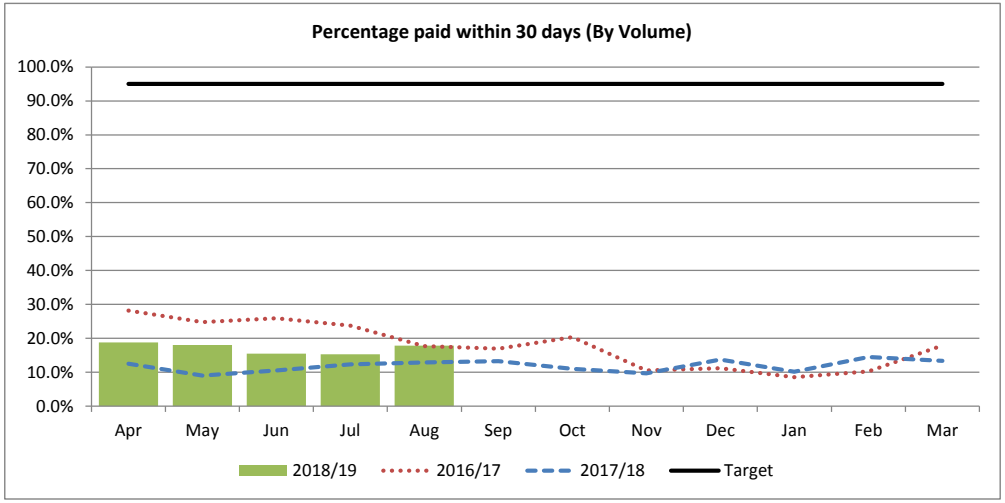
- East Kent CCGs owing: South Kent Coast CCG £1.1m, Canterbury & Coastal CCG £1.5m, Ashford CCG £0.9m and Thanet CCG £1.7m. (outstanding invoices for 1718 overperformance offset by unallocated cash payments on their accounts)
- East Kent Medical Services £1.7m

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

NB the aged debt position shown below nets down the 'on account payments' made by EK CCGs

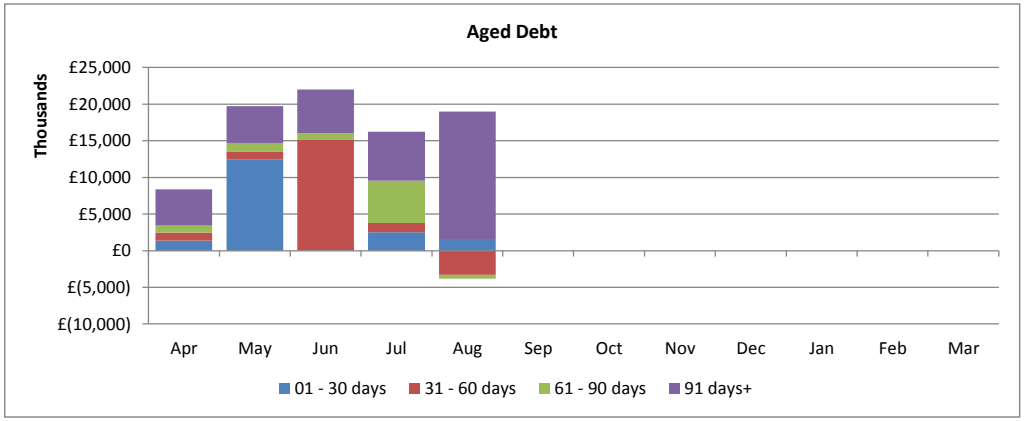
Better Payment Practice Code

	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	(72,099)	(11,794)	(18,861)	(2,286)
30+ days	(83,349)	(5,756)	(16,860)	(1,379)
By Volume				
0 - 30 days	7,694	111	1,788	16
30+ days	36,694	1,074	8,133	213
% by Value £	46.4%	67.2%	52.8%	62.4%
% by Volume	17.3%	9.4%	18.0%	7.0%
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	0	0	0	0	0	0
Oct	0	0	0	0	0	0
Nov	0	0	0	0	0	0
Dec	0	0	0	0	0	0
Jan	0	0	0	0	0	0
Feb	0	0	0	0	0	0
Mar	0	0	0	0	0	0
		10%	-22%	-3%	115%	



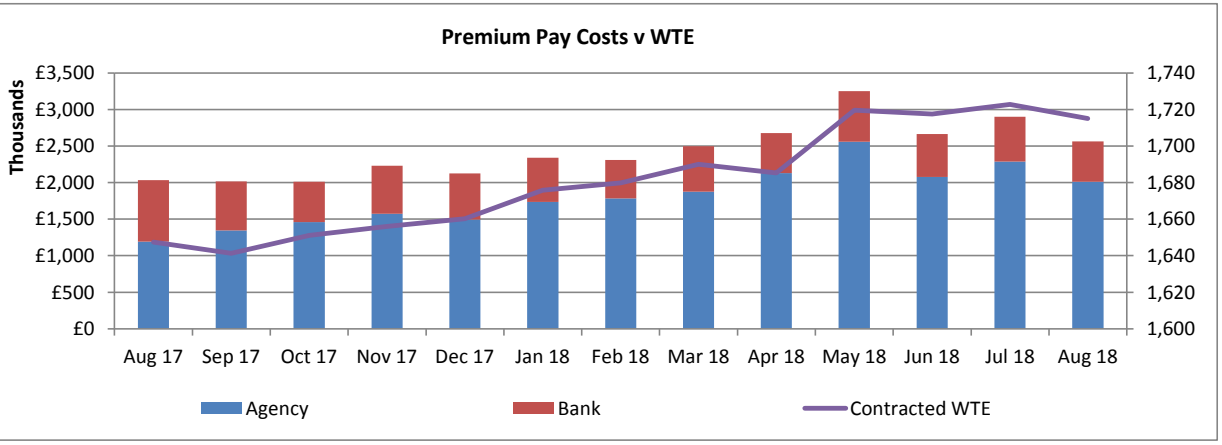
Divisional Performance
Month 05 (August) 2018/19

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
Urgent Care and Long Term Conditions	9,135	39,899	12,332	8,660	2,024	42	6,236	343	(47,109)	(12,883)	18,679
Surgical Services	23,962	17,076	0	13,672	2,768	57	7,189	841	(41,382)	(17,419)	6,764
Clinical Support Services	223	11	0	1,826	6,407	28	14,763	2,470	(25,677)	(18,739)	(18,689)
Specialist Services	5,678	13,818	0	8,460	11,183	19	19,859	818	(28,510)	(16,039)	15,285
Clinical Divisions Total	**38,998**	**70,805**	**12,332**	**32,618**	**22,383**	**146**	**48,046**	**4,472**	**(142,679)**	**(65,081)**	**22,040**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	5,095	(5,601)	(17,027)	(17,533)
Corporate	0	0	0	0	0	0	0	7,271	(9,477)	(12,814)	(15,020)
Divisional Total	**38,998**	**70,805**	**12,332**	**32,618**	**22,383**	**146**	**48,046**	**16,838**	**(157,756)**	**(94,922)**	**(10,513)**
Central		70	0	0	138	1	1,536	4,577	(1,117)	290	5,494
							EBITDA				**(5,019)**
							Capital Charges and Interest			(10,819)	(10,819)
							Income and Expenditure Surplus/(Deficit)				(15,838)

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
Urgent Care and Long Term Conditions	137	2,295	1,143	(442)	(187)	6	(44)	42	(2,715)	(772)	(538)
Surgical Services	(2,929)	689	0	(613)	(386)	45	1,516	8	(2,286)	(330)	(4,286)
Clinical Support Services	(60)	3	0	98	(43)	(10)	390	143	(640)	(498)	(617)
Specialist Services	(329)	(529)	0	67	(57)	2	(255)	(24)	(1,074)	(235)	(2,436)
Clinical Divisions Total	**(3,182)**	**2,458**	**1,143**	**(890)**	**(673)**	**42**	**1,607**	**169**	**(6,714)**	**(1,836)**	**(7,876)**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	360	357	(534)	183
Corporate	0	0	0	0	0	0	0	(30)	264	(133)	101
Divisional Total	**(3,182)**	**2,458**	**1,143**	**(890)**	**(673)**	**42**	**1,607**	**500**	**(6,094)**	**(2,503)**	**(7,592)**
Central	1,723	97	26	(51)	(137)	()	2,388	2,728	(544)	750	6,979
							EBITDA				**(613)**
							Capital Charges and Interest			211	211
							Income and Expenditure Surplus/(Deficit)				(402)

Urgent Care and Long Term Conditions
Month 05 (August) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	2,008	1,666	(342)	8,999	9,135	137
Non-Electives	7,247	7,725	478	37,604	39,899	2,295
Accident & Emergency	2,190	2,454	264	11,189	12,332	1,143
Outpatients	1,989	1,715	(274)	9,103	8,660	(442)
High Cost Drugs	442	419	(24)	2,211	2,024	(187)
Private Patients	7	5	(2)	36	42	6
Other NHS Clinical	1,251	1,066	(185)	5,650	5,641	(10)
Other Clinical	126	126		629	595	(34)
Prior Month Adjustment	0	80	80	0	()	()
Total Clinical Income	**15,259**	**15,255**	**(4)**	**75,421**	**78,329**	**2,907**
Non Clinical Income	58	66	8	301	343	42
Total Income	**15,317**	**15,321**	**4**	**75,722**	**78,672**	**2,949**
Expenditure						
Substantive Staff	(7,638)	(7,088)	550	(36,387)	(33,043)	3,343
Bank	(582)	(554)	28	(2,883)	(3,001)	(119)
Agency	(995)	(2,012)	(1,017)	(5,126)	(11,065)	(5,939)
Total Pay	**(9,216)**	**(9,653)**	**(438)**	**(44,395)**	**(47,109)**	**(2,715)**
Non Pay	(2,354)	(2,525)	(171)	(12,111)	(12,883)	(772)
Total Expenditure	**(11,570)**	**(12,178)**	**(609)**	**(56,506)**	**(59,992)**	**(3,487)**
Contribution	**3,748**	**3,143**	**(605)**	**19,217**	**18,679**	**(538)**



The Division is £0.6m adverse in August and £0.5m adverse YTD.

Income delivered to plan in August compared to £2.9m over-performance for April - July; A&E and NEL remained on-trend but Outpatients (notably Neurology and Rheumatology) and Elective (General Medicine and Endoscopy) were significantly behind plan. In addition the Endoscopy Bowel Scope plan is phased from Mth 5 but rollout is limited, leading to an under-performance of £0.2m.

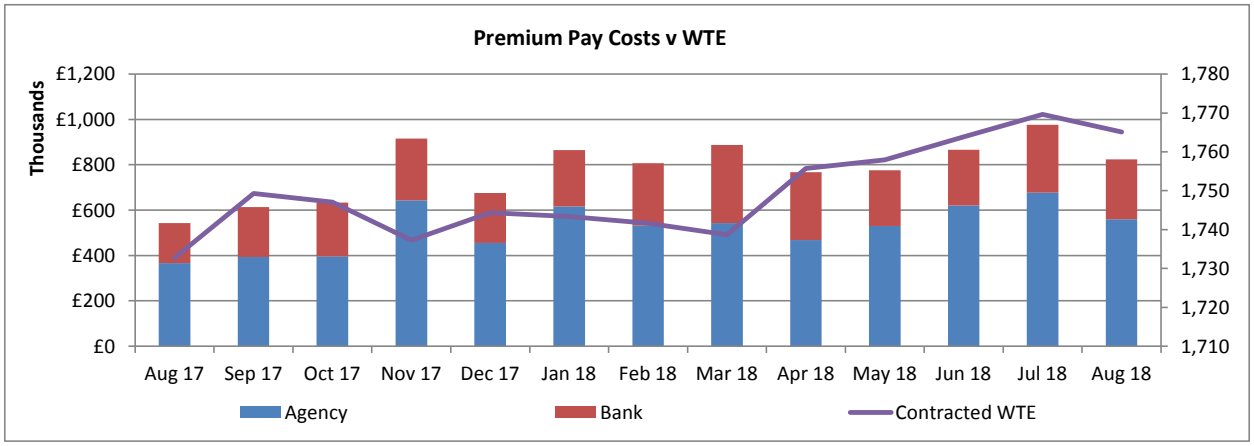
Pay overspent by £0.4m in August, an improvement compared to previous months (£2.7m ytd); the run rate increased by £0.3m compared to July relating solely to the pay award arrears. Agency spend decreased by £0.3m notably in Nursing and ED Middle Grades. TFS Agency usage is reducing, from September HCAs are by exceptional approval only and all TFS is planned to cease by early December; in the meantime rates are being reduced from October. Roster cleanse has been carried out which should reduce Agency spend further; the Division has 2 remaining issues to address notably under-funding on Cambridge J and management of rosters within funded levels at QEQM ED. Agency Middle Grade spend decreased in both EDs and is awaiting approval of the Business Case to increase the roster.

The non pay run rate fell by £0.2m compared to July relating to rechargeable drugs and devices, other clinical consumables and recruitment fees.

CIPs fell slightly short of the monthly £0.5m target due to non-delivery of Agency and Procurement schemes.

Surgical Services
Month 05 (August) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	5,593	4,726	(867)	26,891	23,962	(2,929)
Non-Electives	3,350	3,436	86	16,388	17,076	689
Accident & Emergency	0	0	0	0	0	0
Outpatients	3,125	2,586	(539)	14,285	13,672	(613)
High Cost Drugs	631	586	(44)	3,154	2,768	(386)
Private Patients	3		(2)	13	57	45
Other NHS Clinical	1,172	1,377	205	5,613	7,130	1,517
Other Clinical	12	20	8	61	59	(1)
Prior Month Adjustment	0	131	131	0	0	0
Total Clinical Income	**13,885**	**12,863**	**(1,023)**	**66,404**	**64,725**	**(1,679)**
Non Clinical Income	160	151	(9)	832	841	8
Total Income	**14,045**	**13,013**	**(1,032)**	**67,237**	**65,566**	**(1,671)**
Expenditure						
Substantive Staff	(7,544)	(7,975)	(430)	(35,966)	(37,173)	(1,207)
Bank	(219)	(263)	(44)	(1,110)	(1,351)	(241)
Agency	(404)	(560)	(156)	(2,021)	(2,858)	(837)
Total Pay	**(8,167)**	**(8,798)**	**(631)**	**(39,097)**	**(41,382)**	**(2,286)**
Non Pay	(3,382)	(3,598)	(216)	(17,089)	(17,419)	(330)
Total Expenditure	**(11,549)**	**(12,396)**	**(846)**	**(56,186)**	**(58,801)**	**(2,616)**
Contribution	**2,496**	**617**	**(1,879)**	**11,051**	**6,764**	**(4,286)**



The division is £1.9m adverse to plan in month and £4.3m adverse YTD.

Below plan elective income (£2.9m) is mostly due to underperformance in Orthopaedics (£1.4m), and unachieved CIPs (£0.8m). Orthopaedic activity has been significantly impacted by reduced capacity issues, i.e. beds and Independent sector. However with the set up of the new Elective Orthopaedic Centre in November, the production plan forecasts that the Orthopaedic elective plan will be achieved by year end. Although Elective CIP plans were not achieved, this was offset from savings realised by ITU and Non Elective overperformances.

Non-Elective income is above plan (£689k) with high levels of General Surgery, Vascular & Maxillo Facial activity. Trauma is now below plan, however income has remained steady whilst the plan for August significantly increased.

Outpatient performance is adverse (£613k), with significant underperformance across all specialties in August and Orthopaedics (£289k) the largest YTD which is mostly due to the greater than anticipated impact of the Virtual Fracture Clinics. Forecast production plans indicate another poor month in September but thereafter monthly overperformances which will deliver the year end plan.

High Cost Drugs under performance (£386k) is solely in relation to Ophthalmology AMD patients, and is offset with an underspend in expenditure.

Other NHS Clinical Income is favourable mostly due to ITU (£1.4m).

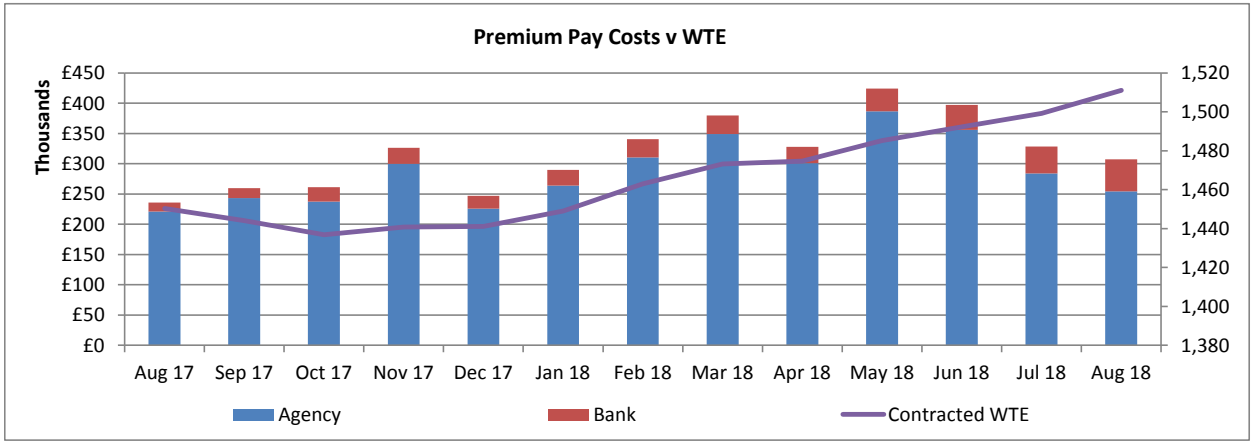
Pay is adverse with the continuation of high medical agency costs for middle grade vacancies in General Surgery, Urology, Vascular and also additional support for the ED's. Interviews and appointments have been made, and the delays on VISAs for foreign nationals is slowly unblocking. Nursing agency is still high at WHH for ITU and bedding of patients overnight in the Day Surgery Unit. These have contributed to an unmet CIP Pay target (£738k), which has instead been met through Income. Business cases for ITU, SEAU and Hospital at Home services are awaiting review and approval of funding.

Non Pay is adverse (£330k) YTD with underspends on Drugs (£202k) and Independent Sector usage (£199k) for Orthopaedic services, more than offset by Clinical Supplies overspend (£245k) and CIP underachievement (£406k). However this CIP underachievement has been partially met through Income.

Included in the above expenditure is approximately £603k for medical patient outliers with no additional income. This has equated to the loss on average of 24 Surgical beds per day. Also incurred is £452k supporting the Winter/ED plan.

Clinical Support
Month 05 (August) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	76	56	(19)	284	223	(60)
Non-Electives	2	1	(1)	8	11	3
Accident & Emergency	0	0	0	0	0	0
Outpatients	366	337	(29)	1,728	1,826	98
High Cost Drugs	1,290	1,265	(25)	6,450	6,407	(43)
Private Patients	8	4	(3)	38	28	(10)
Other NHS Clinical	2,957	3,038	81	14,372	14,762	390
Other Clinical	0	(1)	(1)	0		
Prior Month Adjustment	0	(34)	(34)	0	()	()
Total Clinical Income	**4,698**	**4,668**	**(30)**	**22,880**	**23,258**	**379**
Non Clinical Income	464	478	14	2,327	2,470	143
Total Income	**5,162**	**5,146**	**(16)**	**25,206**	**25,728**	**522**
Expenditure						
Substantive Staff	(5,124)	(5,220)	(96)	(23,974)	(23,891)	83
Bank	(24)	(53)	(29)	(118)	(204)	(86)
Agency	(339)	(255)	85	(946)	(1,582)	(636)
Total Pay	**(5,487)**	**(5,528)**	**(41)**	**(25,038)**	**(25,677)**	**(640)**
Non Pay	(3,786)	(3,845)	(59)	(18,241)	(18,739)	(498)
Total Expenditure	**(9,273)**	**(9,373)**	**(100)**	**(43,279)**	**(44,417)**	**(1,138)**
Contribution	**(4,111)**	**(4,227)**	**(116)**	**(18,072)**	**(18,689)**	**(617)**



The Clinical Support Division is reporting a deficit for August. This is primarily due to overspends in expenditure across all departments except Pathology.

Overall, the Income plan was very slightly under plan in Month. Pathology and Radiology overperformed against plan on direct access and outpatient imaging. However Homecare income and cost is reported as slightly below plan. An estimated position was included for Homecare due to a delay in the processing of invoices this month. This will be adjusted in month 6 to reflect the actual cost. The Therapies income position was behind plan by a narrow margin too. This was due to continued underperformance in Occupational Therapy, which is now £84k behind plan (15%) year to date. Plans are in place to increase productivity by utilising community based accommodation, to address this shortfall.

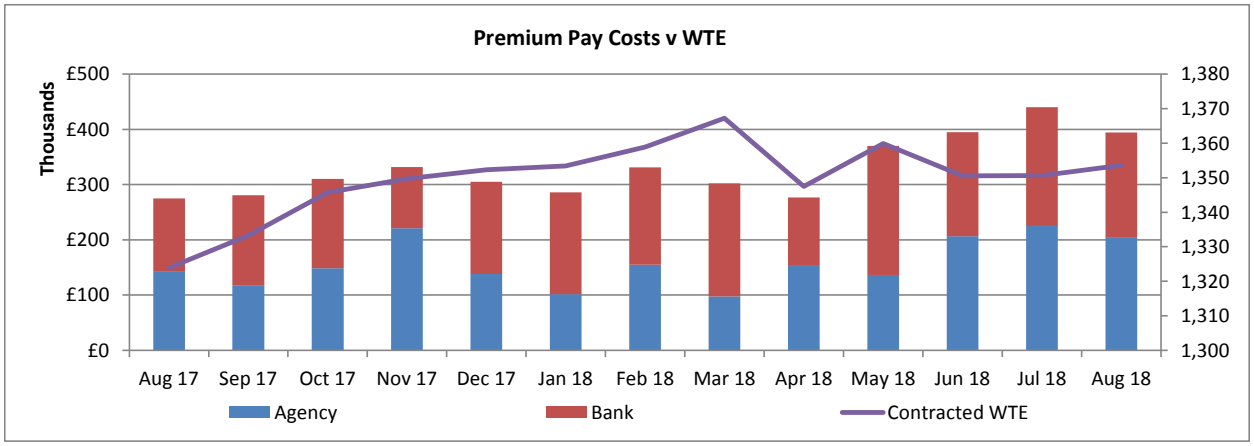
Pay was overspent in the month reflecting the challenging landscape of delivering increasing demand within a tight budget which includes £2.4m of CIP targets. Four of the five departments overspent in August on pay, Pathology being the only department that did not. Therapies, Pharmacy and Radiology overspends related to PAM/Prof & tech staff groups, however agency costs in medical staff reduced again this month and this was the first month that total agency cost was within budget this year.

There was a net overspend on non-pay in the Division, primarily in Radiology and Pharmacy. The Radiology overspend was on medical equipment maintenance contracts, particularly an invoice relating to an MRI scanner and image intensifier now out of warranty for the period of April to August. The Pharmacy non-pay overspend relates to a JAC software upgrade upgrade and licenses and medical equipment consumables costs. Medical gases was also overspent in month but underspent year to date.

The Division made good progress on delivery of CIPs this month, particularly with regard to medical agency cost reduction and the Medicines optimisation programme. £2.1m CIP has been delivered so far this year, which is £0.2m above plan.

Specialist Services
Month 05 (August) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,216	1,110	(106)	6,007	5,678	(329)
Non-Electives	2,764	2,746	(18)	14,347	13,818	(529)
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,754	1,602	(153)	8,392	8,460	67
High Cost Drugs	2,248	2,174	(74)	11,240	11,183	(57)
Private Patients	3	4		17	19	2
Other NHS Clinical	4,088	3,998	(90)	20,021	19,817	(204)
Other Clinical	18	6	(13)	92	41	(51)
Prior Month Adjustment	0	109	109	0	0	0
Total Clinical Income	**12,093**	**11,748**	**(345)**	**60,117**	**59,016**	**(1,101)**
Non Clinical Income	152	163	11	843	818	(24)
Total Income	**12,245**	**11,911**	**(333)**	**60,960**	**59,834**	**(1,126)**
Expenditure						
Substantive Staff	(5,502)	(5,631)	(129)	(26,104)	(26,633)	(529)
Bank	(161)	(190)	(29)	(792)	(950)	(158)
Agency	(109)	(204)	(95)	(539)	(927)	(387)
Total Pay	**(5,772)**	**(6,025)**	**(253)**	**(27,435)**	**(28,510)**	**(1,074)**
Non Pay	(3,129)	(3,190)	(61)	(15,804)	(16,039)	(235)
Total Expenditure	**(8,901)**	**(9,215)**	**(314)**	**(43,239)**	**(44,549)**	**(1,310)**
Contribution	**3,344**	**2,697**	**(647)**	**17,721**	**15,285**	**(2,436)**



Elective income is significantly adverse to plan in month. This is predominantly driven by gynaecology and dermatology underperformance. 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). Work is being prioritised to address efficiency and capacity problems affecting Gynaecology. Whilst there has been some success in reducing waiting time breaches, achieving planned activity levels remains a challenge.

Despite some improvement in month, non-elective income is still adverse to plan in August and significantly below plan year to date. Activity variances are relatively small but due to high value tariffs in the shortfall areas, the effect on income is significant. This is spread across a number of specialties-Obstetrics, Paediatrics, Renal and Clinical Haematology. A change in guidance relating to Sepsis related activity and a small fall in high value (tariff) activity in renal have been identified. Otherwise, coding issues have been discounted. It is probable that the deficit in income will not recover over the course of the year.

Overall outpatient income was also significantly below plan in month. Although above plan, performance in Dermatology and Oncology was not as strong as in previous months and was insufficient to offset shortfalls in gynaecology and paediatrics. Some gynaecology capacity was switched in order to focus on elective activity/breach avoidance. Paediatrics diverted junior/middle grade resource to support provision of a safe medical rota.

Rechargeable high costs drugs under performance was significant in month and the majority will be offset in expenditure.

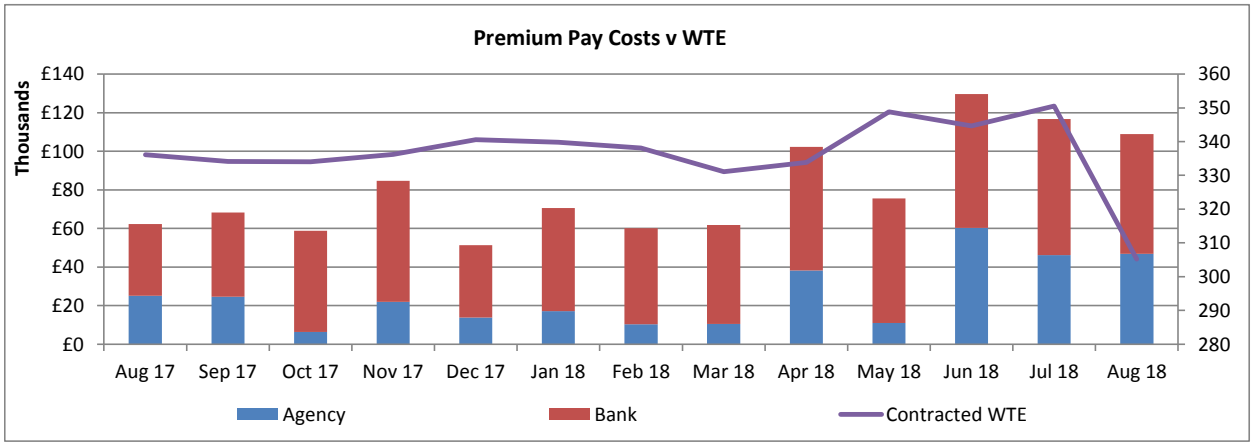
The YTD adverse performance in the 'Other NHS Clinical' category is driven by lower than planned activity in NICU/SCBU, the maternity pathway, palliative care and renal dialysis. Income stabilised in month in renal dialysis, maternity pathway and palliative care, but fell in chemotherapy and deteriorated further NICU/SCBU .

Overall pay was significantly overspent in August and year to date. Savings shortfalls (£130k in month) are a key driver. Temporary pay costs are also, on average, £80k a month higher than last year with junior/middle grade vacancies/sickness/maternity leave being a particular issue. Improved recruitment in the second half of 2017/18 has also put pressure on the pay budget. The non-pay overspend in month is predominantly driven by higher consumable, security and dictation charges, as well as savings shortfalls.

CIP performance was unfavourable to plan in August and is £132k adverse year to date. Shortfalls in pay and non-pay schemes are being offset with income scheme over performance, particularly in Cancer Services.

Strategic Development and Capital Planning
Month 05 (August) 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	915	831	(84)	4,735	5,095	360
Total Income	**915**	**831**	**(84)**	**4,735**	**5,095**	**360**
Expenditure						
Substantive Staff	(1,105)	(1,025)	81	(5,572)	(5,068)	504
Bank	(56)	(62)	(6)	(249)	(330)	(81)
Agency	(27)	(47)	(19)	(137)	(203)	(66)
Total Pay	**(1,189)**	**(1,134)**	**56**	**(5,958)**	**(5,601)**	**357**
Non Pay	(3,709)	(3,698)	11	(16,493)	(17,027)	(534)
Total Expenditure	**(4,899)**	**(4,832)**	**67**	**(22,451)**	**(22,629)**	**(178)**
Contribution	**(3,983)**	**(4,001)**	**(18)**	**(17,716)**	**(17,533)**	**183**



The position as at month 5 is £183k favourable. The inc/exp positions are showing large variances due to the SaCP/PAS project being behind schedule , these net each other off. Income (excl SaCP/PAS) is £118k favourable YTD. Pay £357k favourable YTD and Non Pay (excl SaCP/PAS) £(292)k adverse YTD.

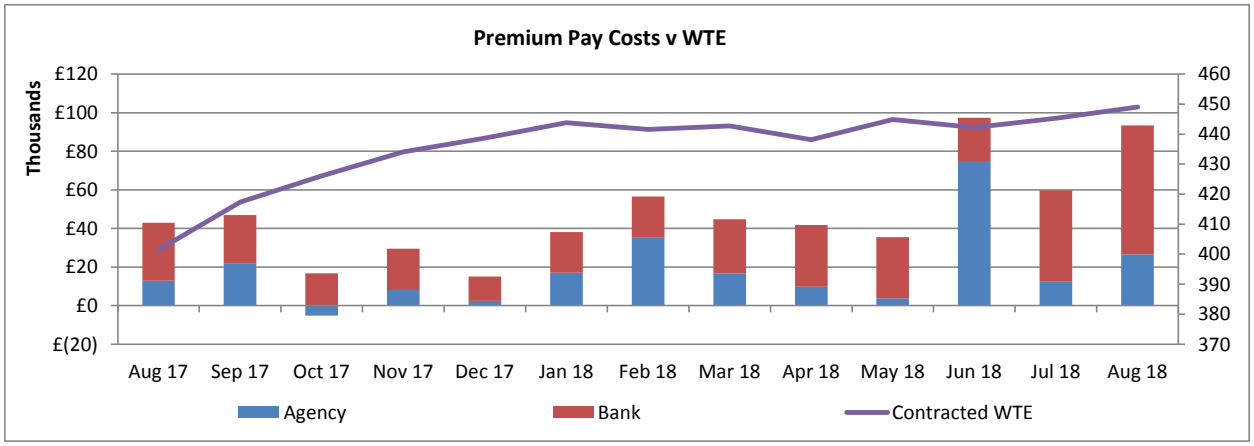
Income is £38k favourable in month and £118k favourable YTD (excl SaCP/PAS). The position YTD is mostly attributable to car parking, laundry, and external utility recharges. The favourable position in month is mainly due to the rental income savings achieved backdated to April.

Pay is favourable £357k YTD. The Division currently has a vacancy rate (comparing contracted/budgeted WTE) of 10%. The vacancies are mainly at senior manager level and recruitment has been slow due to the implementation of 2gether Support Solutions. Bank staff expenditure is mostly within Facilities for Oakleaf/Junior Drs transportation project driver and funded centrally, also within Strategic Development Management department supporting the 2gether project and WHH Hospital Management covering vacancies Agency and Bank staff expenditure is mostly Laundry and Procurement (April to July) which is supported by increased income/delivery of the Trusts savings plan. There is also support for the vacant Deputy Director of Estates post and projects around the future of service delivery. The reduction in contracted WTE is due to Procurement Dept transfer to 2gether Support Solutions.

Non Pay is adverse £(292)k YTD (excluding SaCP/ PAS). The main areas are as follows:
Waste adverse £(76)k YTD, approx. £(39)k is due to prior year costs due to data issues from the supplier and the rest is due to the sharps bins saving scheme not being funded via divisions - this is currently being validated.
Utilities is adverse £(145)k YTD due to:
- A gas valve issue at QEQM earlier in the year meant that the site was run on oil, which is 3 times more expensive than gas. This resulted in an overspend of approx. £46k.
- Water and waste water bills rate increase is yet to be validated, overspend across all sites is £(102)k YTD. In addition at the WHH the waste water rate has increased from 35% to 67% since previous supplier Southern Water was bought by Business Stream back in March 2017, this is currently being looked into by the dept and a/c is currently on hold.
- Ring-fenced adverse £(66)k YTD. Favourable variances are in IT £60k YTD and Strategic Estates, carbon tax and rent £58k YTD. All the variances are being continuously monitored alongside with the relevant departmental leads.

Savings are £12k favourable against plan due to procurement work plan schemes being validated, the divisional schemes are all on plan. All of the schemes are continually being monitored. Forecast savings to be achieved in full.

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	1,426	1,418	(8)	7,300	7,271	(30)
Total Income	**1,426**	**1,418**	**(8)**	**7,300**	**7,271**	**(30)**
Expenditure						
Substantive Staff	(2,046)	(1,957)	89	(9,729)	(9,149)	580
Bank	(2)	(67)	(65)	(12)	(201)	(189)
Agency	0	(26)	(26)	0	(127)	(127)
Total Pay	**(2,048)**	**(2,051)**	**(3)**	**(9,741)**	**(9,477)**	**264**
Non Pay	(2,608)	(2,712)	(105)	(12,681)	(12,814)	(133)
Total Expenditure	**(4,656)**	**(4,763)**	**(107)**	**(22,421)**	**(22,290)**	**131**
Contribution	**(3,230)**	**(3,345)**	**(115)**	**(15,121)**	**(15,020)**	**101**



The position is £101k favourable as at month 5.

Income is adverse £(30)k YTD. All directorates are incurring minor under achievements. These are being validated with departmental leads.

Pay is £264k favourable position YTD due to vacancies being just over 44 WTE. The percentage vacancy rates, budgeted against contracted, are on average just under 9% in each directorate. Validation ongoing.

The agency staff costs shown below are mostly attributable to temporary PMO staff and agency clinical coders, most of these are being funded by the existing vacancies within each dept, the PMO posts have now gone out to advert.

The bank staff costs are within all of the directorates but mostly within CQ&PS Legal and Patient Experience department and Finance, PMO, as stated, and Clinical Coding.

Non pay is £(133)k adverse YTD, this mainly is due to Trust Board: recruitment fees, management consultancy and transcription services for committee minutes. In addition, HR border agency permits adverse £(54)k YTD, cost pressure raised due to the cost trebling and settlement discount not achieved in month, £(12)k adverse YTD.

These are offset by underspends such in Finance, predominantly audit, and CQ&PS.

A. Year on Year Analysis
Month 05 (August) 2018/19

	Annual	Prior Year to Date	Year on Year	
	Plan	Actual	Variance	Variance %
Income				
Electives	103,209	36,579	2,419	6.6%
Non-Electives	161,862	65,572	5,303	8.1%
Accident and Emergency	26,226	10,948	1,384	12.6%
Outpatients	81,011	31,872	746	2.3%
High Cost Drugs	55,662	22,898	(377)	(1.6%)
Private Patients	248	95	51	53.9%
Other NHS Clinical Income	109,496	46,796	2,252	4.8%
Other Clinical Income	1,845	748	(30)	(4.0%)
Total Clinical Income	**539,558**	**215,509**	11,748	5.5%
Non Clinical Income	44,059	21,514	(100)	(0.5%)
Total Income	**583,617**	**237,024**	11,648	4.9%
Expenditure				
Substantive Staff	(326,479)	(124,628)	(7,022)	(5.6%)
Overtime	0	(2,000)	(374)	(18.7%)
Waiting List Payments	(2,723)	(643)	(657)	(102.1%)
Medical Locums/Short Sessions	(3,766)	(1,608)	255	15.8%
Bank	(13,411)	(5,555)	(379)	(6.8%)
Agency	(15,883)	(6,065)	(9,898)	(163.2%)
Direct Engagement - Agency	(3,548)	(1,971)	1,672	84.8%
Total Pay	**(365,810)**	**(142,470)**	(16,403)	(11.5%)
Non-Pay				
Drugs	(67,802)	(28,459)	1,645	5.8%
Clinical Supplies and Services	(66,208)	(28,492)	(421)	(1.5%)
Non-Clinical Supplies and Services	(22,245)	(8,479)	(1,137)	(13.4%)
Purchase of Healthcare	(9,138)	(3,097)	(962)	(31.1%)
Education & Training	(2,951)	(1,003)	184	18.4%
Consultancy	(861)	(314)	(4)	(1.3%)
Premises	(20,552)	(7,593)	(2,322)	(30.6%)
Clinical Negligence	(21,336)	(9,015)	(248)	(2.8%)
Transport	(3,877)	(1,482)	(70)	(4.7%)
Establishment	(3,296)	(1,481)	(134)	(9.1%)
Misc Other Operating Expenses	(3,880)	(2,171)	424	19.5%
Total Non-Pay	**(222,146)**	**(91,587)**	(3,044)	(3.3%)
Total Expenditure	**(587,956)**	**(234,058)**	(19,448)	(8.3%)
EBITDA	**(4,339)**	**2,966**	(7,800)	(263.0%)
Non-Operating Expenses	(26,648)	(10,597)	(222)	(2.1%)
Income and Expenditure Surplus/(Deficit)	**(30,987)**	**(7,631)**	(8,022)	(105.1%)

Clinical Income

- Non Elective income and A&E Activity and case mix is increasing
- Other NHS Clinical Activity in the current year includes the 2018/19 pay award.

Non Clinical Income

- No PSF income 18-19 but £3.2m in 17-18
- PAS Project income 18-19
- Serco contract early exit fee £2.1m 18-19

Pay

- Pay inflation, incl AfC Pay Award
- Consultant Job Plan and Junior Doctors roll out.
- No RMO usage in this period 17-18.
- No A&E Improvement costs in this period 17-18.
- Divisional run rate increases to support activity and operational requirements including use of TFS Nurse Agency.

Non Pay

- Drugs - lower expenditure on rechargeable between years.
- Clinical Supplies - inflation and activity related cost of delivery.
- Purchase of Healthcare increased use of insourcing companies
- Premises - PAS project costs 18-19 and Estates non pay profile

B. Cash Flow

Month 05 (August) 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	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
7,157	**Opening Bank Balance**	7,882	15,985	8,102	7,157	16,287	4,760	7,090	15,985	9,247	7,034	7,998	1,821	4,373	2,892	2,891
32,376	Ashford CCG	5,919	5,775	(143)	7,445	5,494	7,891	5,771	5,775	5,770	5,770	5,770	5,770	5,770	5,770	5,770
51,033	C4G	9,844	9,622	(223)	10,918	9,344	11,531	9,619	9,622	9,621	9,619	9,619	9,619	9,619	9,619	9,619
58,346	South Kent Coast CCG	11,105	10,846	(259)	12,809	10,529	12,943	11,220	10,846	10,827	10,827	10,827	10,827	10,827	10,827	10,827
39,268	Thanet CCG	8,048	7,835	(213)	8,180	7,824	8,233	7,195	7,835	7,835	7,835	7,835	7,835	7,835	7,835	7,835
	Additional Income															
270	Dartford, Gravesham & Swanley CCG	38	92	54	38	38	38	63	92	38	38	38	38	38	38	38
966	Medway CCG	164	173	9	263	165	190	174	173	167	164	164	164	164	164	164
1,538	Swale CCG	306	304	(2)	306	306	299	323	304			273	306	306	306	306
2,140	West Kent CCG	449	428	(21)	377	377	531	427	428	449	449	449	449	449	449	449
41,317	NHS England	8,059	9,707	1,648	8,082	7,728	8,453	7,346	9,707	7,840	8,059	8,059	8,059	8,059	8,059	8,059
15,747	All Other NHS Organisations	960	2,866	1,906	5,317	1,119	801	5,645	2,866	1,517	5,335	1,223	1,423	5,335	1,223	1,423
0	Capital Receipts															
14,058	All Other Receipts	1,783	2,866	1,083	2,664	2,277	2,274	3,976	2,866	2,193	2,274	1,190	2,247	2,200	2,127	2,563
5,603	Provider Sustainability Fund							5,603								
9,352	Working Capital Facility	3,725	3,708	(17)	2,234			3,410	3,708	5,103			7,988	3,746	3,532	7,856
	Working Capital Facility Repaid															
	Permanent Loan															
272,014	**Total Receipts**	**50,401**	**54,222**	**3,821**	**58,633**	**45,202**	**53,184**	**60,772**	**54,222**	**51,360**	**50,369**	**45,446**	**54,724**	**54,348**	**49,948**	**54,909**
	Payments															
(134,966)	Monthly Payroll inc NI & Super	(27,846)	(28,165)	(319)	(26,383)	(26,617)	(26,681)	(27,120)	(28,165)	(28,854)	(27,839)	(27,708)	(27,710)	(27,885)	(27,931)	(27,780)
(128,596)	Creditor Payment Run	(25,705)	(31,892)	(6,187)	(21,600)	(27,605)	(23,054)	(24,445)	(31,892)	(20,354)	(20,314)	(22,650)	(22,790)	(26,627)	(20,117)	(21,105)
(6,255)	Capital Payments	(1,206)	(848)	358	(1,503)	(2,508)	(1,085)	(312)	(848)	(1,012)	(1,195)	(1,265)	(1,642)	(1,262)	(1,787)	(1,469)
	PDC Dividend Payment									(2,634)						(3,007)
(107)	Interest Payments	(55)	(55)		(18)		(34)		(55)	(719)	(57)		(30)	(55)	(114)	(747)
(269,924)	**Total Payments**	**(54,813)**	**(60,960)**	**(6,147)**	**(49,503)**	**(56,730)**	**(50,854)**	**(51,877)**	**(60,960)**	**(53,572)**	**(49,406)**	**(51,623)**	**(52,172)**	**(55,829)**	**(49,948)**	**(54,107)**
2,090	**Total Movement In Bank Balance**	**(4,412)**	**(6,738)**	**(2,326)**	**9,130**	**(11,527)**	**2,330**	**8,895**	**(6,738)**	**(2,212)**	**963**	**(6,177)**	**2,552**	**(1,481)**	**()**	**801**
9,247	**Closing Bank Balance**	**3,470**	**9,247**	**5,777**	**16,287**	**4,760**	**7,090**	**15,985**	**9,247**	**7,034**	**7,998**	**1,821**	**4,373**	**2,892**	**2,891**	**3,693**
	Plan				15,584	3,861	3,529	7,882	3,470	5,153	5,618	3,493	3,879	2,890	2,890	3,693
	Variance				704	899	3,561	8,102	5,777	1,881	2,380	(1,672)	494	1	1	()

C. Clinical Income - by Commissioner

Month 05 (August) 2018/19

	Annual £000	Year to Date £000			This Month £000		
Commissioner	**Plan**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Ashford CCG	69,236	28,481	30,964	2,483	5,748	6,078	329
NHS Canterbury & Coastal CCG	115,422	47,902	49,730	1,828	9,526	9,627	101
NHS South Kent Coast CCG	129,925	54,385	56,255	1,870	11,252	10,930	(322)
NHS Thanet CCG	94,021	39,210	40,736	1,527	8,066	7,682	(383)
East Kent CCGs	408,603	169,978	177,685	7,708	34,593	34,317	(275)
NCA - England	4,686	2,179	2,348	170	493	563	69
NHS England - Armed Forces	159	72	91	19	14	13	(1)
NHS England - Specialised Services	79,165	33,317	33,497	180	6,738	7,026	288
NHS England - Health In Justice	116	48	33	(15)	10	7	(3)
NHS England - Secondary Dentistry	6,429	2,680	2,854	173	558	579	21
NHS England - Public Health	7,811	3,024	2,792	(232)	684	555	(129)
Kings	264	110	109	(1)	22	22	
NCA - Wales	142	59	63	4	12	16	4
NCA - Northern Ireland	5	2	6	4		2	2
NCA - Scotland	22	9	7	(3)	2	1	(1)
Other Trusts	1,793	747	968	221	149	189	40
East Kent Overseas		29	337	309	8	68	60
NHS Dartford, Gravesham & Swanley CCG	455	242	206	(36)	45	25	(20)
NHS Medway CCG	2,075	899	810	(89)	190	194	4
NHS Swale CCG	3,643	1,620	1,392	(227)	340	278	(63)
NHS West Kent CCG	5,122	2,239	2,327	88	446	469	23
Other Organisations	16,059	4,014	341	(3,673)	(765)	1,117	1,882
Cancer Drugs Fund	3,007	1,253	1,437	185	251	315	64
Adjust Prior Month Reported Position			()			200	200
Prior year Income			(232)	(232)		15	15
Total	539,558	222,522	227,072	4,553	43,789	45,968	2,180

East Kent Commissioner contracts are all over performing YTD, although collectively under plan in month. NHSE Specialised Services is now ahead of plan YTD following a large over performance in month. The Cancer Drugs Fund and West Kent CCG are both ahead of plan, while the North Kent CCG's are collectively behind plan. Other Organisations include provisions for risks along with the planned CIP schemes and £2m ytd unplanned income to fund AfC pay awards.

EK CCGs continue to materially challenge Trust data on a monthly basis, however through joint discussions they are reducing. In July £2m of patient level data queries were received, again of which only a handful of challenges were accepted with minimal financial impact.

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 Trust holds a provision in its accounts to cover this. There are no material contracting issues with any of our other Commissioners.

D. KPIs

Month 05 (August) 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							
	Variance	-479	1,367	482	1,687	2,377							
	Quarterly rolling average spend	43,089	44,782	45,617	47,395	47,342							
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							
	Variance	-146	54	1,258	2,096	104							
	Quarterly rolling average spend	5,875	6,087	3,914	4,672	4,687							
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							
	Variance	-481	-1,326	-1,090	-1,631	-3,534							
	Quarterly rolling average spend	-31,203	-31,818	-31,882	-32,216	-32,859							
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							
	Variance	1,335	-251	-707	-2,182	623							
	Quarterly rolling average spend	-19,920	-20,168	-18,795	-19,715	-19,418							
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							
	Variance	110	14	49	16	59							
	Quarterly rolling average spend	-1,942	-1,971	-2,170	-2,202	-2,189							
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							
	Variance	-1,337	-2,219	-1,647	-1,859	-1,489							
	Quarterly rolling average spend	-3,237	-3,484	-3,457	-3,532	-3,208							
CIPS	**Plan**	1,502	1,533	1,552	3,357	2,156	1,289	2,895	2,927	2,944	3,208	3,267	3,370
Unconsolidated	**Actual**	1,155	1,758	1,629	4,081	1,777							
	Variance	-348	225	77	723	-378							
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							
	Variance	704	901	3,561	8,102	5,777							

E. Cost Improvement Summary

Month 05 (August) 2018/19

Planned Summary	2018 - 2019			Target Variance	
Programme Divisions £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Clinical Support	4,159	3,942	3,531	(217)	(1,132)
Specialist	4,075	3,961	3,773	(114)	(350)
Surgery	7,015	6,385	5,453	(630)	(1,936)
UC&LTC	6,400	6,861	6,840	461	(230)
Corporate - Other	71	81	84	10	(1)
SD&CP	1,300	1,305	1,243	5	(172)
Procurement	2,693	1,792	1,602	(901)	(412)
Medicines Value	871	1,262	1,350	391	(3)
Sub-total	**26,584**	**25,589**	**23,876**	**(994)**	**(4,236)**
Central	3,416	4,411	4,055	994	1,024
Grand Total	**30,000**	**30,000**	**27,931**	**-**	**(3,212)**

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	6,137	6,065	5,412	(71)	(724)
Workforce *	169	253	498	84	329
Procurement	2,693	1,357	1,175	(1,336)	(1,518)
Medicines Value	871	1,262	1,350	391	479
Division Schemes **	16,156	16,140	14,587	(16)	(1,569)
Sub-total	**27,025**	**26,077**	**24,022**	**(948)**	**(3,003)**
Central	2,975	3,923	3,909	948	934
Grand Total	**30,000**	**30,000**	**27,931**	**-**	**(2,069)**

E. Cost Improvement Phasing

Month 05 (August) 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	544	529	520	721	674	(248)	505	533	526	597	621	614	6,137
Workforce	2	2	2	4	20	20	20	20	20	20	20	20	169
Procurement	109	129	146	188	258	265	266	266	266	266	267	267	2,693
Medicines Value	30	45	50	55	66	68	70	79	88	98	108	116	871
Clinical Support	184	188	190	275	272	275	274	270	267	295	293	294	3,078
Specialist	69	74	79	89	112	93	459	463	463	469	469	468	3,308
Surgery	413	413	413	419	419	419	636	636	636	719	744	744	6,615
UC&LTC	37	37	37	103	103	103	227	227	227	227	227	227	1,784
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	**1,502**	**1,533**	**1,552**	**1,969**	**2,039**	**1,110**	**2,738**	**2,775**	**2,775**	**2,971**	**3,030**	**3,031**	**27,025**
Central	-	-	-	1,388	117	179	157	152	169	237	237	339	2,975
Grand Total	**1,502**	**1,533**	**1,552**	**3,357**	**2,156**	**1,289**	**2,895**	**2,927**	**2,944**	**3,208**	**3,267**	**3,370**	**30,000**

Workstream RAG adj £'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	646	365	448	408	347	311	459	479	482	473	495	499	5,412
Workforce	22	53	2	25	44	50	50	50	50	50	50	50	498
Procurement	35	44	59	106	54	108	125	125	125	132	132	130	1,175
Medicines Value	42	57	109	222	194	85	88	94	104	111	119	126	1,350
Clinical Support	157	184	234	330	357	188	195	197	197	244	244	244	2,773
Specialist	127	163	185	206	176	173	377	406	422	398	445	456	3,534
Surgery	14	628	380	475	316	386	386	386	386	384	384	384	4,509
UC&LTC	(9)	56	96	188	209	219	253	256	329	286	286	286	2,454
Corporate - Other	-	11	7	7	7	6	6	6	6	6	6	6	73
SD&CP	20	198	108	113	172	108	105	105	105	105	105	(1)	1,243
Sub-total	**1,055**	**1,758**	**1,629**	**2,081**	**1,877**	**1,634**	**2,210**	**2,271**	**2,373**	**2,356**	**2,433**	**2,346**	**24,022**
Central	100	-	-	2,000	(100)	(259)	613	311	211	345	343	345	3,909
Grand Total	**1,155**	**1,758**	**1,629**	**4,081**	**1,777**	**1,375**	**2,824**	**2,582**	**2,584**	**2,700**	**2,776**	**2,691**	**27,931**

F. Debtor Balances

Month 05 (August) 2018/19

Debtor	Top ten debtor balances outstanding as at 31/08/2018						Creditor balance as at 31/08/2018	Notes
	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total		
51136-EAST KENT MEDICAL SERVICES	165,656.20	162,554.98	151,315.75	123,626.54	1,159,822.88	1,762,976.35	1,051,067.48	Reciprocal payment arrangement in place
62033-NHS THANET CCG	7,527.78	12,978.70	(344,526.55)	(353,100.00)	2,422,319.75	1,745,199.68	80,522.00	Invoices and Payments on account for 1718 overperformance
61865-NHS CANTERBURY AND COASTAL CCG	4,702.38	(8,934.17)	(947,425.40)	(348,850.00)	2,793,582.49	1,493,075.30	80,426.00	Invoices and Payments on account for 1718 overperformance
62003-NHS SOUTH KENT COAST CCG	24,774.74	12,490.26	(1,509,125.94)	(468,150.00)	3,058,972.10	1,118,961.16	99,968.00	Invoices and Payments on account for 1718 overperformance
61818-NHS ASHFORD CCG	3,703.74	6,715.66	(1,366,818.88)	(252,900.00)	2,498,821.50	889,522.02	57,352.00	Invoices and Payments on account for 1718 overperformance
50010-MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	145,128.12	124,554.44	41,287.10	30,219.62	532,911.59	874,100.87	1,731,717.73	
62048-NHS WEST KENT CCG	15,584.05	20,246.31	11,382.84	13,567.73	722,551.10	783,332.03		
51708-MEDWAY NHS FOUNDATION TRUST	49,251.39	76,962.21	17,890.50	61,943.71	492,834.39	698,882.20	1,150,038.79	Reciprocal payment arrangement in place with Medway FT
95741-KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	424,449.48	121,299.16	292.56	0.00	(506.28)	545,534.92	139,613.25	
62138-NHS ENGLAND SOUTH EAST COMMISSIONING HUB (14G)	0.00	73,900.17	147,800.34	0.00	295,600.68	517,301.19		
Other Govn.	304,022.28	574,834.38	204,444.85	488,002.08	2,437,089.15	4,008,392.74		
Other Non Govn.	237,151.51	277,364.48	315,763.59	175,781.98	1,130,843.36	2,136,904.92		
	1,381,951.67	1,454,966.58	(3,277,719.24)	(529,858.34)	17,544,842.71	16,574,183.38	4,390,705.25	

F. Creditor Balances

Month 05 (August) 2018/19

Unpaid at last Payment Run

Supplier Name	Total
Other Creditors	2,354
TFS Healthcare	644
NHS Professionals Ltd	534
IHSS Ltd	284
NHS Supply Chain 8HD71 - Stock	255
Novartis Pharmaceuticals UK Ltd	183
NHS Blood & Transplant T1460	145
Alcura UK Ltd	142
GE Medical Systems Ltd	132
Roche Products Ltd	129
InHealth Ltd	127
Total	**4,931**

At the last payment run of the period we had a total of £9.5m of invoices authorised and ready for payment.

Of the £9.5m, £4.6m was released leaving £4.9m unpaid due to low liquidity. Aged Creditors now stands at £32.2m.

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

Top Ten Aged Creditor

Supplier Name	Current	1-30	31-60	60-90	90 +	Total
Other Creditors	10,511	7,515	1,517	250	1,277	21,070
TFS Healthcare	897	904				1,802
Maidstone & Tunbridge Wells NHS Trust (RWF)	463	664	337	39	228	1,732
NHS Supply Chain 8HD71 - Stock	1,084	255				1,339
2gether Support Solutions Ltd	2,105	891				1,214
Medway NHS Foundation Trust (RPA)	163	302	8	157	520	1,150
East Kent Medical Services Ltd T/a The Spencer Wing		151	74	27	799	1,051
NHS Professionals Ltd	243	541	5		10	799
NHS Supply Chain 8HD71 - Maintenance	667	16	2	0		686
Medtronic Ltd	270	195	31	35	145	676
Healthcare At Home Ltd	632	15				647
Total	**17,036**	**9,667**	**1,974**	**510**	**2,979**	**32,167**

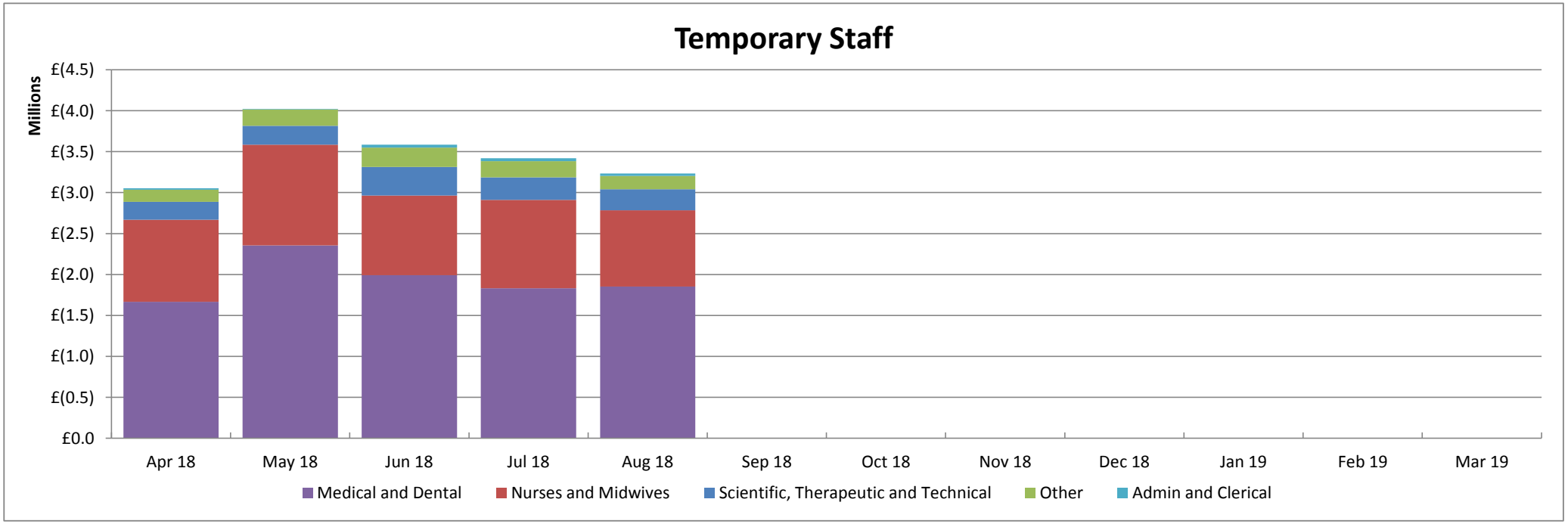
Aged Creditor By Reason

Reason Description	Current	1-30	31-60	60-90	90 +	Total
Current	17,036					17,036
Cash Flow		4,929				4,929
Waiting on a GRN		1,977	546	186	538	3,248
Waiting on Authorisation		1,945	826	28	127	2,926
Disputed		217	100	34	1,368	1,719
Creditor Debit Balance		118	73	27	752	969
Not Recorded		76	180	187	31	475
Purchase Order Value Exceeded		109	139	18	43	309
Price Query		66	74	21	79	239
Procurement Issue		194	0	0	2	197
Other		36	35	9	40	120
Total	**17,036**	**9,667**	**1,974**	**510**	**2,979**	**32,167**

G. Pay Analysis - Temporary Staff

Month 05 (August) 2018/19

In Month £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medical and Dental	**(1,667)**	**(2,356)**	**(1,990)**	**(1,832)**	**(1,851)**							
Agency	(1,476)	(2,079)	(1,571)	(1,702)	(1,515)							
Medical Locum and Short Session	(191)	(277)	(420)	(130)	(336)							
STAFFflow												
Scientific, Therapeutic and Technical	**(217)**	**(231)**	**(348)**	**(275)**	**(257)**							
Agency	(217)	(231)	(348)	(275)	(257)							
Nurses and Midwives	**(1,002)**	**(1,230)**	**(974)**	**(1,080)**	**(933)**							
Agency	(1,002)	(1,230)	(974)	(1,080)	(933)							
Admin and Clerical	**(18)**	**(6)**	**(33)**	**(36)**	**(28)**							
Agency	(18)	(6)	(33)	(36)	(28)							
Other	**(150)**	**(201)**	**(239)**	**(198)**	**(164)**							
Agency	(150)	(201)	(239)	(198)	(164)							
Total	**(3,054)**	**(4,018)**	**(3,551)**	**(3,385)**	**(3,205)**							



G. Pay Analysis - Temporary Staff

Month 05 (August) 2018/19

Temporary Staff Actual £m	M & D	N & M	PAMS	A&C Other	Total	Variance v 2018/19	Variance v 2017/18
Urgent Care & LongTerm Conditions	1.15	0.76	0.03	0.12	2.05	(0.07)	0.55
Surgical Services	0.42	0.15	0.04		0.60	0.01	0.05
Clinical Support Services	0.05		0.20		0.26	(0.06)	0.02
Specialist Services	0.21	0.03			0.24	0.02	0.06
Strategic Development and Capital Planning				0.05	0.05	0.01	0.03
Corporate				0.03	0.03		0.01
Central	(0.17)		(0.01)		(0.18)	(0.08)	(0.13)
Total	**1.66**	**0.94**	**0.26**	**0.20**	**3.06**	**(0.17)**	**0.59**
Variance v 2018/19 average	(0.04)	(0.11)	(0.01)	(0.02)	(0.18)		
Variance v 2017/18 average	0.03	0.33	0.11	0.13	0.59		

Temporary Staff Year to Date £m	M & D	N & M	PAMS	A&C Other	Total	Average per Month
Urgent Care & LongTerm Conditions	5.51	4.28	0.13	0.71	10.62	2.13
Surgical Services	2.08	0.72	0.18	0.01	2.99	0.60
Clinical Support Services	0.54		1.04		1.58	0.32
Specialist Services	0.94	0.19			1.13	0.23
Strategic Development and Capital Planning				0.20	0.20	0.04
Corporate	0.01			0.13	0.14	0.03
Central	(0.55)	0.04	(0.02)	0.02	(0.52)	(0.10)
Total	**8.53**	**5.23**	**1.33**	**1.07**	**16.16**	**3.25**
Average per month	1.70	1.04	0.27	0.22	3.23	

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**INTEGRATED PERFORMANCE REPORT (IPR)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: INTEGRATED PERFORMANCE REPORT REPORT ISSUED AUGUST 2018**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Performance Report is produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The Integrated Performance Report provides assurance to the Board that all areas of performance are monitored with sentinel indicators, allowing the Board to gain assurance regarding actual performance, Trust priorities and remedial actions.
Below are the highlights from the August 2018 report. The report has been discussed in detail by the Board's Quality Committee, Finance and Performance Committee and Strategic Workforce Committee. A summary of discussions at these meetings are included in Chair Reports to the Board of Directors.

A&E 4 Hour Compliance

August performance for the 4 hour target was 80.0%; against the NHS Improvement trajectory of 85.4%.This represents an increase in performance compared to the previous month. There were no 12 Hour Trolley Waits in August. The number of patients who left the department without being seen continued to be compliant at 2.5%, whilst unplanned re-attendances remained un-compliant at 9.8%. Time to treatment improved from July, but remained un-compliant at 48.0% for August.

August performance has improved despite being challenged by an increased number of attendances and increased patient acuity due to a continuation of the extremely high temperatures experienced and seasonal variation.

18 Weeks Referral to Treatment (RTT) Standard

August performance reduced to 79.06%, performance is now 1.95% behind the improvement trajectory.

The number of patients waiting over 52 weeks for first treatment has decreased to 125. This is within the trajectory submitted to NHSI, breaches have occurred within the following specialties; Gynaecology (93), General Surgery (16), Trauma & Orthopaedics (6), ENT (3), Dermatology (2), Ophthalmology (1), and Other Specs (2).

Cancer 62 day GP Referral to Treatment Standard

August performance is currently 66.53% against the improvement trajectory of 57.87%, validation continues until the beginning of October in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,689 and there were 25 patients waiting 104 days or more for treatment or potential diagnosis.

6 Week Referral to Diagnostic Standard

The standard has not been met for August 2018 with a compliance of 98.03%. As at the end of the month there were 298 patients who had waited over 6 weeks for their diagnostic procedure.

Patient Experience, Safety and Effectiveness

In terms of patient safety, the following positive improvements were reported:

- The rate of falls has again remained below the national average - registering green for August.
- New harms, as reported in the harm free care metric, remains positive and similar to last month. Overall harm free care has improved this month rising from below the lower control limit last month to above the upper control limit this month.
- There has been a significant improvement in the omitted medicines safety metric.
- The ratio of compliments to complaints is also positive with a high number of recorded compliments to every single complaint. Complaint response times have met our standard for the 7th month running.
- The Friends and Family test inpatient satisfaction rate remains positive at 96% and overall patient experience is registering green this month, similar to last month. However, this month we have reported overall patient experience as amber based on the inpatient real time surveys. We are exploring with the ward teams what has led to this to determine the action required to improve.

Avoidable category two pressure ulcers continues to report as amber in August, slightly below our improvement trajectory. The Integrated Performance Report provides more detail around actions the Trust is putting in place to drive improvement (page 27).

Infection control continues to be a cause for concern. As previously reported to the Board, there are general and specific actions that the infection prevention and control team are taking around this, reported on page 25 of the Integrated Performance Report.

Unfortunately, whilst the number of mixed sex breaches has decreased, we continue to report mixed sex breaches within the clinical decision units and some of our escalation areas. As reported previously to the Board, this is due to the challenges we face around patient flow and decongesting the emergency departments to maintain safety.

Financial Performance

Performance is monitored in detail by the Finance and Performance Committee and reported to the Board of Directors. Below summarises the August 2018 position.

The Trust's detailed finance position can be found on page 43 of the report. The Trust delivered a year to date deficit at Month 5 at £4.3m deficit, which is £0.4m behind plan. This is a consolidated position including Spencer Wing and after technical adjustments.

We continue to work with our regulators to monitor the Trust's Financial Recovery plan.

Human Resources

The Turnover rate in month decreased to 12.1%, and the 12 month average is the same as the previous 12 months at 13.5%. Focus remains on hard to recruit roles to replace agency, but also to identify new ways and methods of attracting to hard to recruit roles. Exit data is reviewed to highlight any areas of concern.

The vacancy rate increased to 12.6% 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.

Our Human Resources Team is working hard with Divisions to identify new ways and methods of recruitment in a more timely way and to explore different workforce models. Exit interviews are 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 Divisional level in our monthly Executive Performance Reviews.

A full report on the HR metrics can be found from page 46 in the IPR.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The report links to the corporate and strategic risk registers.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
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	Executive Performance Reviews. Management Board. Quality Committee. Finance and Performance Committee. Strategic Workforce Committee.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report.

NHS
East Kent Hospitals University
NHS Foundation Trust

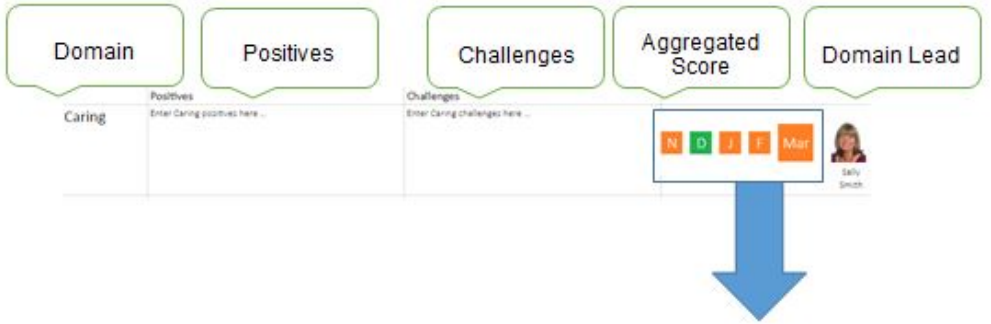
AUGUST 2018

INTEGRATED PERFORMANCE REPORT

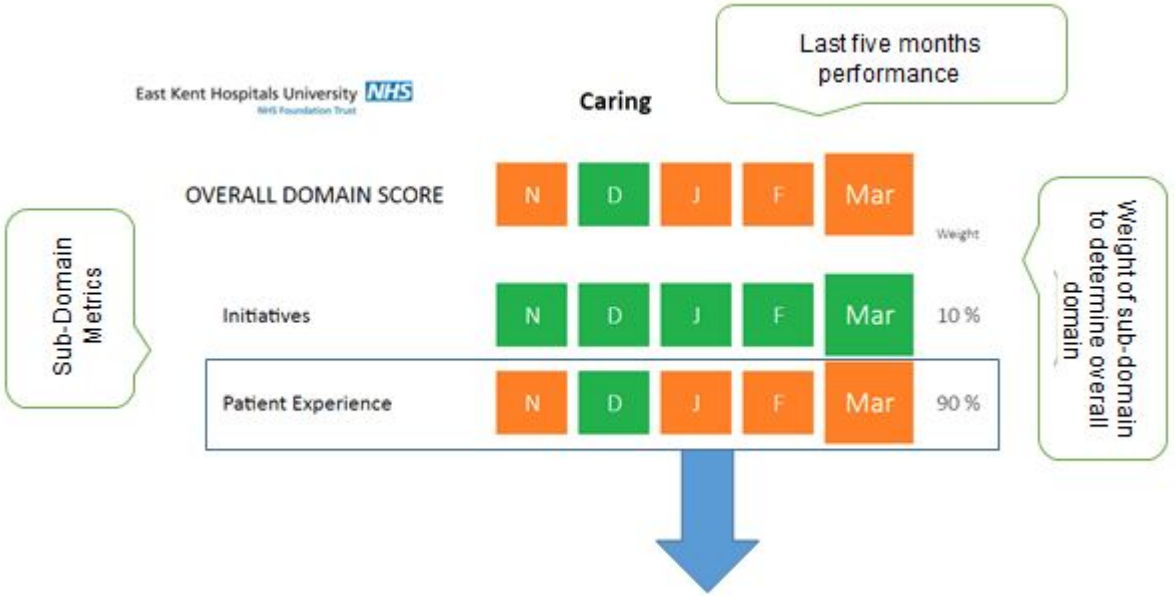
East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

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



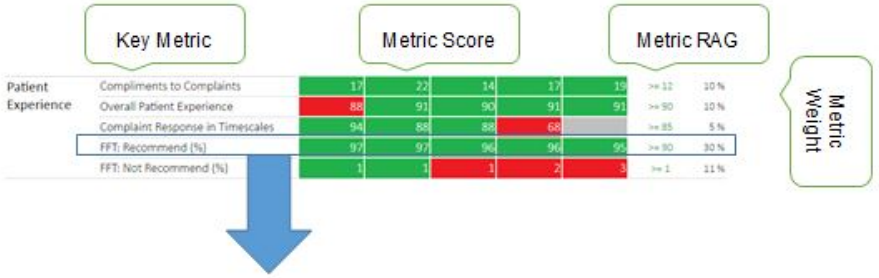
2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall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



East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

3 **Key Metrics:** This section provides the actual data that builds up into the domain, the actual performance in percentage or volume terms for any given metric. These metrics are explored in more detail in the next section, Strategic Themes.



4 **Strategic Themes**: The Strategic Theme pages house key metrics with additional analysis, showing trend over the last 12 months. They show the latest month RAG together with the last 12 months position status (ie improved or worsened % from the previous 12 months plus average metric score). The 12 month positions will either be an average (if a % or index) or total sum (if a number). In addition to this it includes a metric description and data assurance stars which reflects how assured the data is. Description for how the data assurance stars are formulated is explained in the Glossary.

All RAGs are banded as Green, Amber and Red. A grey cell indicates that data is not yet available. The threshold for the green RAG point is indicated in the Glossary pages together with how much weight each metric holds towards the sub-domain.

NHS
East Kent Hospitals University
NHS Foundation Trust

Strategic Priorities

NHS
East Kent
Hospitals University
NHS Foundation Trust

Contents

East Kent Hospitals University NHS Foundation Trust

Headlines

	Positives	Challenges	
Caring	The Friends and Family test inpatient satisfaction rate remains positive at 96%. The ratio of compliments to complaints is positive with a high number of recorded compliments to every single complaint. Complaint response times have met our standard being responded to within the timescales agreed with the client. This is the 7th month running of achieving our standard.	We are still reporting mixed sex breaches in the Clinical Decision Units and in some of the escalation areas. This is due to patient flow and decongesting the Emergency Departments to maintain safety. This month we have reported overall patient experience as amber based on the inpatient real time surveys. We are exploring with the ward teams what has led to this to determine the action required to improve. There is still a challenge to maintaining clinical safety and quality within the emergency departments during periods of high pressure, highlighted within the recent CQC report. Actions to address this include focussing on improving patient flow, assuring the appropriate staffing in terms of numbers and skill mix and embedding monitoring and assurance systems such as the Bristol Safety checklist	A M J J Aug  Sally Smith
Effective	There has been continued improvement in DTOC's which are averaging at 55 per day; however, this remains higher than the Trust internal target of 30 DTOC's per day. Discharges before 12 noon have improved to 17%. It continues to be a priority to increase the number of discharges before midday. Theatre utilisation has reduced slightly to 79.6%, with theatre start time performance at 84.9%. There have been no non-clinical cancellations within 28 days.	Bed Occupancy has worsened to 101% as a result of increased attendances and a lower level of discharges.	A M J J Aug  Lee Martin

Responsive

4 hour Emergency Access Standard
August performance for the 4 hour target was 80%; against the NHS Improvement trajectory of 85.4%.This represents a slight increase in performance compared to the previous month. There were no 12 Hour Trolley Waits in August. The number of patients who left the department without being seen continued to be compliant at 2.5%, whilst unplanned re-attendances remained non-compliant at 9.8%. Time to treatment improved from July, but remained non-compliant at 48%.

RTT
August's performance reduced to 79.06% and performance is now 1.95% behind the improvement trajectory.

The number of patients waiting over 52 weeks for first treatment has decreased further to 125. This is within the trajectory submitted to NHSI.

DM01
The standard has not been met for August 2018 with a compliance of 98.03%. As at the end of the month there were 298 patients who had waited over 6 weeks for their diagnostic procedure,
The increase in demand for Sleep Studies has impacted on Respiratory performance. CT and MRI have also seen an increase in demand as the focus on reducing the waiting times for patients on cancer pathways.

Cancer
August performance is currently 66.53% against the improvement trajectory of 57.87%, validation continues until the beginning of October in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,689 and there were 25 patients waiting 104 days or more for treatment or potential diagnosis.

All patients over 104 days are reviewed at the cancer PTL meetings weekly and daily review is being progressed by the speciality to ensure timely investigations and treatment for patients.

An NHSE/I review of the Trust cancer improvement plan has been undertaken with confirmation that our plans are robust and evidencing continued improvement in performance and

4 hour Emergency Access Standard
The A&E four hour standard remains a priority for the Trust. During the month there was an increased number of attendances and increased patient acuity due to a continuation of the extremely high temperatures experienced, and seasonal variation.

RTT
Insufficient capacity due to vacancy, annual leave and increased demand to meet all standards.

DM01
Demand for diagnostics has increased due to efforts to reduce cancer and RTT waiting times.
Identifying sustainable elective capacity to mitigate the risk of RTT and cancer breaches.

Cancer
Risk of potential patient harm for patients waiting over 104 days. To prevent further 104 day waiters, each patient over 73 days is reviewed at the weekly primary target list (PTL) meeting.

A M J J Aug

Lee Martin

	patient outcomes			
Safe	The rate of falls has again remained below the national average registering green for August. New harms as reported in the harm free care metric remains positive and improved compared to last month. Overall harm free care has also improved this month rising from below the lower control limit last month to above the upper control limit this month. There has been a sustained improvement in the omitted medicines safety metric.	Avoidable category two pressure ulcers remains amber for August and slightly below our improvement trajectory. VTE assessment recording continues to require constant monitoring and is hovering below the 95% standard. Infection prevention and control continues to be a cause for concern.	A M J J Aug	 Paul Stevens
Well Led	Staff Turnover (M4 15% , M5 13.9%) and Appraisal (M4 - 70.5%, M5 -75.9%) rates have both improved in month. I&E CIPS of £10.4m are reported up to Month 5 against a plan of £10.1m. Risks remain in relation to finalising CIP schemes to deliver a net £30m of savings by the year end.	The Trust delivered a £4.3m deficit (after NHSi adjustments) in Month 5 which was £0.4m behind plan. This brings the YTD position to a deficit of £15.3M which is behind plan for the first time this year by £0.3m (consolidated position including Spencer Wing and after technical adjustments). Trust Pay is £2.2m over plan in month and £6.6m over plan YTD. The main overspend is in Agency costs (£8.6m over plan YTD) offset by an underspend on permanent staffing (£2.3m under plan YTD). The key driver for the overspend against plan are the continuing Medical and Nursing pressures in U&LTC. Risks remain in relation to the impact on Income of the recent Expert Determination. The Trust is working with Commissioners to agree the final impact. Total Cash borrowed has risen to £55.6m Staff sickness (M4 -3.9%, M5 4%) and Vacancy (M4 13.6% , M5 -14.8%) rates have both worsened in month.	A M J J Aug	 Susan Acott

East Kent Hospitals University NHS Foundation Trust

Caring

	A	M	J	J	Aug	
OVERALL DOMAIN SCORE						Weight
Patient Experience						90 %

East Kent Hospitals University NHS Foundation Trust

Caring

		Apr	May	Jun	Jul	Aug	Green	Weight
Patient Experience	Compliments to Complaints (#/1)	43	28	28	31	23	>= 12	10 %
	Mixed Sex Breaches	67	69	98	50	73	< 1	10 %
	Overall Patient Experience %	91.6	91.4	91.1	91.9	89.8	>= 90	10 %
	Complaint Response in Timescales %	94.4	91.4	92.0	87.3	90.2	>= 85	5 %
	AE Mental Health Referrals	97	104	134	106	115		5 %
	FFT: Recommend (%)	97	97	97	97	96	>= 90	30 %
	FFT: Not Recommend (%)	1.1	1.8	0.9	1.1	1.7	>= 1	10 %

East Kent Hospitals University NHS Foundation Trust

Effective

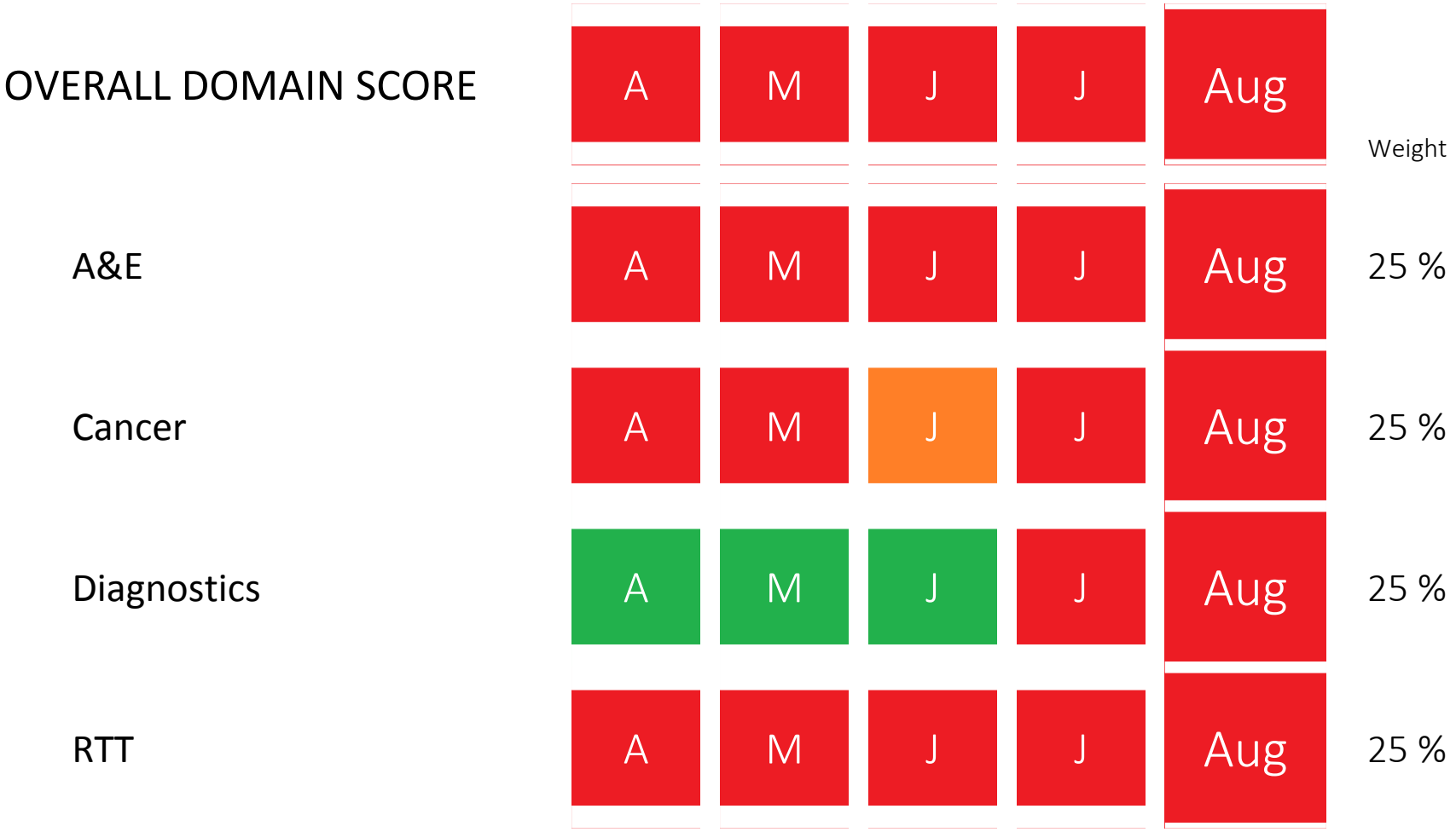
NHS
East Kent Hospitals University
NHS Foundation Trust

Effective

		Apr	May	Jun	Jul	Aug	Green	Weight
Beds	Bed Occupancy (%)	101	100	96	94	95	<= 92	60 %
	IP - Discharges Before Midday (%)	14	14	14	14	13	>= 35	10 %
	DToCs (Average per Day)	63	61	61	57	52	< 35	30 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3.5	3.5	3.5	3.4	3.3	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	15.2	15.3	15.2	14.8	14.4	< 15	15 %
	Audit of WHO Checklist %	98	100	100	96	98	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	7.0	7.0	6.8	7.8	8.5	< 7	
	DNA Rate: Fup %	6.5	6.7	6.8	6.9	7.3	< 7	
	New:FUp Ratio (1:#)	0.3	0.3	0.3	0.3	2.3		
Productivity	LoS: Elective (Days)	3.3	3.5	3.2	3.5	2.8		
	LoS: Non-Elective (Days)	6.6	6.4	6.2	6.2	6.0		
	Theatres: Session Utilisation (%)	77	81	79	82	82	>= 85	25 %
	Theatres: On Time Start (% 30min)	76	73	70	73	75	>= 90	10 %
	Non-Clinical Cancellations (%)	2.4	2.2	2.1	1.8	1.7	< 0.8	20 %
	Non-Clinical Canx Breaches 28 Days (%)	0	1	3	0	0	< 5	10 %
	EME PPE Compliance %	82	81	80	81	78	>= 80	20 %

East Kent Hospitals University NHS Foundation Trust

Responsive



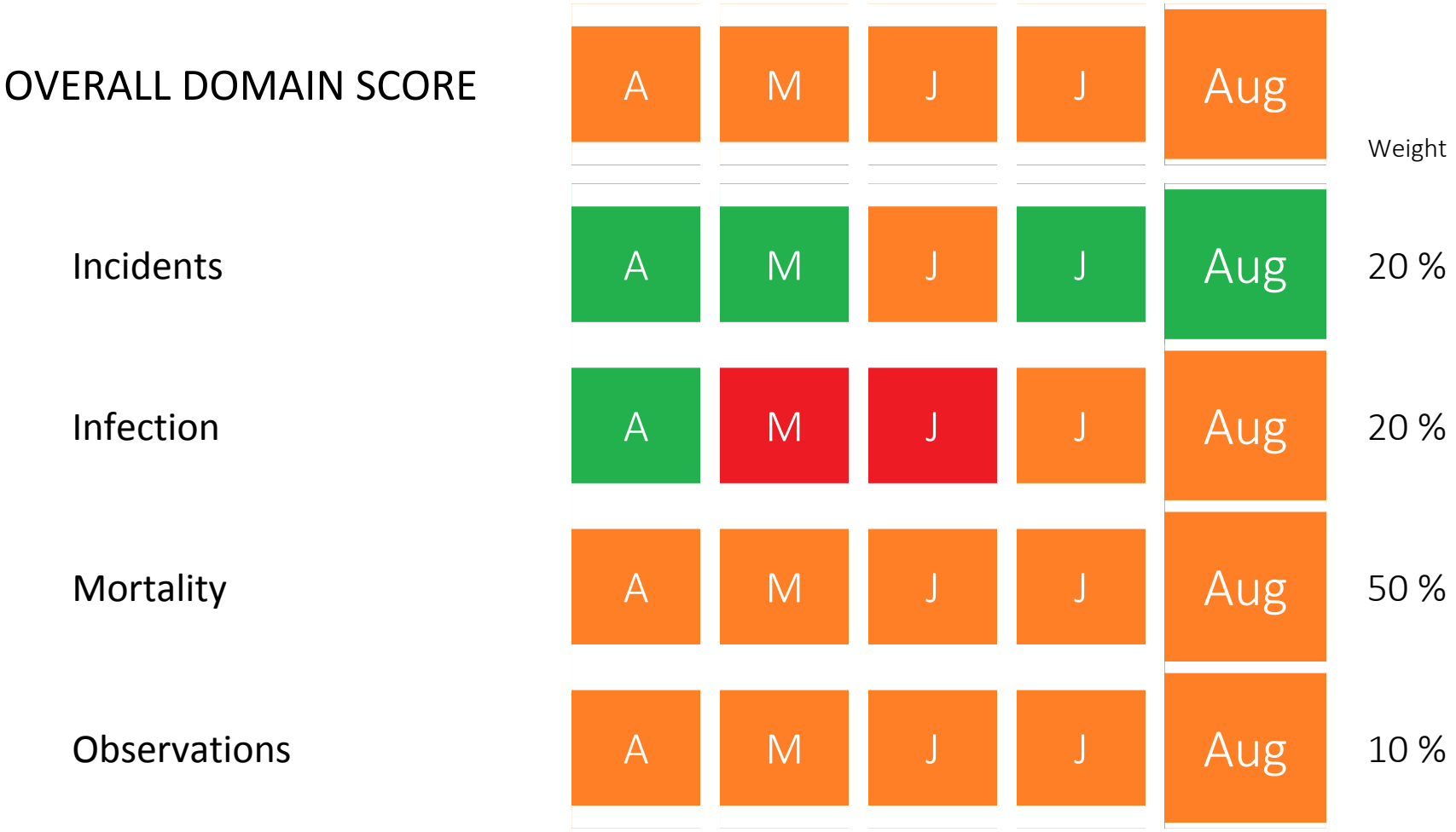
NHS
East Kent Hospitals University
NHS Foundation Trust

Responsive

		Apr	May	Jun	Jul	Aug	Green	Weight
A&E	ED 4hr Performance (incl KCHFT MIUs) %	81.73	83.95	86.92	79.53	83.52	>= 95	100 %
	ED 4hr Performance (EKHUFT Sites) %	76.93	80.80	81.12	79.18	80.04	>= 95	1 %
Cancer	Cancer: 2ww (All) %	89.06	93.84	94.22	94.94	93.79	>= 93	10 %
	Cancer: 2ww (Breast) %	75.16	84.46	94.12	93.13	80.80	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	95.37	96.31	96.43	95.65	94.60	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	88.57	82.05	82.61	94.59	95.45	>= 94	5 %
	Cancer: 31d (Drug) %	97.94	98.88	98.11	99.16	100.00	>= 98	5 %
	Cancer: 62d (GP Ref) %	66.13	65.40	65.32	65.45	66.40	>= 85	50 %
	Cancer: 62d (Screening Ref) %	93.75	84.09	100.00	81.63	91.30	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	89.19	75.86	84.38	85.00	90.70	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.38	99.30	99.09	98.44	98.03	>= 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 (%)	76.66	78.56	79.02	79.65	79.06	>= 92	100 %
	RTT: 52 Week Waits (Number)	222	218	201	167	125	< 1	

East Kent Hospitals University NHS Foundation Trust

Safe



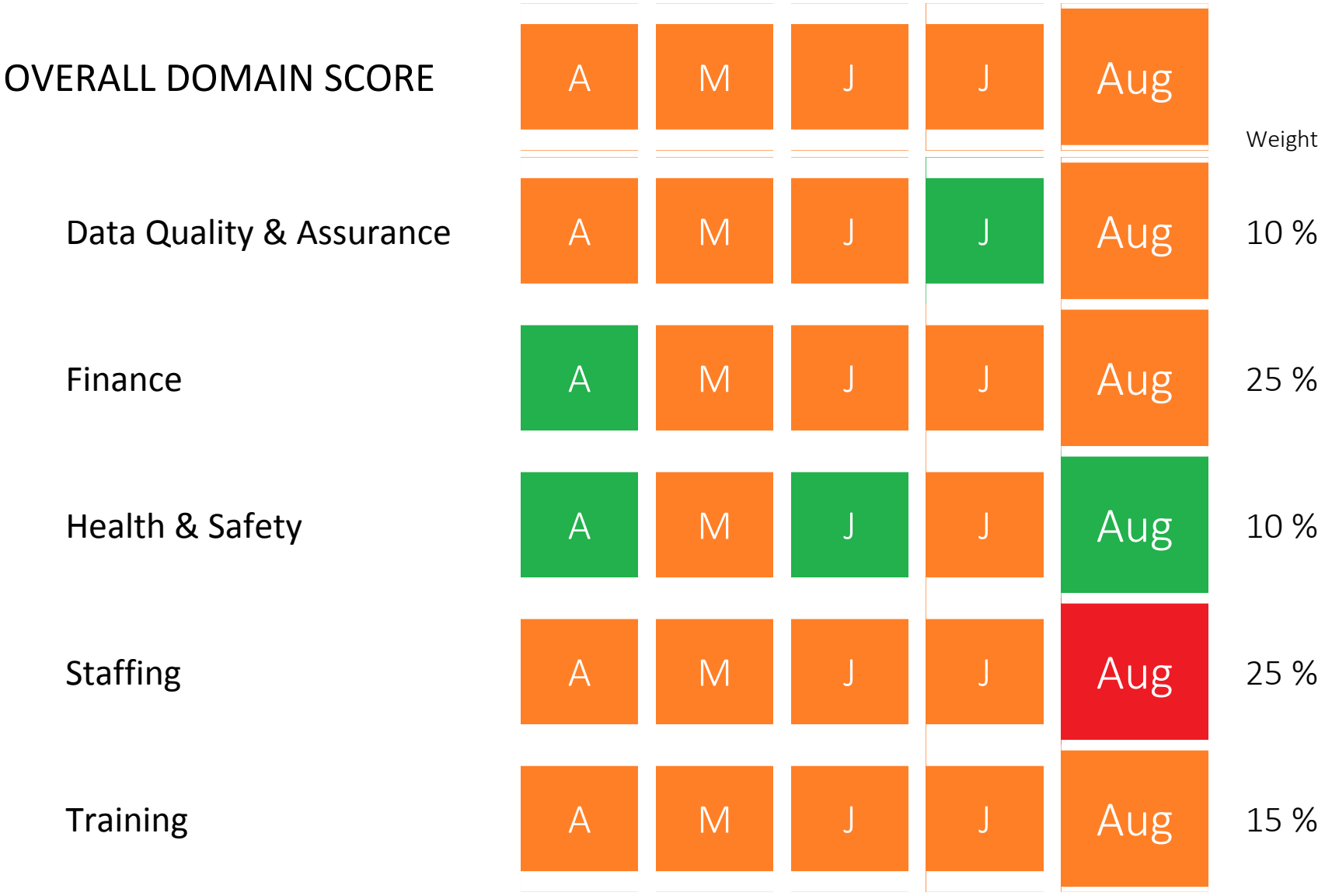
NHS
East Kent Hospitals University
NHS Foundation Trust

Safe

		Apr	May	Jun	Jul	Aug	Green	Weight
Incidents	Serious Incidents (STEIS)	12	13	12	9	11		
	Harm Free Care: New Harms (%)	98.4	98.7	98.3	98.3	99.3	>= 98	20 %
	Falls (per 1,000 bed days)	5.46	4.93	4.90	4.86	4.78	< = 5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.12	0.15	0.22	0.25	0.25	<= 0.15	10 %
	Clinical Incidents: Total (#)	1,327	1,473	1,344	1,479	1,267		
Infection	Cases of C.Diff (Cumulative)	3	12	16	19	22	<= Traj	40 %
	Cases of MRSA (per month)	0	1	1	0	0	< 1	40 %
Mortality	HSMR (Index)	95	95	96			< 90	35 %
	Crude Mortality EL (per 1,000)	0.9	0.8	0.4	0.8	0.0	< 0.33	10 %
	Crude Mortality NEL (per 1,000)	29.5	26.6	25.5	29.1	24.8	< 27.1	10 %
	RAMI (Index)	89	89	89	90	89	< 87.45	30 %
Observations	Cannula: Daily Check (%)	70.0	70.0	71.8	70.8	68.9	>= 50	10 %
	Catheter: Daily Check (%)	41.6	40.6	41.8	39.2	43.7	>= 50	10 %
	Central Line: Daily Check (%)	68.7	67.8	68.1	66.9	66.1	>= 50	10 %
	VTE: Risk Assessment %	61.0	61.5	61.2	61.1	61.0	>= 95	20 %
	Obs. On Time - 8pm-8am (%)	92.5	92.1	92.5	91.9	92.0	>= 90	25 %
	Obs. On Time - 8am-8pm (%)	89.7	89.6	90.0	89.1	89.6	>= 90	25 %

East Kent Hospitals University NHS Foundation Trust

Well Led



East Kent Hospitals University NHS Foundation Trust

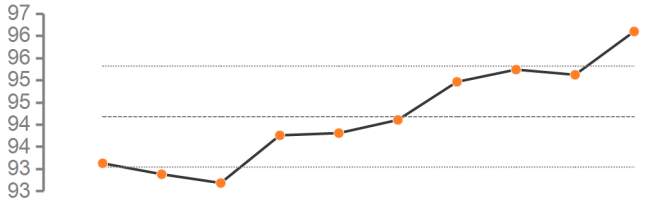
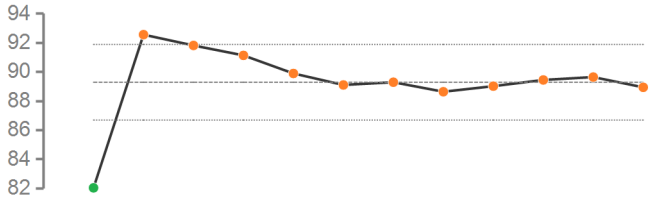
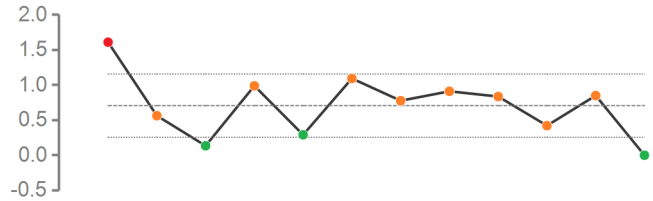
Well Led

		Apr	May	Jun	Jul	Aug	Green	Weight
Data Quality & Assurance	Not Cached Up Clinics %	0.4	0.5	0.4	0.5	0.8	<= 0.1	25 %
	Uncoded Spells %	0.3	0.4	0.3	0.1	0.4	< 0.25	25 %
Finance	I&E £m	-5.0	-3.2	-1.7	-1.3	-4.4	>= Plan	30 %
	Cash Balance £m	16.3	4.8	7.1	16.0	9.2	>= Plan	20 %
	Total Cost £m	-50.1	-53.2	-53.1	-54.0	-54.0	>= Plan	20 %
	Forecast I&E £m	-29.8	-31.0	-31.0	-31.0	-31.0	>= Plan	20 %
	Normalised Forecast £m	-29.8	-30.0	-30.0	-30.0	-30.0	>= Plan	10 %
Health & Safety	RIDDOR Reports (Number)	0	1	2	0	2	<= 3	20 %
	Formal Notices	0	0	0	0	0	< 1	15 %
Staffing	Sickness (%)	3.7	3.7	3.8	3.9	4.0	< 3.6	10 %
	Staff Turnover (%)	13.4	13.2	13.0	15.0	13.9	<= 10	15 %
	Vacancy (%)	13.0	13.6	14.5	13.6	14.8	<= 7	15 %
	Total Staff In Post (SiP)	7015	7052	7058	7136	7027		1 %
	Shifts Filled - Day (%)	99	100	99	96	93	>= 80	15 %
	Shifts Filled - Night (%)	104	105	104	108	105	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	10	11	11	10	11		
	Bank Filled Hours vs Total Agency Hours	56	57	59	59	60		1 %
	Agency %	6.6	7.0	7.2	7.4	7.4	<= 10	
Training	Appraisal Rate (%)	80.1	71.8	67.2	70.5	75.9	>= 85	50 %
	Statutory Training (%)	91	90	91	91	92	>= 85	50 %

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Mortality

Aug	HSMR (Index)	94 (0.4%)		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 (Cha
Aug	RAMI (Index)	89 (0.3%)		Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arro
Aug	Crude Mortality EL (per 1,000)	0.7 (37.2%)		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.

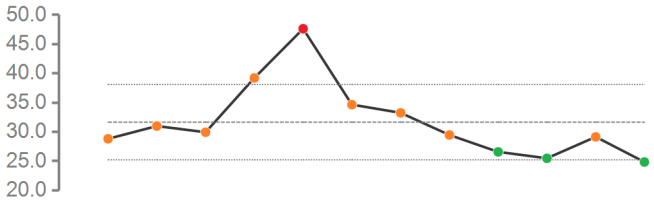
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Aug

Crude Mortality NEL (per 1,000)

31.6 (17.8%)



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:

As predicted last month the re-basing of HSMR has resulted in the Trust HSMR leaping upwards by about 10 points. Normally I would not point to crude mortality but in the context of this leap upwards in HSMR it is important to note that crude mortality (both elective and non-elective) has remained within control limits for the last 7 months. Despite the change in the Trust HSMR it remains below peer.

The RAMI Index also remains unchanged over the last 7 months and is also below peer.

The latest summary hospital mortality index (SHMI) reported on NHS digital is from the April 2017 to March 2018 period and was 1.02 (0.90-1.12, 95% over dispersion control limits). A SHMI of 1.02 is categorised 'as expected' and has not altered since the July 2016 to June 2017 period. For the period April 2017 to March 2018 there were 105,724 admission spells, 4112 deaths expected both in hospital and within 30 days of discharge and 4208 deaths observed. Overall 65.38% of deaths contributing to the SHMI occurred in hospital and 34.62% within the 30 days of discharge, these percentages have remained very consistent since October 2015.

Diagnostic codes with higher than expected deaths were stroke (243 v. 221.7), acute myocardial infarction (150 v. 115.2), cancer of the lung (115 v. 86.4) and sepsis (903 v. 813.7). Notable codes with lower than expected deaths were acute kidney injury (83 v. 94.6) and fracture neck of femur (66 v. 89.8).

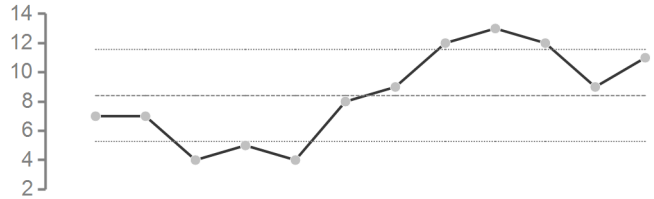
Actions

A review of randomly selected notes is underway for both stroke and acute myocardial infarction is underway and a previous review of sepsis did not reveal any avoidable factors. One further area for action might be to explore our depth of coding, currently (for the April 2017 to March 2018 period) our depth of coding was 3.7 versus and England average of 4.5 versus the England highest of 6.3 (Salford Royal NHSFT).

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Serious Incidents

Aug	Serious Incidents (STEIS)	101 (34.7%)		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.

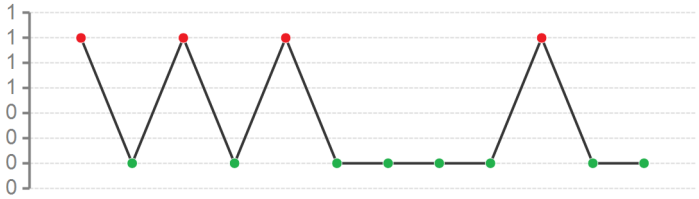
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Aug

Never Events (STEIS)

4
(33.3%)



Monthly number of Never Events. Uses validated data from STEIS.
Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.

Highlights and Actions:

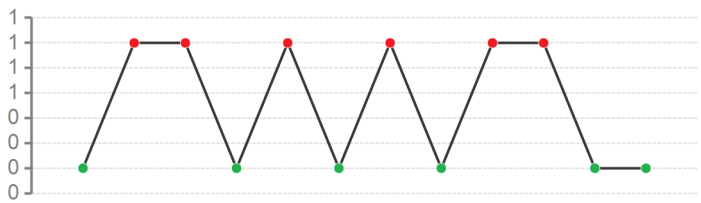
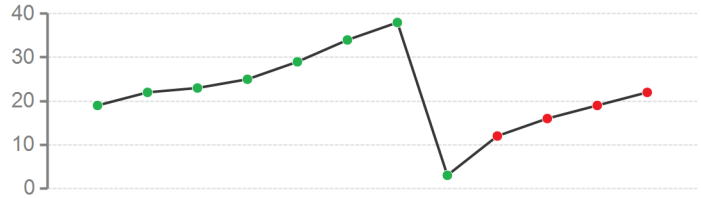
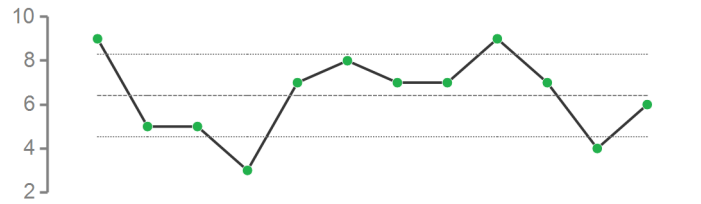
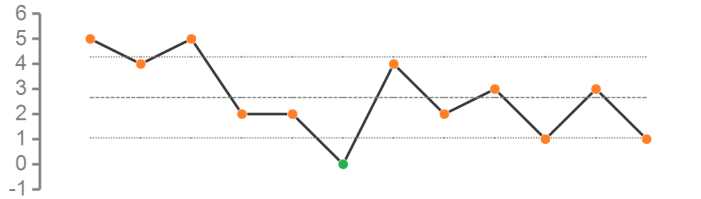
Total open SIs on StEIS in August 2018: 82 (including 11 new)
SIs under investigation: 60
Breaches: 21
Non-breaches: 39
Waiting EKHUFT non-closure response: 9
Waiting CCG response: 14

Supporting Narrative:
The number of breached cases is 21; one of these is awaiting an external review. Breaches are mainly due to delays in report writing and gaps in and the rigour of the analysis. The Root Cause Analysis Panel and weekly corporate/divisional governance team meetings continue to support completion of and the quality of the investigations. The corporate team now attend many of the RCA meetings and are aligned to individual cases to support completion of the analysis and reports. Additionally the corporate team aim to link with the lead investigator early in the process. The Chief Nurse and Medical Director now receive weekly updates on the breached cases and a trajectory for submission for these cases is in place for September.

The 11 new SIs are:
- a screening incident regarding Trisomy screening
- a sub-optimal care of a deteriorating patient who was transferred between sites
- two pressure ulcer cases
- a medication incident relating to insulin
- a procedural case relating to a perforated coronary artery
- an allegation of abuse case in ED
- a self-harm case in ED
- three treatment delay cases relating to ophthalmology

Strategic Theme: Patient Safety

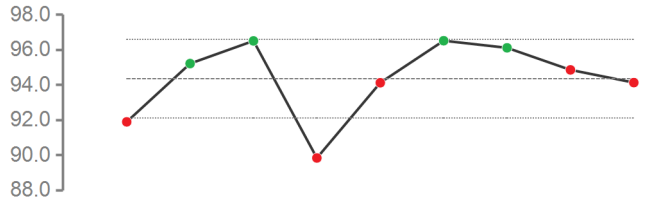
Infection Control

Aug	Cases of MRSA (per month)	6 (-45.5%)		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 varia
Aug	Cases of C.Diff (Cumulative)	22 (15.8%)		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.
Aug	E. Coli	77 (-15.4%)		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.
Aug	MSSA	32 (14.3%)		The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Aug | Hand Hygiene Audit | 94.1



The % of ward staff compliant with hand hygiene standards.
Data source - SharePoint

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 at the end of August (22) is above the trajectory set for the year by the Department of Health (18). In future years we will also be viewing all C.difficile, ie those pre and post 48 hrs from admission. To give an idea of the problem that number for this year is 61 year to date.

How the Trust apportioned number of cases compares is best viewed by comparing the Trust rate of C.difficile per100,000 bed days to others, year to date our rate is 7.04 compared to a regional range of 0.66-9.24, mean 5.38. For all C.difficile (hospital onset and community onset) our rate is 21.11 compared to a regional range of 6.52-32..02, mean 19.27/100,000 bed days.

MRSA

From April 2018, all post 48 hour MRSA bacteraemias have been automatically assigned to the Trust and all pre48 hour cases to the CCG. Year to date there have been 2 MRSA bacteraemias. This is unchanged from the previous report and gives us a rate/100,000 bed days of 0.91. This compares with a regional range of 0.0-6.77 and mean of 0.70.

MSSA

The number of Trust apportioned MSSA bacteraemias year to date is 9, and our current rate/100,000 bed days is 3.06 compared to a regional range of 1.46-7.77 and mean of 4.47.

E.coli

Our current rate of Trust apportioned E.coli bacteraemia is 10.4/100,000 bed days. This compares with a regional average of 10.27 and a range of 4.68-19.37. For all E.coli bacteraemias (hospital onset and community onset) our rate is 74.35/100,000 bed days compared to a regional average of 63.67, range 20.07 -98.38/100,000 bed days.

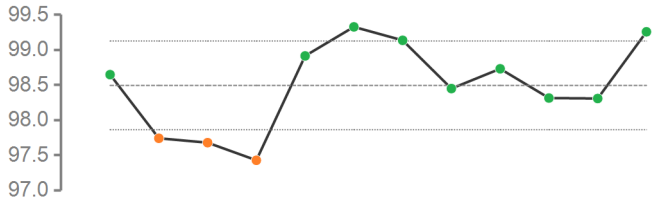
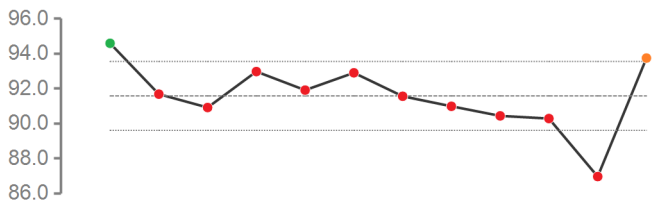
Within this data there is therefore a mixed picture. Overall, despite the C.difficile count being above trajectory our trajectory is flattening and returning to that set by the DH. E.coli data remains within the control limits and similar to the regional average for Trust onset bacteraemias and MSSA data continues to be better than the regional average.

Actions include reinforcing good anti-microbial stewardship through targeted intervention aimed at appropriate anti-microbial prescribing; continued monitoring of the correct application of the Diarrhoea Assessment Tool and reinforcement of the ANTT (aseptic non-touch technique) principles for intravenous catheters together with basic infection prevention and control principles.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Harm Free Care

Aug	Harm Free Care: New Harms (%)	98.5 (-0.1%)		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.
Aug	Harm Free Care: All Harms (%)	91.6 (-1.3%)		Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indic

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 August18 (93.75%) shows a significant improvement since last month (86.97% July-18). The prevalence of catheters & New UTIs has improved for August 18 and decreased to 0.11% (0.20% - July18), which is lower than both the overall National Average (0.29%) and the Acute Hospital only average (0.36%). Improvement work continues including involvement in revision of Kent wide catheter guidelines and planned launch of the catheter passport.

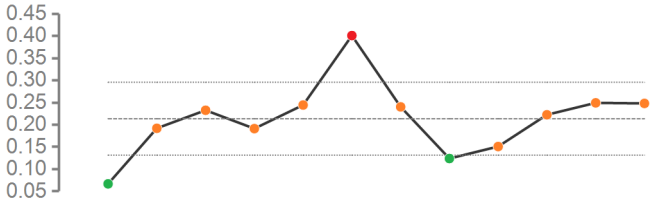
The total of Harm Free Care experienced in our care (New Harms only) at 99.26% has improved since last month (98.31% July-18). A marked improvement for the prevalence of New VTEs (0.64%) are lower than the national average for Acute Hospitals (0.68%) and New Pressure Ulcers (0.32%) are lower the national average for Acute Hospitals (0.74%). The prevalence of Catheters and New UTIs , and Falls with Harm continue to remain below the national average for Acute Hospitals.

Rigorous work will continue to ensure robust validation of prevalence data to ensure harms are kept to a minimum and that patient safety remains a priority.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Pressure Damage

Aug	Pressure Ulcers Cat 2 (per 1,000)	0.21 (-35.0%)		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
Aug	Pressure Ulcers Cat 3/4 (per 1,000)	0.01 (-38.9%)		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

Highlights and Actions:

In August 2018 there were a total of 26 pressure ulcers reported. 18 of these were category 2 ulcers which is equal to last month. The trust remains over the 0.15 avoidable incidence/1000 bed days with a result of 0.248/1000. 8 were avoidable 1 more than last month. 5 of these affected the sacrum. These were avoidable due to lack of evidenced repositioning and delay in pressure relieving equipment.
There were 2 confirmed category 3 ulcers 1 of which was avoidable due to lack of evidenced heel offloading. There were no category 4 ulcers. We have remained consistently under the set 0.15/1000 at 0.031/1000. bed day target for avoidable category 3 and 4 ulcers.
6 potential deep ulcers were reported. 2 of these were avoidable (equal to last month). 1 heel ulcer and one on the sacrum due to lack of offloading. The trust came under the 0.15 avoidable incidence/1000 bed days with a result of 0.062./1000 bed days.

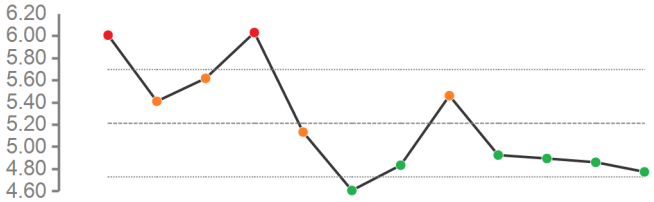
Actions in August 2018:
- Events held in QII HUB
- Bespoke teaching with allied health professionals QEQM and midwives at WHH
- Review and evaluation of pressure relief equipment and specialist dressings continues
- Tissue Viability Tuesday commenced at WHH

Recommendations:
- Continue improvement work with regards to documentation
- Share results of trust-wide annual audit
- Trial equipment of active mattress to ensure sufficient supply for winter period

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Falls

Aug	Falls (per 1,000 bed days)	5.21 (-7.4%)		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 previ

Strategic Theme: Patient Safety

Highlights and Actions:

Falls incidents have remained stable in August 2018 still reporting within control limit (n= 153 compared with n= 155 in June).
• 40 were reported at K&CH (same as in August),

6 falls occurred on Harbledown ward (11 in July), with 1 patient falling 3 times. All appropriate measures were in place including enhanced nursing care. 1 fall on Mount/ McMaster ward resulted in a fractured clavicle. Following investigation by the Falls Team this was deemed unavoidable.

• 35 were reported at QEQMH compared to 53 in July. Work was undertaken at QEQM to focus on reporting within the A&E and CDU departments in July. The Falls Team are about tc undertake an underreporting exercise at QEQMH, using Royal College of Physician tools.

No wards at QEQMH have reported more than 6 falls in August (6- St Augustine's)

• 75 falls were reported at WHH compared with 61 in July.

13 falls occurred on CDU/EAU and 11 on Cambridge L. On each ward 1 patient fell twice. CDU/EAU is a large ward and Cambridge L a frailty ward. There were no falls on either ward that resulted in moderate or above harms.

1 fall on Oxford ward resulted in a lumbar spine fracture. Following investigation by the Falls Team this was deemed unavoidable.

Actions:
1. Fall Stop programme continues with a set rollout programme Trustwide, focusing on rapid assessment of patients at high risk of falls in CDUs and frailty wards.

2. EKHUFT are now involved with the 2nd phase of the NHS Improvement Falls Collaborative. The launch was on the 20th June 2018. This provided opportunity to be involved in a national project of quality improvement around falls. The team is multi-professional, and fits with our action plan for falls and the FallStop programme. The key focus is to work around Lying and Standing blood pressures. Harbledown and Cambridge J wards are 'intervention' wards and Cambridge L is the control ward. Education has taken place and wards have posters demonstrating the correct method of taking blood pressures.

Harbledown have added lying and standing blood pressure recordings to their daily handover sheet. Results are then discussed at the Board Round where medication modification to address postural hypotension takes place. The ward Frailty Pharmacy Technicians screen prescription charts to identify medications which increase risk of falls and refer appropriately to the ward Pharmacist for advice. An audit of this process has been introduced. This has highlighted the need for documentation of the process by the Pharmacist and is being addressed. An audit of lying and standing blood pressure completion was undertaken which demonstrated completion of 87.5% (24% in the 2017 national audit).

Cambridge J have had more difficulty in progressing with the project due to a huge ward change and staffing challenges. They have introduced a staff 'crib sheet' and added blood pressures to the admission checklist.

Plans:
1. Falls Masterclass taking place on Monday 24th September with 50 attendees expected
2. NHSI Falls Collaborative newsletter is being produced for the wards involved
3. Continue rollout of FallStop

4. Under reporting exercise at QEQMH

Andrea Reid is leading on the project with the support of Jane Christmas and Debbie Janaway.

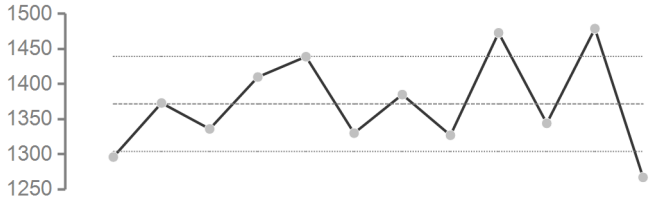
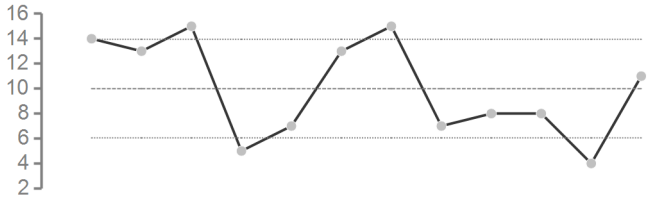
CJ frailty ward and CL also frailty and Harbledown are taking part, the ward managers are engaged and the lying and standing blood pressures are being discussed at the board round daily on Harbledown ward.

CJ are assessing and recording outcomes, both areas will collate data and outcome both the percentage on performance and outcomes.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Incidents

Aug	Clinical Incidents: Total (#)	16,459 (-1.0%)		Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together together with variance (shown by %) against the previous 12 months.
Aug	Blood Transfusion Incidents	120 (-23.6%)		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.

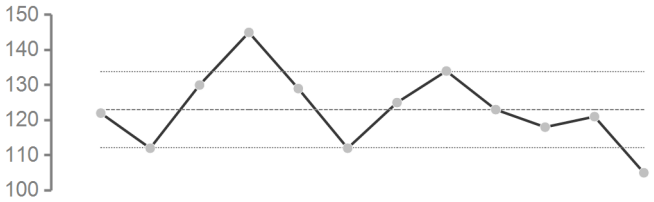
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Aug

Medicines Mgmt. Incidents

1,476 (14.7%)



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.

Highlights and Actions:

Clinical incidents overall summary
A total of 1253 clinical incidents have been logged as occurring in Aug-18 compared with 1479 recorded for Jul-17 and 1290 in Aug-17.
In Aug-18, 11 incidents have been reported on StEIS. 10 incidents have been escalated as a serious near miss, of which 8 are still under investigation. Comparison of moderate harm incidents reported: 12 in Aug-18, 22 in Jul-18 and 2 in Aug-17.
Over the last 12 months incident reporting is rising at QEH and K&CH, and is declining at WHH.

Blood transfusion (submitted by the Blood Transfusion Coordinator)

There were12 Blood Transfusion related incidents for August 2018 (6 in July 2018 and 22 in August 2017).

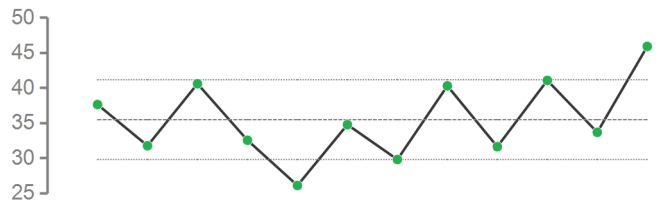
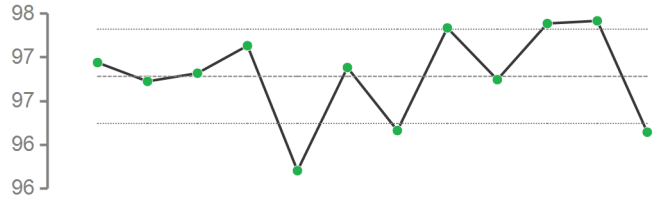
Of the 12 incidents 8 were graded as no harm and 4 as low harm.
There were no themes identified within the incidents reported.
The incidents include a failure to adequately observe a patient during the initial stages of a transfusion due to the member of staff being asked to escort another patient for an urgent CT. The patient did not come to harm and their next set of observations were all normal.
Two suspected transfusion reactions, on investigation both were found to be due to the underlying clinical condition of the patient and not the transfusion.
Reporting by site: 5 at QEQM, 1 at K&CH, 5 at WHH and 1 BHD

Medicines management
As of 17/09/2018 the total number of medication related incidents reported in August 2018 was 112. These included 72 no harm and 39 low harm. The severity of medication related incidents in August 2018 shows that 64.3% of medication related incidents reported were no harm incidents, a decrease from 74.7% in July. There was one incident reported in August that was reported on StEIS, which concerned an insulin dependent diabetic. Whilst the StEIS reported incident requires an RCA as standard, there are 3 other incidents which have been flagged as requiring an RCA.
The top reporting areas for August were Kingston stroke unit (K&CH), Cheerful Sparrows Female (QEH) and Bartholomew Suite (WHH) with 6 medication incidents each.
There were 26 incidents in August 2018 categorised as 'omitted medicine/ingredient', representing 23.2% of all medication related incidents in August.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Friends & Family Test

Aug	FFT: Response Rate (%)	36 (-4.3%)		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 mon
Aug	FFT: Recommend (%)	97 (0.5%)		Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction

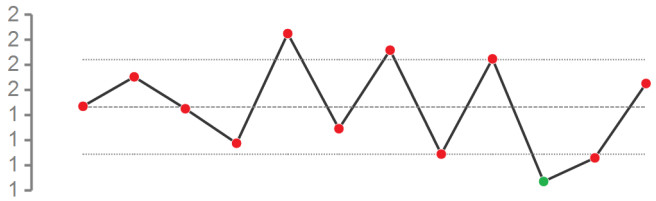
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Aug

FFT: Not Recommend (%)

1.4
(-21.0%)



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 direct

Highlights and Actions:

A total of 2338 responses were received (16.2% eligible patients). Overall response rates increased for inpatients, Maternity and Day cases, EDs were similar to last month. Response rate for the EDs was 16.2% (16.4% July-18), inpatients 45.9% (32.7% July-18), maternity; birth only 70.0% (59.8% July-18) and day cases 22.1% (21.8% July -18).

90.9% of responders would recommend us to their friends and family and 5.4% would not. The Trust star rating in August is 4.57 (4.55 July-18). Recommendations by patients in August were improved to July in the EDs and day cases, remained the same for inpatients however, fell in inpatients, outpatients and maternity. The total number of inpatients, including paediatrics, who would recommend our services 96.1% (97.3% July-18), EDs 83.7% (80.9% July-18), maternity 98.5% (99.2% July-18), outpatients 91.0% (92.1% July-18) and day cases 95.1% (94.8% July-18).

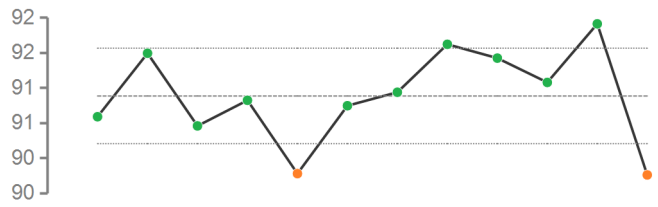
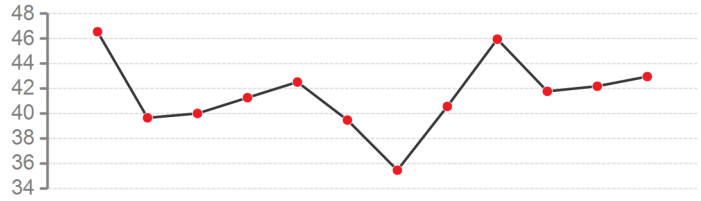
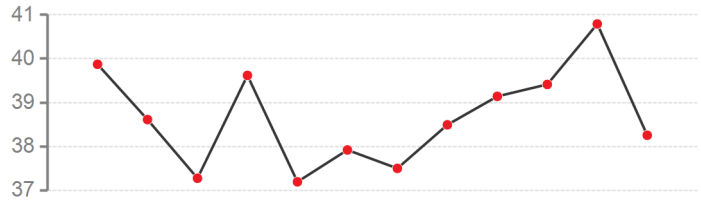
Care, Staff attitude and Implementation of care as the three top positive themes for August-18. The three top negative themes for the trust were Care, Waiting times and Staff attitude demonstrating the importance of improving patients waiting times, ensuring that staff attitude is positive and that the care given is improved to ensure that patients receive safe, compassionate, consistent and high quality care, in order for a good patient experience.

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 Divisional Governance teams.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 1

Aug	Overall Patient Experience %	90.9 (-1.4%)		Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of las
Aug	Privacy for discussions with Nurses %	41 (-1.1%)		Privacy for discussions Nurses
Aug	Aware of Nurse in each shift %	39 (-1.1%)		Aware of nurse in each shift

Highlights and Actions:

Overall patient experience, as a calculated average of the 5 key questions within the local inpatient survey, which enables our patients to record their experience in real-time, shows a slight deterioration this month.

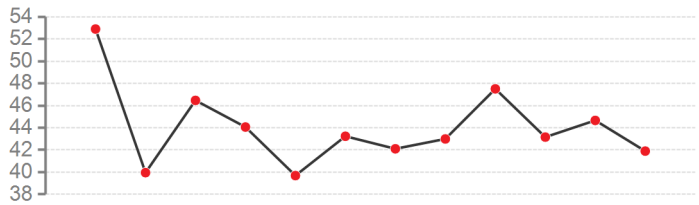
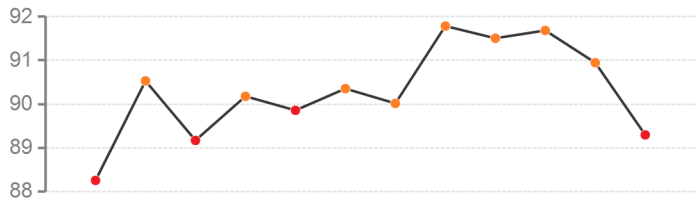
New questions were added into the survey in Aug-17 to enable close monitoring of three key areas where our performance in the 2016 national inpatient survey (published in May-17) was below the national average. This month we received 2,628 completed inpatient surveys. Baseline performance in ensuring privacy when discussing patients' condition or treatment, ensuring patients are aware of which nurse is looking after them each shift and ensuring patients are able to discuss their worries and fears demonstrated significant opportunity for improvement.

This month improvement is seen in one of these three important elements of patient experience. The results of the 2017 national adult inpatient survey shows improvement across all three of these indicators of patient experience. An improvement plan has been drafted and the questions within this local survey will be amended to reflect improvement priorities, with progress monitored through the Patient Experience Group.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 2

Aug	Discuss Worries with Nurses %	44 (-11.2%)		Discuss Worries with Nurses
Aug	Cleanliness? %	90 (-0.7%)		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 show

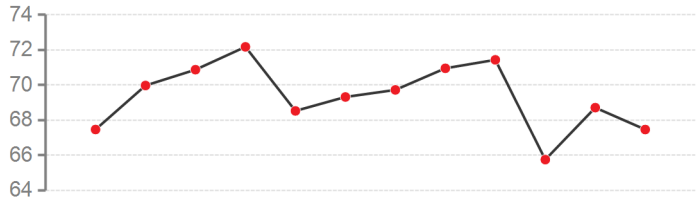
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Aug

Hospital Food? %

70
(-3.9%)



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

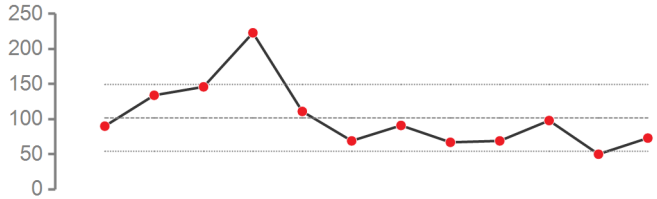
Highlights and Actions:

Patient experience is additionally reported per ward within the heat map and focused work continues to promote this reporting. Nearly all wards have reported their performance (against the patient experience metrics) through the inpatient survey in August 18 although there are still two wards at QEQM who are still experiencing WiFi connectivity problems due to the location of these wards, which are now being investigated.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Mixed Sex

Aug	Mixed Sex Breaches	1221 (121.2%)		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:

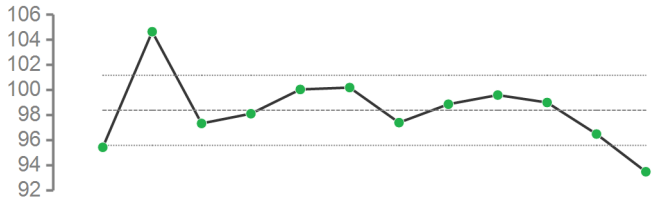
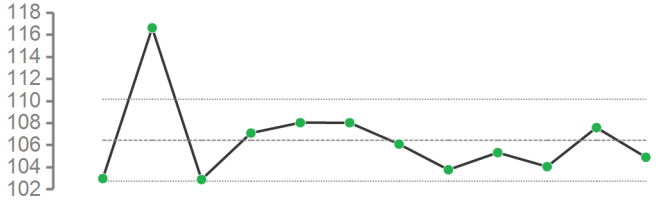
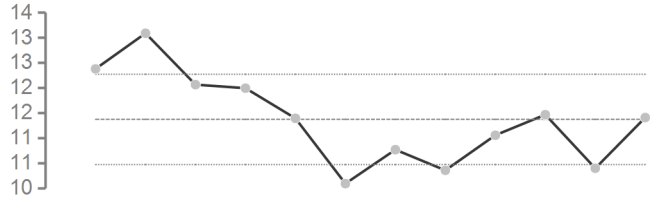
There were 17 mixed sex accommodation occurrences in total, affecting 193 patients during August.
Incidence of mixed sex accommodation breaches increased this month from July and there were 8 non-justifiable occurrences within the WHH CDU linked to flow and capacity issues. This information has been reported to NHS England. The remaining incidents occurred in the WHH CCU (7) and QEQM Fordwich (2), which were justifiable based on clinical need.

Daily reporting of mixed sex occurrences has been sustained in certain areas demonstrating understanding of the reporting method for mixed sex breaches. Rigorous work continues as the Trust is working closely with the CCGs and NHSI on the Mixed Sex Accommodation Improvement Collaborative over the next6 months. This will support the trust in achieving compliance with the national definition of mixed sex accommodation.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Safe Staffing

Aug	Shifts Filled - Day (%)	98 (0.4%) ↑		Percentage of RN 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.
Aug	Shifts Filled - Night (%)	106 (-1.2%) ↓		Percentage of RN 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.
Aug	Care Hours Per Patient Day (CHPPD)	11 (48.0%)		Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12

Highlights and Actions:

% 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 and overall fill rate was97.0% (99.8% July-18).

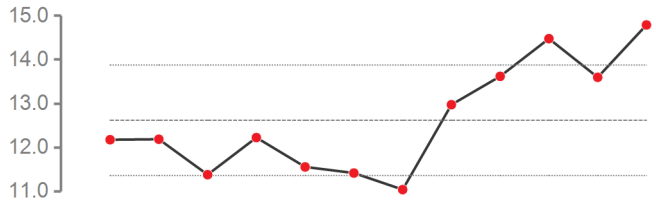
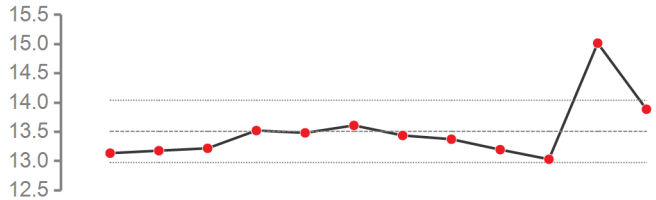
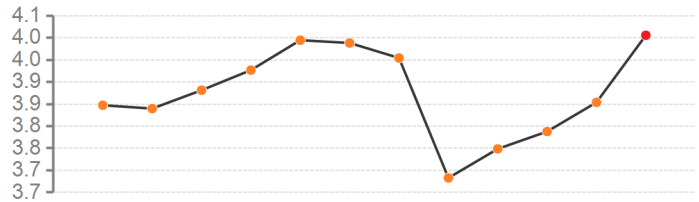
Low fill rates were seen on several wards due to a combination of high sickness, maternity leave and vacancies (Cambridge K, CCU QE, Deal, Harvey, Cambridge L, Treble, Mount McMaster, Kingston, RSU, Harbeldown, St Augustines, Quex, WHH CDU, Kent, Kings C2, Seabathing, and Birchington).

Care Hours per patient day (CHPPD) relates actual staffing to patient numbers and includes registered staff and care staff hours against the cumulative total of patients on the ward at 23.59 each day during the month. Average CHPPD in August was 8.1 (8.3 July-18). The range is from around 5.5 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required. Comparative data within the Model Hospital Dashboard (Apr-18 data) shows EKHUFT average CHPPD is in the mid to low 25% (Quartile 2) and in line with our recommended peer group and peer median based on spend and clinical output.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Gaps & Overtime

Aug	Vacancy (%)	12.6 (18.2%)		% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Staff Turnover (%)	13.5 (5.9%)		% 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
Aug	Sickness (%)	3.9 (-1.4%)		% 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 mont

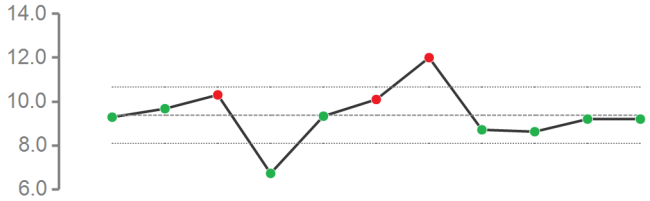
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Aug

Overtime %

9.4
(5.6%)



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

Highlights and Actions:

Gaps and Overtime

The vacancy rate increased to 12.6% (up from 12.4%) 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. There are currently over 300 candidates in the recruitment pipeline - i.e. those who have been offered positions and are gaining pre-employment clearances. This includes 216 Nursing and Midwifery staff (including 69 Newly Qualified Nurses) and 63 Medical and Dental staff.

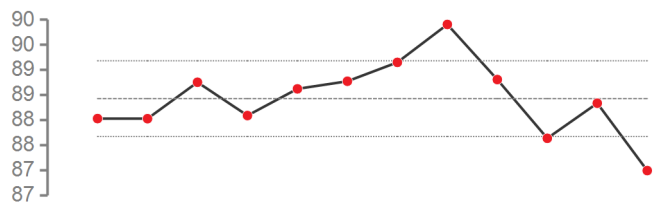
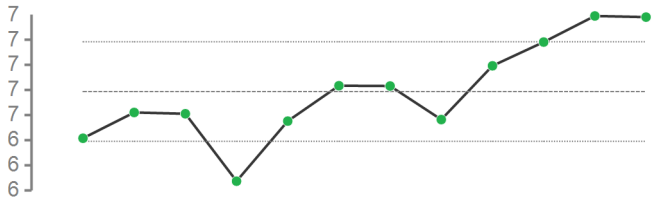
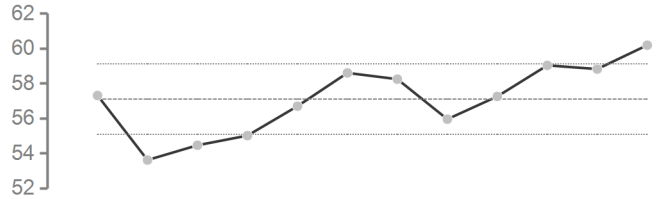
The Turnover rate in month decreased to 12.1% (last month 12.8%), and the 12 month average is the same as the previous 12 months at 13.5%. Focus remains on hard to recruit roles to replace agency, but also to identify new ways and methods of attracting to hard to recruit roles. Exit data is reviewed to highlight any areas of concern.

The in month sickness absence position for July was .06% - which is an increase from3.87% in June. However, the 12 month average fell to 3.9%. Divisions are working to develop sickness absence reduction plans, with a focus on long term sickness absence and an integrated approach to proactively managing absence with Occupational Health through case conferencing and regular contact. This includes supporting stress, anxiety and compassion fatigue through Respect & Resilience workshops, Mindfulness Courses and Mental Health First Aid training. A Sickness Absence Helpline is being piloted by the Occupational Health department with the Surgical Services wards across the Trust to see if this can support improvements in early referrals to OH in order to get staff back to work.

Overtime as a % of wte decreased slightly last month. The average over the last 12 months increased slightly to 9.4%. All metrics are reviewed and challenged at a Divisional level in the monthly Executive Performance Reviews.

Strategic Theme: Human Resources

Temporary Staff

Aug	Employed vs Temporary Staff (%)	88.4 (-1.2%)		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 %) again
Aug	Agency %	6.8 (21.0%)		% of temporary (Agency and Bank) staff of the total WTE Number indicates average of last 12 months data (as shown in graph).
Aug	Bank Filled Hours vs Total Agency Hours	57 (-0.1%)		% 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) decreased from 7154 in Junly to 7044 in July, which left a vacancy factor of approx. 887 wte across the Trust. As stated in the previous section, there are currently over 300 candidates in the recruitment pipeline.

Agency staffing as a percentage of WTE remains approximately 7%, and still remains at high levels compared to the beginning of the year. The 12 months average shows a slight increase to 6.8% of WTE (6.7% in the previous month).

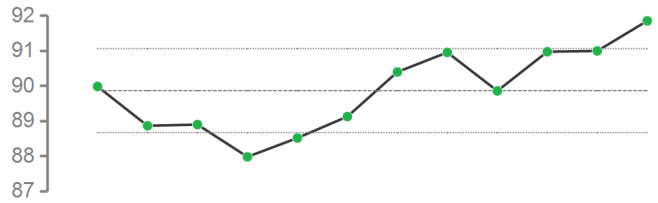
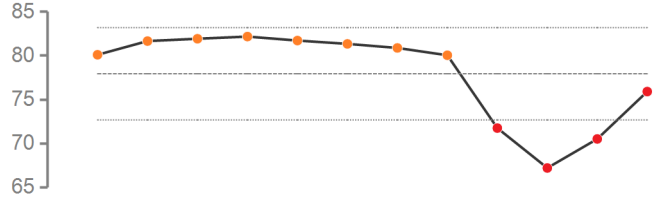
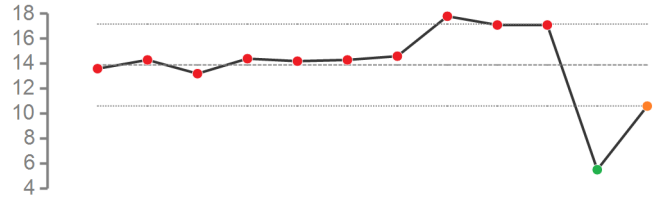
The average percentage of employed staff vs temporary staff over the last 12 months fell slightly to 88.4% (88.6% last month).

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

Aug	Statutory Training (%)	90 (1.6%)		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 pr
Aug	Appraisal Rate (%)	77.9 (-4.5%)		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.
Aug	Time to Recruit	14 (16.0%)		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.

East Kent Hospitals University NHS Foundation Trust

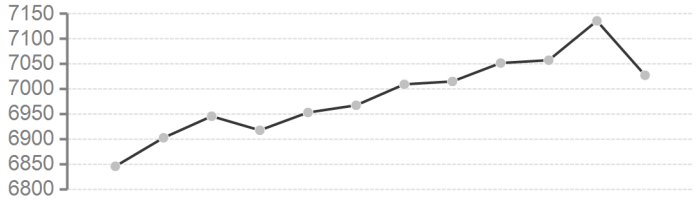
Strategic Theme: Human Resources

Aug

Total Staff In Post (SiP)

7027

(-1.5%)



Count of total staff in post (WTE)

Highlights and Actions:

Workforce & Culture

Average Statutory training 12 month average is 90% and remains 90% in month for July. This remains above the target of 85%. Divisions are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements.

The Trust staff average appraisal rate increased to76% in month for August (71% in July). The Clinical Support Services Division (81%) and Surgical Services Division (87%) are above Trust Average. Divisions are working on plans to complete outstanding appraisals as well as to avoid a further drop in appraisal rates for those due to be renewed in coming months, particularly with the expected fall in compliance at the beginning of each financial year.

The average time to recruit is 10 weeks, which is a slight increase on last month, but an improvement on the previous 12 months. The Resourcing Ream are on track to reduce time to recruit to below 8 weeks to ensure recruitment time meets the demands of our services. The new Trac system will support this reduction.

Strategic Theme: Activity

East Kent Hospitals University NHS Foundation Trust

Activity vs. Internal Business Plan

Key Performance Indicators

Aug

	Aug-18				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	13,173	14,416	(-1,243)	-9%	72,178	71,951	227	0%	72,178	72,948	(-770)	-1%	<=0%
Referral Non-Primary Care	13,526	13,734	(-208)	-2%	74,277	69,406	4,871	7%	74,277	69,496	4,781	7%	<=0%
OP New	18,087	20,074	(-1,987)	-10%	92,207	94,210	(-2,003)	-2%	92,207	90,075	2,132	2%	>=0%
OP Follow Up	38,212	43,655	(-5,443)	-12%	201,720	203,718	(-1,998)	-1%	201,720	195,537	6,183	3%	>=0%
Elective Daycase	6,302	6,989	(-687)	-10%	32,353	32,999	(-646)	-2%	32,353	30,457	1,896	6%	>=0%
Elective Inpatient	1,200	1,420	(-220)	-16%	6,229	6,704	(-475)	-7%	6,229	6,150	79	1%	>=0%
A&E	18,646	17,613	1,033	6%	92,819	89,924	2,895	3%	92,819	89,280	3,539	4%	>=0 & <5%
Non-Elective Inpatient	6,751	6,502	249	4%	33,728	34,121	(-393)	-1%	33,728	33,851	(-123)	0%	>=0 & <5%
Chemotherapy	1,282	1,258	24	2%	6,142	5,912	230	4%	6,142	6,011	131	2%	>=0%
Critical Care	1,812	1,650	162	10%	9,018	8,190	828	10%	9,018	9,184	(-166)	-2%	>=0%
Dialysis	6,925	7,325	(-400)	-5%	34,091	34,872	(-781)	-2%	34,091	34,170	(-79)	0%	>=0%
Maternity Pathway	1,114	1,194	(-80)	-7%	5,681	5,925	(-244)	-4%	5,681	5,944	(-263)	-4%	>=0%
Pre-Op Assessments	3,297	3,680	(-383)	-10%	17,285	16,788	497	3%	17,285	14,365	2,920	20%	>=0%
Diagnostic	27,978	28,751	(-773)	-3%	1,884,485	1,783,131	101,354	6%	1,884,485	2,196,487	(-312,002)	-14%	<=0%
Other	5,178	4,910	268	5%	25,568	23,771	1,797	8%	25,568	23,612	1,956	8%	>=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.

August 2018

Elective Care

In August Primary Care referrals were 9% below expected levels reducing the YTD variance to +0% (+227). An administrative error within the Paediatric service has now been resolved however the Paediatric Blood Clinics where the recording issue was identified remains in the YTD position. Rapid Access referrals remain (+12%) above plan with biggest increases observed in Urology, Breast, Gynaecology & Dermatology.

The Trust under-achieved the new outpatient plan in August with appointments 10% below planned levels, generating a YTD variance of -2%. General Medicine, Neurology, T&O and Urology remain the biggest drivers behind the under-performance. Services are actively producing quantified recovery plans intended to respond to specialty level underperformance and deliver the full new outpatient plan. The impact of the Virtual Fracture Clinic implemented in mid-February is likely to render the Orthopaedic plan unachievable due to high discharge rates that were not anticipated. The Ophthalmology service continues to provide additional weekend capacity at KCH delivered through an insourcing provider. It is expected this will recover the Ophthalmology YTD underperformance and support the RTT backlog recovery.

Outpatient productivity delivered by the Trust in August was above demand and enabled the Trust to clear a further 900 patients from the outpatient waiting list. The Trust has now reduced the number of patients waiting for a first outpatient appointment by over 3,100 since the beginning of the financial year.

The Trust under-performed the follow up plan in August (-12%) with YTD performance now underachieving by (-1%). General Medicine (-1,402), Rheumatology (-1,500), Orthopaedics (-1,238) and Ophthalmology (-1,173) continue to underperform the business plan.

In August the Trust under-achieved the Daycase plan by 687 patients eradicating the YTD over performance. Large underperformances were seen in key elective specialties Orthopaedics, Dermatology, Gynaecology, Ophthalmology, ENT and Pain Service. The Orthopaedic service generated the biggest under-performance; the biggest contributing factor was due to theatre rental for high productivity spinal injections lists being unavailable until the end in April. Additional weekend injection lists commenced in June and additional capacity is to be delivered at KCH through an insourcing provider in order to start to recover the position. A mandated change in recording will render the Dermatology plan unachievable, it is anticipated an over performance in Outpatient with procedure will offset the daycase underperformance. The Ophthalmology service has developed long term plans to address the underperformance through improved theatre booking efficiencies.

Elective Admissions are 7% behind the plan in the YTD with large underperformances observed in Urology (-256) and Gynaecology (-263). Due to emergency pressures, elective inpatient activity was limited for the Urology service at the start of the financial year. In order to ensure theatre utilisation was maximised additional daycase patients were booked and this is reflected in the Urology YTD daycase performance. In August the Trust was unable to keep pace with demand and the inpatient waiting list increased by 49 patients. The Trust has developed recovery plans that will deliver the Daycase and Elective activity plans.

Non Elective Care

The Trust sees non elective admissions to all of its 3 sites. These are typically some of the patients who attend the Trust Accident & Emergency departments, or are admitted directly through to the wards upon agreement with General Practitioners. These patients have an urgent clinical need that cannot wait for an elective pathway or outpatient appointment to be given, and so are monitored within the hospital site as diagnosis and treatment for their clinical condition is conducted.

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

The Bed Occupancy of the Trust continued to be at challenging levels and increased slightly in August to an overall Trust wide position of 94.0% of funded beds. Queen Elizabeth the Queen Mother Hospital demonstrated the most challenge with the bed occupancy position at 99.1% for August, an improved position from July of 101.9%. The William Harvey Hospital position worsened slightly with an overall bed occupancy of 94.6% in August (94.3% in July). Bed occupancy positions are taken from midnight snapshots of Trust systems and compared against the number of available funded bed establishment.

The Medical Outliers metric shows the daily average number of medical patients which were bedded in non-medical wards. This can happen for a variety of reasons; such as care being recently transferred to a medical specialty consultant, or as a result of the ward in question having free beds available for patients at the time of clinical need. Patients remain under the medical consultant responsible for their care for the purpose of treatment and clinical review. During August the number of medical outliers remained similar to July with a monthly average of 50 medical outliers across the Trust. Individual site levels of medical outliers over the month were 9 at the Queen Elizabeth the Queen Mother Hospital and 37 at William Harvey Hospital.

Whilst an increased volume of patients through the Accident & Emergency Department contributes to increased pressures in non-elective care, there was less demand on the department in August with 22,607 attendances compared to July (24,402).

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	5,417	6,717	-19%	-1,300
300 - General Medicine	38	590	-94%	-552
100 - General Surgery	1,127	1,543	-27%	-416
120 - Ear, Nose & Throat	4,069	4,469	-9%	-400
340 - Respiratory Medicine	1,599	1,977	-19%	-378
410 - Rheumatology	1,523	1,167	31%	356
101 - Urology	3,251	2,853	14%	398
103 - Breast Surgery	3,148	2,729	15%	419
110 - Trauma & Orthopaedics	4,025	3,399	18%	626
330 - Dermatology	5,892	5,254	12%	638
Total	**66,306**	**66,042**	**0%**	**264**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
502 - Gynaecology	2,503	2,867	-13%	-364
420 - Paediatrics	848	1,143	-26%	-295
400 - Neurology	729	927	-21%	-198
330 - Dermatology	564	718	-21%	-154
100 - General Surgery	1,297	1,150	13%	147
301 - Gastroenterology	1,214	1,046	16%	168
140 - Maxillo Facial	996	822	21%	174
300 - General Medicine	1,304	550	137%	754
130 - Ophthalmology	6,232	4,805	30%	1,427
110 - Trauma & Orthopaedics	9,035	7,570	19%	1,465
Total	**67,701**	**63,784**	**6%**	**3,917**

OP New

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	6,396	7,164	-11%	-768
101 - Urology	3,457	4,169	-17%	-712
400 - Neurology	1,645	2,270	-28%	-625
502 - Gynaecology	5,417	5,959	-9%	-542
420 - Paediatrics	3,251	3,757	-13%	-506
300 - General Medicine	805	1,285	-37%	-480
120 - Ear, Nose & Throat	5,349	5,764	-7%	-415
800 - Clinical Oncology	1,828	1,502	22%	326
650 - Physiotherapy	7,625	7,109	7%	516
330 - Dermatology	5,678	4,870	17%	808
Total	**84,710**	**86,050**	**-2%**	**-1,340**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	956	2,238	-57%	-1,282
410 - Rheumatology	4,009	5,246	-24%	-1,237
110 - Trauma & Orthopaedics	16,586	17,685	-6%	-1,099
130 - Ophthalmology	20,363	21,245	-4%	-882
400 - Neurology	3,216	3,726	-14%	-510
120 - Ear, Nose & Throat	6,245	6,710	-7%	-465
340 - Respiratory Medicine	3,328	2,754	21%	574
330 - Dermatology	7,981	7,227	10%	754
800 - Clinical Oncology	16,810	15,953	5%	857
101 - Urology	9,056	8,185	11%	871
Total	**185,183**	**185,832**	**0%**	**-649**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	1,813	2,438	-26%	-625
330 - Dermatology	1,619	2,132	-24%	-513
502 - Gynaecology	955	1,203	-21%	-248
120 - Ear, Nose & Throat	977	1,189	-18%	-212
191 - Pain Management	936	1,136	-18%	-200
130 - Ophthalmology	1,911	2,077	-8%	-166
300 - General Medicine	8,120	7,929	2%	191
100 - General Surgery	818	579	41%	239
301 - Gastroenterology	622	340	83%	282
800 - Clinical Oncology	2,270	1,717	32%	553
Total	**29,854**	**30,212**	**-1%**	**-358**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
502 - Gynaecology	420	671	-37%	-251
101 - Urology	1,085	1,329	-18%	-244
100 - General Surgery	450	529	-15%	-79
110 - Trauma & Orthopaedics	1,329	1,407	-6%	-78
320 - Cardiology	82	149	-45%	-67
430 - HCOOP	33	68	-51%	-35
120 - Ear, Nose & Throat	247	278	-11%	-31
340 - Respiratory Medicine	51	17	196%	34
503 - Gynaecology Oncology	164	69	139%	95
300 - General Medicine	815	543	50%	272
Total	**5,819**	**6,148**	**-5%**	**-329**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	9,407	10,045	-6%	-638
430 - HCOOP	3,874	4,336	-11%	-462
180 - Accident & Emergency	1,364	1,759	-22%	-395
560 - Midwifery	950	1,110	-14%	-160
104 - Colorectal Surgery	107	37	191%	70
140 - Maxillo Facial	159	83	92%	76
101 - Urology	1,630	1,543	6%	87
301 - Gastroenterology	262	118	122%	144
340 - Respiratory Medicine	318	130	144%	188
100 - General Surgery	2,629	2,249	17%	380
Total	**31,052**	**31,562**	**-2%**	**-510**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	1872578	1770257	6%	102,321
A&E	85560	83117	3%	2,443
Other	22542	20348	11%	2,194
Pre-Op	15898	15254	4%	644
Critical Care	7177	6541	10%	636
Dialysis	27094	27547	-2%	-453
Maternity Pathway	5171	5461	-5%	-290
Chemotherapy	5610	5397	4%	213

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

4 Hour Emergency Access Standard

Key Performance Indicators

80.04%

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Green
4 Hour Compliance	70.51%	70.66%	76.21%	69.13%	69.33%	73.75%	75.08%	76.93%	80.80%	82.55%	79.18%	80.04%	95%
12 Hour Trolley Waits	0	0	0	2	2	0	2	1	0	0	0	0	0
Left without being seen	4.45%	3.67%	2.73%	3.45%	2.75%	2.29%	2.70%	2.71%	2.42%	2.12%	2.81%	2.48%	<5%
Unplanned Reattenders	8.75%	8.69%	8.33%	9.05%	8.97%	8.91%	9.09%	9.61%	9.09%	9.29%	9.76%	9.80%	<5%
Time to initial assessment (15 mins)	93.4%	90.6%	91.1%	88.6%	93.6%	96.0%	94.4%	94.6%	95.4%	92.8%	94.7%	91.7%	90%
% Time to Treatment (60 Mins)	45.9%	47.8%	54.6%	53.3%	55.5%	47.8%	42.5%	46.2%	49.5%	51.7%	42.6%	48.0%	50%

2018/19 Trajectory (NHSI return 2nd May)

-5.32 %

	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%	82.6%	79.2%	80.0%								

*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.

Summary Performance

August performance for the 4 hour target was 80.0%; against the NHS Improvement trajectory of 85.4%.This represents an increase in performance compared to the previous month. There were no 12 Hour Trolley Waits in August. The number of patients who left the department without being seen continued to be compliant at 2.5%, whilst unplanned reattendances remained uncompliant at 9.8%. Time to treatment improved from July, but remained uncompliant at 48.0% for August.

August performance has improved despite being challenged by an increased number of attendances and increased patient acuity due to a continuation of the extremely high temperatures experienced and seasonal variation.

The Emergency Care Improvement Plan continues to progress with the Chief Operating Officer leading a weekly oversight meetings to monitor, support and progress the workstream actions. Highlight improvements for August have been:

- Deputy Heads of Clinical Operations are in post which has allowed the Head of Clinical Operations to focus on standardisation of best practice processes.
- Recruitment of Site Clinical Practitioners (SCP) is almost completed which will enable two SCP's to be on duty at all times and deliver a greater clinical focus on each site.
- Urgent Care Centre model progressing to include primary and secondary care integrated service.
- Reducing length of stay, improving board rounds, reinforcing SAFER principles.
- Launch of the ED Escalation pack.
- Continued roll out of the electronic white board programme.
- Trust winter plans have progressed to include:

    - Final drafts of the Full Capacity Protocol and associated protocols being presented to the Clinical Executive Management Group in September.
    - Business cases for additional ITU bed capacity.
    - Winter ward additional capacity.
    - Orthopaedic elective bridging project.
    - Business case for A&E Observation wards at WHH and QEQMH.

Risk to delivery:

- Workforce, due to vacancy, annual leave and junior doctor changeover in August.
- Surges in activity.
- Response to ED from specialities

Mitigations:

- Continued focus on recruitment, including overseas and UK. Planning for additional medical staff to be available during induction periods. Annual leave being managed within agreed Trust policy limits.
- Launch and high commitment to the ED Escalation pack being proactively implemented and followed.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

Cancer Compliance

Key Performance Indicators

66.40 %

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Green
62 day Treatments	74.55%	74.37%	71.97%	74.17%	74.87%	73.40%	71.88%	66.13%	65.40%	65.32%	65.45%	66.40%	>=85%
>104 day breaches	25	29	28	23	28	26	32	33	34	40	42	25	0
Demand: 2ww Refs	3,281	3,505	3,464	2,799	3,528	3,206	3,738	3,694	3,934	3,682	3,700	3,585	2990 - 3305
2ww Compliance	95.26%	94.63%	96.43%	96.28%	95.76%	97.10%	91.42%	89.06%	93.84%	94.22%	94.94%	93.79%	>=93%
Symptomatic Breast	95.50%	94.29%	94.44%	92.37%	89.84%	98.50%	90.28%	75.16%	84.46%	94.12%	93.13%	80.80%	>=93%
31 Day First Treatment	93.23%	98.97%	97.00%	95.67%	94.06%	97.74%	96.08%	95.37%	96.31%	96.43%	95.65%	94.60%	>=96%
31 Day Subsequent Surgery	85.42%	95.12%	85.71%	84.85%	87.23%	91.43%	89.47%	88.57%	82.05%	82.61%	94.59%	95.45%	>=94%
31 Day Subsequent Drug	96.77%	100.00%	100.00%	94.59%	98.85%	98.33%	98.21%	97.94%	98.88%	98.11%	99.16%	100.00%	>=98%
62 Day Screening	93.55%	92.86%	89.29%	93.33%	90.91%	79.31%	100.00%	93.75%	84.09%	100.00%	81.63%	91.30%	>=90%
62 Day Upgrades	85.71%	82.98%	84.00%	92.11%	85.00%	77.27%	100.00%	89.19%	75.86%	84.38%	85.00%	90.70%	>=85%

2018/2019 Trajectory

8.52 %

	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	66.13%	65.40%	65.32%	65.45%	66.40%								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.

Summary Performance

August performance is currently 66.4% against the improvement trajectory of 57.87%, validation continues until the beginning of October in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,689 and there were 25 patients waiting 104 days or more for treatment or potential diagnosis.

62 Day Performance Breakdown by Tumour Site

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
01 - Breast	81.8%	100.0%	96.6%	96.2%	88.9%	83.3%	100.0%	92.9%	96.6%	95.8%	93.8%	79.1%
03 - Lung	100.0%	46.4%	70.0%	84.6%	90.3%	100.0%	81.0%	61.4%	91.7%	73.0%	71.7%	74.4%
04 - Haematological	57.1%	53.3%	40.0%	58.3%	75.0%	33.3%	33.3%	50.0%	25.0%	50.0%	70.6%	16.7%
06 - Upper GI	82.6%	71.1%	81.0%	78.3%	70.0%	64.3%	73.3%	66.7%	69.2%	85.2%	93.3%	57.1%
07 - Lower GI	78.8%	70.8%	53.7%	61.3%	65.9%	43.8%	63.2%	62.9%	47.6%	65.9%	68.3%	76.3%
08 - Skin	84.1%	92.3%	95.0%	92.5%	92.7%	100.0%	88.9%	88.0%	89.3%	97.1%	97.7%	96.4%
09 - Gynaecological	75.0%	73.3%	52.4%	57.1%	80.0%	63.6%	75.0%	30.8%	32.0%	42.1%	52.0%	63.6%
10 - Brain & Nervous System								100.0%				
11 - Urological	58.5%	63.8%	55.7%	63.7%	52.0%	63.5%	63.2%	57.7%	52.1%	38.2%	39.4%	47.3%
13 - Head & Neck	90.5%	73.3%	87.5%	28.6%	66.7%	85.7%	78.6%	18.2%	30.0%	93.3%	60.0%	100.0%
14 - Sarcoma			0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	
15 - Other	100.0%		42.9%	0.0%	0.0%	0.0%		50.0%	0.0%	40.0%	100.0%	50.0%

Improvements have been seen in Lung, Lower GI, Gynaecology, Urology and Head and Neck, with Skin remaining complaint. Upper GI has seen a decrease in performance in month due to an increased focus on pulling 62+ day patients through their pathways. This has resulted in a higher number of patients breaching in month.

To improve the waiting times for current patients and to prevent further 104 day waiters, a weekly focused meeting remains in place which reviews the performance of each tumour site. All patients over 104 days are reviewed at the Chief Operating Officer chaired primary target list (PTL) meetings. The purpose of these reviews is to gain assurance that the next key event is being progressed for each patient to ensure their pathways are not delayed. Each of the patients over 104 days is reported on Datix; which stimulates a clinical review by the Clinical Lead for the tumour site and Head of Nursing for the Division. This also provides an audit trail for any potential patient harm events.

To prevent further 104 day waiters, each patient over 73 days is reviewed at the weekly primary target list (PTL) meeting any concerns in regards to getting these patients treated within national standard timeframes are raised and action taken.

The Deputy Chief Operating Office for Planned Care continues to progress the Cancer Improvement Programme. Phase 1 actions for August have included a meeting with the Deputy Medical Director and each tumour site Clinical Lead to re-engage the senior clinicians, identify actions to enable the national best practice timed pathways to be implemented. Agreed actions have also included resetting the terms of reference and membership of the Cancer Clinical Working Group and development of performance dashboards. Phase 2 includes MDM workshops to review the TSSG timed pathways and develop individual recovery plans to be taken forward as Phase 3.

Other improvement actions include strengthening communication with the patient's GP to ensure patients are receiving the appropriate support whilst on a two week wait pathway.

Risks to delivery of the standard:

- Key areas of concern for the Trust are Gynaecology, Urology, Lung, Lower GI and adequate capacity to meet the patients required next step, eg OPD capacity, theatre capacity, diagnostic or treatment.
- Significant increases in 2 week wait referrals.
- Response from Tertiary centres for patients who are on complex diagnostic or treatment pathways.

- **Actions taken to mitigate risk and improve performance:**
- Re-engagement of senior clinicians in managing their tumour sites.
- Daily cancer huddle meetings have been implemented.
- Weekly reviews of capacity, including monitoring of effective booking and capacity utilisation.
- Improved focus on booking all 2ww referrals within 48 hours of receipt.
- Clinical reviews of patients who have breached with potential harm reports.
- Improved communication with GPs to improve communication with patients regarding referral to a cancer pathway and availability to attend a 2ww appointment.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

18 Week Referral to Treatment Standard

Key Performance Indicators

79.06 %

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Green
Performance	81.56%	81.18%	80.87%	78.67%	77.62%	77.03%	76.08%	76.66%	78.56%	79.02%	79.65%	79.06%	>=92%
52w+	51	64	67	80	108	141	201	222	218	201	167	125	0
Waiting list Size	54,749	54,783	54,777	54,383	52,942	54,306	54,519	54,979	54,964	53,411	53,193	53,552	<38,938
Backlog Size	10,096	10,312	10,481	11,599	11,847	12,474	13,039	12,830	11,785	11,207	10,824	11,212	<2,178
Demand: PC Referrals	15,231	16,666	16,111	12,585	15,579	14,600	15,668	15,249	16,501	15,748	15,342	13,853	<15,484
Demand: Additions to IP WL	3,047	3,288	3,533	2,654	3,210	2,824	3,176	2,875	3,258	3,281	3,389	3,098	<3,076

2018/2019 Trajectory

-1.95 %

	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%								Sept

-75

	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								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%.

Summary Performance

August performance reduced to 79.06%, performance is now 1.95% behind the improvement trajectory.

The number of patients waiting over 52 weeks for first treatment has decreased to 125. This is within the trajectory submitted to NHSI, breaches have occurred within the following specialties; **Gynaecology (93), General Surgery (16), Trauma & Orthopaedics (6), ENT (3), Dermatology (2), Ophthalmology (1), and Other Specs (2)**

The Chief Operating Officer chaired weekly Patient Target List (PTL) performance meetings are established with every clinical specialities performance monitored across all admitted and non-admitted pathways. There has been sustained improvement through a robust focus on each specialities waiting list; challenging operational focus to bring patients forward and driving efficient and effective use of outpatient capacity and theatre activity.

An RTT improvement plan is in place, which is being monitored weekly by the Deputy Chief Operating Officer for Planned Care. Weekly monitoring of elective activity production plans is in place and led by the Director of Performance to confirm and challenge the schemes to deliver the contract and also to identify risks and mitigations to delivery.

A priority for August was to proactively manage demand throughout periods of planned annual leave and explore opportunities with the independent sector in order to increase activity for patients who have been waiting over 52 weeks or a risk of breaching 14 or 62 day on a cancer pathway.

The Chief Operating Officer has continued to engage with senior clinicians in surgical specialities and gynaecology in order to increase activity and reduce waiting times. Additional dedicated senior general management support is being sought for Gynaecology and Cancer services.

The intense focus on every individual patient waiting over 52 weeks has continued, resulting in an ongoing reduction in the number of patients waiting; however there remains a continued risk due to the number of patients currently waiting over 35 weeks who may tip over into 52 weeks. These patients are being actively managed and monitored daily.

A clinical review of all 52 week breaches is established, with potential clinical harm reports completed. The improvement plan and potential harm reports have been presented to the Board, Finance and Performance Committee and Quality Committee.

Key issues impacting on delivery of the standard:

- Long waiting times for elective surgery in Gynaecology and Urology, Trauma and Orthopaedics due to high demand and backlog.
- Long waiting times for outpatients in specialities such as Dermatology, ENT, Community Paediatrics, Neurology due to medical workforce constraints.
- Consultant capacity to provide additional theatre lists

Actions taken to mitigate risk and improve performance:

- Chief Operating Officer chairs additional weekly performance meeting to monitor the recovery plan for Gynaecology.
- Deputy Chief Operating Officer for Planned Care provides daily oversight and support.
- Director of Performance provides weekly review of speciality Production Plans to identify risks and mitigations to delivery.
- A continued focus on all patients currently at 35 weeks and above to reduce the patients waiting at 52 weeks, this includes a patient by patient personal treatment plan, monitored weekly.
- Weekly monitoring of theatre efficiency.
- 3 new substantive consultant neurologists are joining the Trust in September.
- Exploring independent sector capacity.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

6 Week Referral to Diagnostic Standard

Key Performance Indicators

98.03 %

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Green
Performance	99.47%	99.59%	99.85%	99.64%	99.45%	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%	>=99%
Waiting list Size	14,827	15,419	14,321	14,345	13,637	14,125	14,174	14,597	15,192	16,350	16,888	15,126	<14,000
Waiting > 6 Week Breaches	79	63	22	52	75	62	49	91	106	149	264	298	<60
Average Wait													<4

2018/19 Trajectory

-1.07 %

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
STF Trajectory	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.11%
Performance	99.47%	99.59%	99.85%	99.64%	99.45%	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%

Summary Performance

The standard has not been met for Aug 2018 with a compliance of 98.03%. As at the end of the month there were 298 patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 148; 130 in Computed Tomography, 15 in Non-Obstetric ultrasound, 3 in MRI
- Cardiology: 6
- Urodynamic: 17
- Sleep Studies : 121
- Cystoscopy : 5
- Colonoscopy : 1

The DMO1 was not achieved for the second month and the reason for the decline in performance is due to the continued increase in demand for Sleep Studies which has continued to put pressure on the Respiratory Department. A robust plan was developed in June 2018 in order to respond to the increased demand and also to plan ahead to achieve a sustainable service going forward. The plan includes organising additional administrative staff; NHSP are currently being booked with the aim of booking 33 patients per day. An additional 45 machines have been purchased which provides the ability to see 165 patients per week, which is sufficient capacity to meet the current demand.

CT and MRI have also seen an increase in demand due to the increased focus on reducing the waiting times for patients on cancer pathways. We have continued to treat additional potential cancer and RTT waiting patients, which has in turn created an increased demand for investigations.

Risk to delivery

- Workforce resilience – consistent availability of administrative staff to book.
- Recruitment to respiratory technicians and administrative staff.
- E-referral due to GP's being able to book outside of the 6 week standard.
- Ability to meet increased emergency and cancer demand along with reduced turnaround times

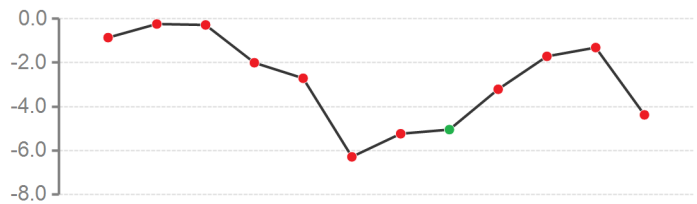
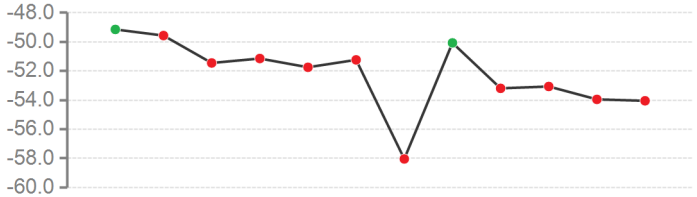
Mitigations:

- Recruitment to respiratory technician posts.
- Additional respiratory diagnostic equipment has been delivered and in use.
- Communication to GPs to remind them to book within 6 weeks on the E-referral system.
- Increasing third party provider support for MRI backlog and Cardiac CT in particular.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Finance

Finance

Aug	I&E £m	-15.7 (234.4%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £6.3m deficit adjusted for "extra" CIPS
Aug	Cash Balance £m	9.2 (-42.2%)		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.
Aug	Total Cost £m	-54.0 (0.2%)		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.
Aug	Forecast I&E £m	-31.0 (0.0%)		This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Finance

Aug

Normalised Forecast £m

-30.0 (0.0%)

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

Highlights and Actions:

The Trust has generated a consolidated deficit in month of £4.4m and a year to date (YTD) deficit of £15.6m which is £0.2m behind plan. YTD position includes some significant variances. The main variances include:-
-Higher than planned A&E activity and Non Elective case mix driving higher income
-High Other Clinical Income driven by central funding of pay awards. This is offset by higher pay costs.
-High Other Income driven by SACP progress and Serco transfer payment (this was budgeted as a cost reduction so also appears as a cost over run YTD)
-Off set by YTD under performance of complex Elective and Out Patient activity driving low income but also low non rechargeable drugs costs.
-Very high agency spend mainly driven by U&LTC operational pressures

As the Trust is in FSM it is measured against its performance excluding technical adjustments. After these are removed the Trusts YTD I&E deficit to Month 5 (August) was £15.3m (consolidated position including our Subsidiaries and after technical adjustments) against a planned deficit of £15m.

Trust unconsolidated pay costs in the month of £32.5m are £0.6m more than July. This increase is driven by non medical pay arrears paid in month (funded in clinical income) off set by the release of a reserve for this years medical pay award based on NHSi guidance. These adjustments give a net increase of £0.9m month on month. After removing the pay award adjustments, staff costs were £0.3m less than last month due to reductions in temporary staffing. Agency spend in month is £1.5m more than plan. Permanent staff costs (including Overtime and waiting list work) are £0.6m more than plan and were £0.2m higher than July (the latter after allowing for pay award adjustments). The main driver for the pay overspend against plan in month remains U&LTC where medical staffing are being used above establishment and recruitment to nursing has been slower than expected.

Clinical income was ahead of plan by £0.8m in month once the impact of central pay award funding (£1.6m) is removed. The net YTD position is now £2.7m ahead of plan. The key drivers to this are over performance in non-electives, A&E and ITU offset by under performance in elective and Outpatient activity.

Against the full year £30m CIPS target, including income, £10.4m has been reported YTD against a target of £10.1m, £0.3m ahead of plan. The main issues in month were that delivery from Agency reduction schemes and Procurement initiatives have fallen behind plan whilst Divisional schemes are over performing. Of the YTD reported position 49% is non recurrent.

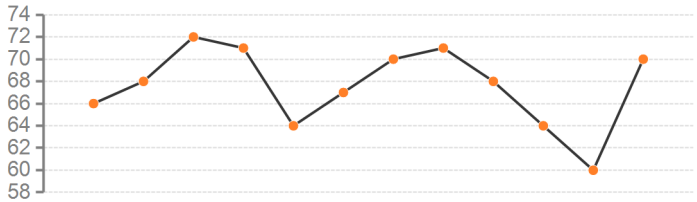
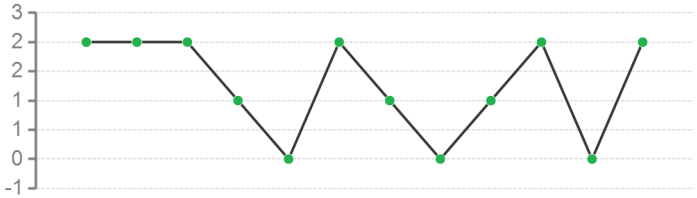
The cash balance as at the end of June was £9.2m, £5.8m above plan. The Trust's total cash borrowing is now £55.6m.

The Trust continues to carry and estimated £9.5m of risk to the year end position in relation to expert determination on income, CIP delivery and activity related costs. The Trust is currently re-forecasting and is reviewing the financial risks .The Trust will seek to mitigate these risks as we move through the year.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

Aug	Representation at H&S	811 (22.3%) ↑		% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	RIDDOR Reports (Number)	15 (-21.1%) ↓		RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Formal Notices			Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).
Aug	Health & Safety Training	3261 (31.9%) ↑		H&S Training includes all H&S and risk avoidance training including manual handling

Highlights and Actions:

Representation at H&S meetings increased positively last month. This is following a renewed focus on meeting attendance at site level, additionally the newly formed site leadership model will be used to increase the profile of the site H&S meeting. This is being piloted at QEQM initially.

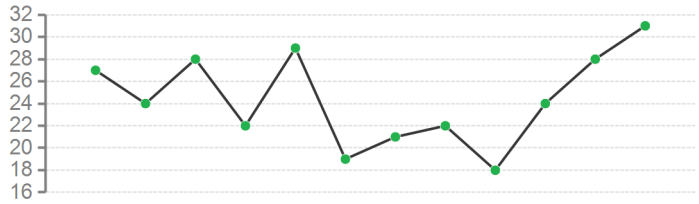
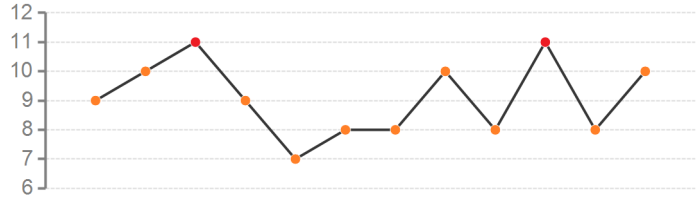
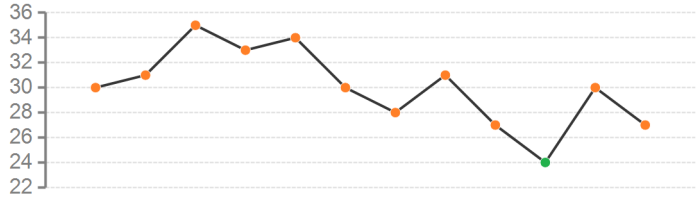
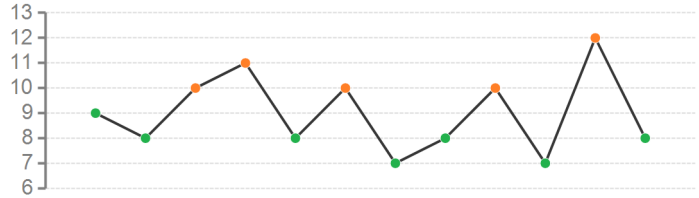
There were 2 RIDDORs to report in August - both related to patient activity and manual handling.

There where no formal notices this month.

H&S training remains high and inline with previous months.

Strategic Theme: Health & Safety

Health & Safety 2

Aug	Accidents	293 (-7.0%)		Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Fire Incidents	109 (-18.0%)		Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Violence & Aggression	360 (-14.1%)		Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
Aug	Sharps	108 (-38.6%)		Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Highlights and Actions:

The number of accidents increased this month, which although showing a slow increase for the last quarter remains within acceptable tolerances given the size of workforce and organisation. the H&S committee will continue to monitor.

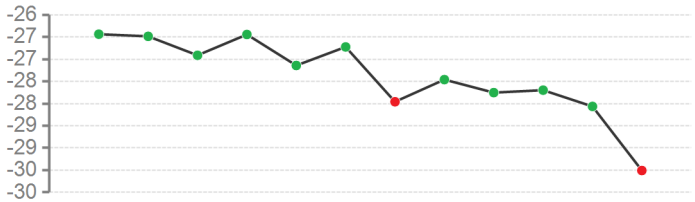
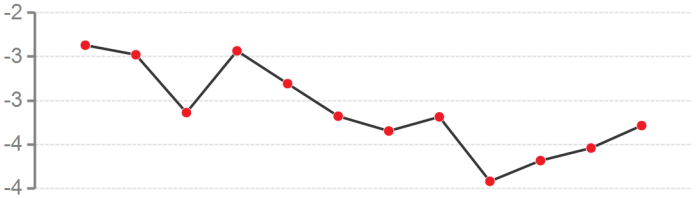
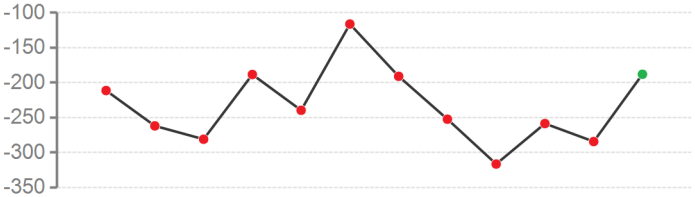
The number of Fire incidents increased slightly in month, there is usually an increase in August and September following the new intake of students. The KPI remains Amber.

V&A and sharps both decreased in August, with Sharps returning to Green.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

Aug	Payroll Pay £m	-29.5 (5.1%)		Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Aug	Agency Spend £m	-3.3 (-7.2%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Aug	Additional sessions £k	-188 (-33.9%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

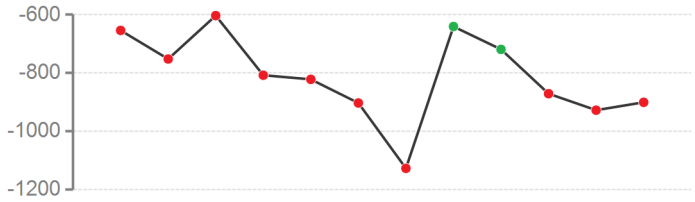
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Use of Resources

Aug

Independent Sector £k

-901 (-2.9%)



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 togeth

Highlights and Actions:

Pay performance is adverse to plan in August by £2.2m and by £6.6m ytd (4.4%). Pay CIPs are adverse to plan in month by £0.3m and by £1.5m ytd.

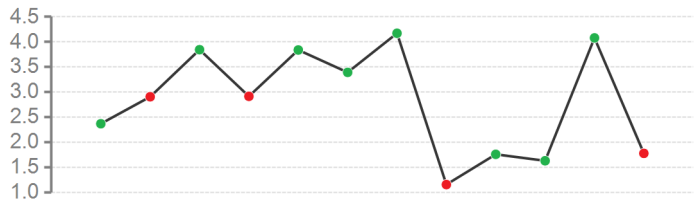
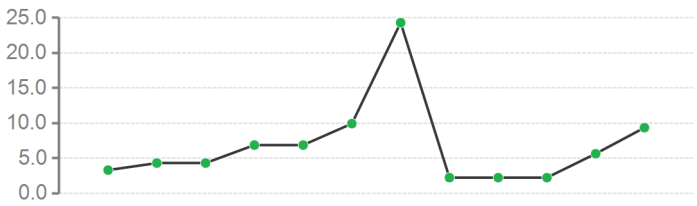
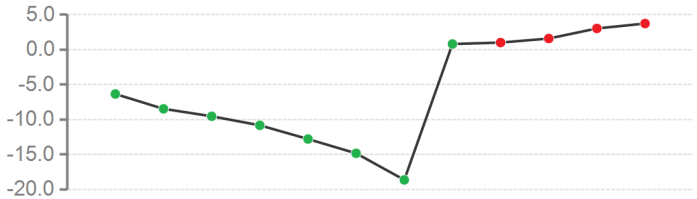
Total expenditure on pay in August was £32.5m, £0.6m higher than in July. This includes £1.3m of non medical pay award arrears paid in August relating to April - June but is offset by the release of medical pay award accruals for April - July totalling £0.3m following announcement from the DoHSC that the medical pay award will be effective from October. Expenditure on temporary staffing, medical locums sessions and waiting list payments fell in total by £0.4m.

Substantive staff expenditure is adverse to plan by £0.6m August and favourable to plan by £2.3m ytd. Other pay groups account for the majority of the overspend in month driven by HCA's, with minor overspends in nursing, ST&T and A&C offsetting an underspend against plan on medical staff.

Agency and Direct Engagement performance continues to be adverse to plan by £1.5m in month and £8.7m ytd. Despite a reduction in actual spend of £0.5m in month when compared to July, all staffing groups are adverse to plan. Expenditure on medical staff continues to show the highest overspend with adverse variances again in all clinical divisions except Clinical Support Services which is favourable to plan in month by £0.3m. Nursing and HCA agency usage remains high in UC&LTC though usage of TFS HCAs at premium rates is reducing from September.

Strategic Theme: Use of Resources

Balance Sheet

Aug	CIPS £m	10.4 (-56.4%)		Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.
Aug	Cash borrowings £m	189.4 (-19.0%)		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Aug	Capital position £m	10.2 (23.2%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.

Highlights and Actions:

DEBT
Total invoiced debtors have decreased from the opening position of £28.5m by £11.9m to £16.6m. The largest debtors at 31st August were East Kent CCGs £5.2m and East Kent Medical Services £1.7m.

CAPITAL
Total YTD expenditure for Mth 5 2018/19 is £1.0m below the NHSI plan

CASH
The closing cash balance for the Trust as at 31st August was £9.2m.

FINANCING
£726k of interest was incurred in respect of the drawings against working capital facilities to 31st March 2018 (£46.2m) and April 2018 (£2.2m), July 2018 (£3.4m) and August (3.7m).

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Improvement Journey

		Apr	May	Jun	Jul	Aug	
MD02 - Emergency Pathway	ED 4hr Performance (incl KCHFT MIUs) %	81.73	83.95	86.92	79.53	83.52	>= 95
	ED - 1hr Clinician Seen (%)	46	49	51	43	48	>= 55
MD04 - Flow	IP - Discharges Before Midday (%)	14	14	14	14	13	>= 35
	Medical Outliers	57	57	48	47	51	
	DToCs (Average per Day)	63	61	61	57	52	< 35
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	66.13	65.40	65.32	65.45	66.40	>= 85
MD07 - Maternity	Midwife:Birth Ratio (%)	26	28	28	30	28	< 28
	Staff Turnover (Midwifery)	13	13	13	14	13	<= 10
	Vacancy (Midwifery) %	8	7	7	6	6	<= 7
MD08 - Recruitment & Staffing	Staff Turnover (%)	13.4	13.2	13.0	15.0	13.9	<= 10
	Vacancy (%)	13.0	13.6	14.5	13.6	14.8	<= 7
	Staff Turnover (Nursing)	13	13	13	14	13	<= 10
	Vacancy (Nursing) %	14	15	15	16	16	<= 7
	Vacancy (Medical) %	11	11	13	13	16	<= 7
MD09 - Workforce Compliance	Appraisal Rate (%)	80.1	71.8	67.2	70.5	75.9	>= 85
	Statutory Training (%)	91	90	91	91	92	>= 85
KF01 - Complaints	Complaint Response in Timescales %	94.4	91.4	92.0	87.3	90.2	>= 85
	Complaint Response within 30 days %	40.3	38.6	44.7	47.4	30.6	>= 85

KF09 - Medicines Management

Pharm: Fridges Locked (%)	82					>=95
Pharm: Fridge Temps (%)	100					>= 100
Pharm: Drug Trolleys Locked (%)	100					>= 90
Pharm: Resus. Trolley Check (%)	73					>= 90
Pharm: Drug Cupboards Locked (%)	82					>= 90

East Kent Hospitals University NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 1hr Clinician Seen (%)	% of A&E attendances seen within 1 hour by a clinician	>= 55	
	ED 4hr 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)	>= 95	1 %
	ED 4hr Performance (incl KCHFT MIUs) %	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge for all sites including KCFT MIU Sites	>= 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 P	<= 92	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	< 35	30 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Medical Outliers	Number of patients recorded as being under a Medical specialty but was discharged from a Surgical Ward (Patients admitted to a ward which is not related to their clinical reason, mainly due to capacity reasons)		
Cancer	Cancer: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 2ww (Breast) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (CB_B7).	>= 93	5 %
	Cancer: 31d (2nd Treat - Surg) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (CB_B9).	>= 94	5 %
	Cancer: 31d (Diag - Treat) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (CB_B8)	>= 96	15 %
	Cancer: 31d (Drug) %	Cancer 31 day waits, as stated by NHS Operating Framework. % of patients receiving subsequent treatment for cancer within 31-days, where that treatment is an Anti-Cancer Drug Regimen (CB_B10).	>= 98	5 %
	Cancer: 62d (Con Upgrade) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.	>= 85	5 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %
	Cancer: 62d (Screening Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.	>= 90	5 %

Clinical Outcomes	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	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 - select	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90	5 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>=95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. Th	< 2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team.	< 15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.	>= 81.4	40 %
	Staff FFT - Work (%)	Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the nationa submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %)	>= 60	50 %
Data Quality & Assurance	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings.	<= 0.1	25 %
	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	< 0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code %	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %

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: Fup %	Follow up appointments where the patient did not attend (appointment type=2, appointment status=3) as a % of all follow up appointments.	< 7	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	< 7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments		
Diagnostics	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from	>= 99	100 %
Finance	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown ir the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	Forecast I&E £m	This shows the latest forecast year end Income & Expenditure position as at 31st March 2017. The latest plan is yet to be agreed. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
	I&E £m	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position. The year to date plan = £6.3m deficit adjusted for “extra” CIPS	>= Plan	30 %
	Normalised Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	10 %
	Total Cost £m	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.	>= Plan	20 %
Health & Safety	Accidents	Accidents excluding sharps (needles etc) but including manual handling. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 40	15 %
	Fire Incidents	Fire alarm activations (including false alarms). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 5	10 %
	Formal Notices	Formal notices from HSE (Improvement Notices, Prohibition Notices). Number indicates sum of last 12 months data (as shown in graph).	< 1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	Representation at H&S	% of Clinical Divisions representation/attendance at each site's Health & Safety Committee. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 76	20 %

Health & Safety	RIDDOR Reports (Number)	RIDDOR reports sent to HSE each month. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 3	20 %
	Sharps	Incidents with sharps (e.g. needle stick). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	5 %
	Violence & Aggression	Violence, aggression and verbal abuse. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 25	10 %
Incidents	All Pressure Damage: Cat 2	Number of all (old and new) Category 2 pressure ulcers. Data source - Datix.	< 1	
	Blood Transfusion Incidents	The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Clinical Incidents: Total (#)	Number of Total Clinical Incidents reported, recorded on Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	Falls (per 1,000 bed days)	Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previ	< = 5	20 %
	Falls: Total	Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix.	< 3	0 %
	Harm Free Care: All Harms (%)	Percent of Inpatients deemed free from harm (ie, free from old & new harm- pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indic	>= 94	10 %
	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer.	>= 98	20 %
	Medicines Mgmt. Incidents	The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
	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.	< 1	30 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls	>= 1	0 %
	Pressure Ulcers Cat 2 (per 1,000)	Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12	<= 0.15	10 %

Incidents	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	< 1	10 %
	Serious Incidents (STEIS)	Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months.		
Infection	Bare Below Elbows Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	C. Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	< 1	
	Cases of C.Diff (Cumulative)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month.	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with varia	< 1	40 %
	Commode Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	E. Coli	The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 44	10 %
	Hand Hygiene Audit	The % of ward staff compliant with hand hygiene standards. Data source - SharePoint	>= 95	
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	< 1	
	MSSA	The total number of MSSA bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	MSSA - 48hr (per 100,000 bed days)	The total number of Trust assigned (post 48h) MSSA bacteraemia per 100,000 bed days.	< 1	
Initiatives	Antimicrobial Resistance & Stewardship CQUIN Delivered %	CQUIN made up of two parts – reducing antibiotic consumption in named antibiotics and review of patients on antibiotics after 48/72 hours	>= 100	20 %

Initiatives	End of Life Pathway CQUIN Delivered %	CQUIN linked to current improvement work and multi-agency policy	>= 100	20 %
	Patient Flow CQUIN Delivered %	CQUIN linked to SAFER project	>= 100	20 %
	Sepsis CQUIN Delivered %	CQUIN including acute wards and with antibiotic review at 72 hours	>= 100	20 %
	Staff Health & Wellbeing CQUIN Delivered %	CQUIN made up of three parts – staff access to healthy activities, health food options on site and flu vaccine uptake	>= 100	20 %
Mortality	Crude Mortality NEL (per 1,000)	The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Cha	< 90	35 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arro	< 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 %
	Catheter: Daily Check (%)	The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Central Line: Daily Check (%)	The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC	>= 50	10 %
	Obs. On Time - 8am-8pm (%)	Number of patient observations taken on time	>= 90	25 %
	Obs. On Time - 8pm-8am (%)	Number of patient observations taken on time	>= 90	25 %
	VTE: Risk Assessment %	Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant.	>= 95	20 %
Patient Experience	AE Mental Health Referrals	The Number of Referrals made to a Mental Health team from A&E		5 %
	Aware of Nurse in each shift %	Aware of nurse in each shift	>= 89	4 %
	Care Explained? %	Based on a question asked within the Trust's Inpatient Survey, was your care or treatment explained to you in a way you could understand by the medical/nursing/support staff? % of inpatients who answered 'yes always' or 'yes sometimes'. Arrow indicates	>= 89	

Patient Experience	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 show	>= 95	5 %
	Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	5 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	Discuss Worries with Doctors %	Discuss Worries with Doctors	>= 89	
	Discuss Worries with domestic %	Discuss Worries with domestic	>= 89	
	Discuss Worries with Nurses %	Discuss Worries with Nurses	>= 89	4 %
	Discuss Worries with support %	Discuss Worries with support	>= 89	
	FFT: Not Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direct	>= 1	10 %
	FFT: Recommend (%)	Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction	>= 90	30 %
	FFT: Response Rate (%)	The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 mon	>= 15	1 %
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in	>= 85	5 %
	Mixed Sex Breaches	Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	< 1	10 %
	Number of Complaints	The number of complaints recorded per ward. Data source - Datix.	< 1	0 %
	Number of Compliments	The number of compliments recorded overall Data source - Patient Experience Team (Kayleigh McIntyre).	>= 1	0 %

Patient Experience	Overall Patient Experience %	Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of las	>= 90	10 %
	Privacy for discussions with Doctors %	Privacy for discussions Doctors	>= 89	
	Privacy for discussions with Nurses %	Privacy for discussions Nurses	>= 89	2 %
	Privacy for discussions with Support %	Privacy for discussions Support	>= 89	
Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use– allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	EME PPE Compliance %	EME PPE % Compliance	>= 80	20 %
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	< 0.8	20 %
	Non-Clinical Canx Breaches 28 Days (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total Non-Clinical Cancellations	< 5	10 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	< 1	
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for pa	>= 92	100 %
Staffing	1:1 Care in labour	The number of women in labour compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Communit	>= 99	
	Agency %	% of temporary (Agency and Bank) staff of the total WTE Number indicates average of last 12 months data (as shown in graph).	<= 10	
	Agency & Locum Spend	Total agency spend including NHSP spend		

Staffing

Agency Filled Hours vs Total Agency Hours	% hours worked which were filled by the NHSP against the total number of hours worked by agency staff		
Agency Orders Placed	Total count of agency orders placed. Number indicates average of last 12 months data (as shown in graph).	<= 100	
Agency Staff WTE (Bank)	WTE Count of Bank Hours worked		
Agency Staff WTE (NHSP)	WTE Count of NHSP Hours worked		
Bank Filled Hours vs Total Agency Hours	% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff		1 %
Bank Hours vs Total Agency Hours	% hours worked by Bank (Staffflow) against the total number of hours worked by agency staff		
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		
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 %) again	>= 92.1	1 %
Local Induction Compliance %	Local Induction Compliance rates (%) for temporary employee's to the Trust. Number indicates average of last 12 months data (as shown in graph).	>= 85	
Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwive	< 28	2 %
NHSP Hours vs Total Agency Hours	% hours worked by NHSP against the total number of hours worked by agency staff		
Overtime %	% of Employee's that claim overtime. Number indicates average of last 12 months data (as shown in graph).	<= 10	
Overtime (WTE)	Count of employee's claiming overtime	<= 60	1 %
Shifts Filled - Day (%)	Percentage of RN 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 %
Shifts Filled - Night (%)	Percentage of RN 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 %
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 mont	< 3.6	10 %

Staffing

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		
Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate– WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		
Staff Turnover (%)	% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous	<= 10	15 %
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	<= 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 th	<= 10	
Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
Time to Recruit	Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 10	
Total Staff Headcount	Headcount of total staff in post		
Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
Total Staff In Post (SiP)	Count of total staff in post (WTE)		1 %
Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	< 100	5 %
Vacancy (%)	% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	15 %
Vacancy (Medical) %	% Vacant positions against Whole Time Equivalent (WTE) for Medical Staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
Vacancy (Midwifery) %	% Vacant positions against Whole Time Equivalent (WTE) for Midwives. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	
Vacancy (Nursing) %	% Vacant positions against Whole Time Equivalent (WTE) for Nurses. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	<= 7	

Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
	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 pr	>= 85	50 %
Use of Resources	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	
	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow. The Annual Plan is £14.27m.	< 0	
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	< 0	
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	< 0	
	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 togeth	< 0	
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	< 0	

Data Assurance Stars


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


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


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

East Kent Hospitals University NHS Foundation Trust

Human Resources Heatmap

	Clinical	Corporate	Finance & Perform	HR	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term
Agency %	2.7	2.0	2.7	0.8	1.5	4.7	10.4	7.7	14.4
Appraisal Rate (%)	80.8	61.1	80.9	75.8	70.3	75.1	45.5	86.8	67.6
Employed vs Temporary Staff (%)	89.0	87.7	88.3	93.9	87.6	91.0	76.3	91.6	79.7
Sickness (%)	4.2	2.2	2.1	3.2	4.9	4.2	3.5	4.1	3.9
Staff Turnover (%)	14.4	9.0	13.2	11.4	9.2	11.1	8.7	13.6	17.6
Statutory Training (%)	92	87	96	93	89	91	95	92	92
Total Staff In Post (SiP)	1492	86	132	126	120	1346	283	1755	1687
Vacancy (%)	19.2	15.2	11.7	6.9	12.4	9.2	23.7	8.4	20.3

Apdx.

NHS
East Kent Hospitals University
NHS Foundation Trust

Patient Safety Heatmap - AUGUST 2018

KEY

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

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Aware of Nurse in each shift %	Privacy for discussions with	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
K&C - KENT & CANTERBURY HOSPITAL																	
Specialist																	
KBRA - BRABOURNE (KCH)	100.0	0	3	0	0	0	8	50	100	50	52	91	9.1	98.6	88	100	14
MARL - MARLOWE WARD	100.0	0	2	0	0	0	77	33	33	50	64	98	0.0	83.5	95	89	8
Surgical																	
CLKE - CLARKE WARD	94.1	3	3	0	0	0	101	50	50	100	40	97	3.0	84.1	87	92	7
KENT - KENT WARD	100.0	3	4	0	0	0	12	100	100	100	29	95	0.0	94.3	96	101	9
KITU - KCH ITU	100.0	0	0	0	0	0	39	N/A	N/A	N/A	N/A	N/A	N/A	90.5	78	75	25
Urgent & Long Term																	
HARB - HARBLEDOWN WARD	100.0	0	6	0	0	0	46	50	50	50	35	93	0.0	78.1	87	124	6
INV - INVICTA WARD	100.0	0	3	0	0	0	0	50	50	50	41	100	0.0	94.2	104	112	6
KING - KINGSTON WARD	100.0	1	5	0	0	0	0	50	50	50	49	100	0.0	87.3	95	110	5
KNRU - EAST KENT NEURO REHAB UNIT	94.4	0	3	0	0	0	0	100	100	100	75	88	0.0	91.9	100	101	6
MTMC - MOUNT/MCMASTER WARD	100.0	1	5	0	0	0	0	50	50	100	11	100	0.0	95.6	75	97	5
TREB - TREBLE WARD	100.0	0	5	0	0	2	0	33	50	50	92	100	0.0	92.3	80	89	9
QEQM - QUEEN ELIZABETH QUEEN MOTHER HOSPITAL																	
Specialist																	
BIR - BIRCHINGTON WARD	100.0	0	0	0	0	2	0	100	100	100	19	100	0.0	88.9	89	121	6
KIN - KINGSGATE WARD	100.0	0	0	0	0	1	0	N/A	N/A	N/A	N/A	N/A	N/A	86.1	85	92	23
QSCB - QEH SPECIAL CARE BABY UNIT	100.0	0	0	0	0	1	2	N/A	N/A	N/A	N/A	N/A	N/A	95.3	100	99	10
RAI - RAINBOW WARD	100.0	0	0	0	0	1	0	N/A	N/A	N/A	17	100	0.0	91.4	85	90	13
Surgical																	
BIS - BISHOPSTONE WARD	100.0	1	0	0	0	1	158	50	50	50	101	95	1.2	77.6	70	91	8
CSF - CHEERFUL SPARROWS FEMALE	100.0	0	3	0	2	1	2	33	50	50	100	99	0.0	91.6	124	134	7
CSM - CHEERFUL SPARROWS MALE	100.0	3	1	0	0	1	11	50	50	50	45	96	0.0	77.7	125	150	7

Apdx.

KEY

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

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Aware of Nurse in each shift %	Privacy for discussions with Nurses %	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
QITU - QEH ITU	100.0	2	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	83.6	81	110	24
SB - SEA BATHING WARD	100.0	0	0	0	0	0	1	33	33	33	45	93	3.7	90.7	101	108	6
Urgent & Long Term																	
DEAL - DEAL WARD	100.0	2	3	0	0	1	0	50	100	50	4	100	0.0	87.1	89	119	5
FRD - FORDWICH WARD STROKE UNIT	100.0	0	3	0	0	0	0	33	100	33	109	100	0.0	81.9	89	115	8
MW - MINSTER WARD	100.0	0	2	0	0	1	6	50	100	100	10	100	0.0	75.8	97	111	8
QCCU - QEH CCU	100.0	0	3	0	0	0	6	50	50	50	51	100	0.0	76.5	81	110	24
QCDU - QEH CDU	100.0	17	3	0	0	1	4	100	50	100	19	79	17.6	79.1	110	159	10
QX - QUEX WARD	100.0	0	2	0	0	1	18	NULL	NULL	NULL	50	100	0.0	NULL	100	114	6
SAN - SANDWICH BAY WARD	100.0	0	1	0	0	0	7	50	100	100	15	82	9.1	97.2	128	137	7
SAU - ST AUGUSTINES WARD	95.0	1	6	0	0	0	5	100	100	100	36	95	0.0	90.9	100	124	5
STM - ST MARGARETS WARD	100.0	0	1	0	0	1	31	NULL	NULL	NULL	56	97	0.0	58.3	88	103	5
WHH - WILLIAM HARVEY HOSPITAL																	
Specialist																	
FF - FOLKESTONE	100.0	0	0	0	0	2	5	33	33	50	N/A	N/A	N/A	85.4	92	91	16
KEN - KENNINGTON WARD	100.0	0	0	0	0	1	9	33	33	50	36	97	2.6	71.9	89	116	7
PAD - PADUA	100.0	0	0	0	0	3	0	N/A	N/A	N/A	37	98	1.6	85.6	84	84	9
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	101.6	100	99	10
Surgical																	
ITU - WHH ITU	100.0	4	2	0	0	0	3	N/A	N/A	N/A	N/A	N/A	N/A	97.7	87	95	27
KA2 - KINGS A2	100.0	1	5	0	0	0	189	33	33	50	65	96	0.0	98.9	105	118	6
KB - KINGS B	100.0	0	3	0	0	0	192	33	33	33	65	94	4.1	94.3	102	116	6
KC - KINGS C1	96.0	2	1	0	0	0	0	33	50	50	136	92	0.0	80.5	106	101	6
KC2 - KINGS C2	100.0	1	2	0	0	0	0	50	50	33	60	98	1.1	68.4	86	92	6
KDF - KINGS D FEMALE	100.0	3	1	0	1	0	3	33	33	50	72	98	0.0	98.9	N/A	N/A	N/A
KDM - KINGS D MALE	100.0	4	3	0	0	1	0	33	33	25	53	96	0.0	N/A	109	109	7
RW - ROTARY WARD	93.8	0	0	0	0	1	21	33	33	33	107	98	0.0	95.2	110	99	8
Urgent & Long Term																	
CCU - CCU	100.0	0	0	0	0	0	0	50	100	50	0	NULL	NULL	NULL	N/A	N/A	N/A
CJ2 - CAMBRIDGE J2	100.0	0	0	0	0	0	0	33	100	100	1	100	0.0	74.2	108	132	8
CK - CAMBRIDGE K	100.0	0	6	0	0	2	0	50	50	33	61	88	2.3	48.9	87	93	6

KEY

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

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	Number of Cardiac Arrests	C. Diff Infections (Post 72h)	Number of Complaints	Number of Compliments	Aware of Nurse in each shift %	Privacy for discussions with Nurses %	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
CL - CAMBRIDGE L REHABILITATION	100.0	3	11	0	0	1	0	33	50	50	93	95	2.3	84.9	83	113	6
CM1 - CAMBRIDGE M1 SHORT STAY	100.0	1	4	0	0	1	0	50	33	100	38	94	5.9	14.5	N/A	N/A	N/A
CM2 - CAMBRIDGE M2	94.7	2	7	0	0	0	5	33	50	33	92	97	0.0	100.2	101	92	6
OXF - OXFORD	100.0	0	2	0	0	0	0	50	100	50	41	100	0.0	89.6	111	118	8
RST1 - RICHARD STEVENS 1 STROKE UNIT	95.8	1	4	0	0	1	0	33	50	33	34	86	9.5	90.6	83	114	7
WBAR - BARTHOLOMEW WARD WHH	NULL	0	0	0	0	0	0	50	50	50	156	98	1.5	NULL	88	100	14
WCDM - WHH CDU MIXED	100.0	8	13	2	0	1	6	50	25	33	16	74	18.5	79.3	77	89	11

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 OCTOBER 2018**
SUBJECT:	**CHARITABLE FUNDS COMMITTEE (CFC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF CHARITABLE FUNDS COMMITTEE**
PAPER AUTHOR:	**CHAIR OF CHARITABLE FUNDS COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

The Charitable Funds Committee remit is to maintain a detailed overview of the Charity's assets and resources in relation to the achievement of the agreed Charity Strategy.

Chair's summary of the key issues highlighted at the Charitable Funds Committee meeting held on 6 September 2018.

1 Applications for Grants

1.1 Fibreoptic Endoscopic Evaluation of Swallowing System (FEES)

1.1.1 The Committee received, considered and approved this application for funding.

1.1.2 This is to purchase FEES scopes for each of the three hospital sites Queen Elizabeth the Queen Mother (QEQM), William Harvey Hospital (WHH) and Kent & Canterbury Hospital (K&CH). These visualise and record images of the throat when assessing patients with swallowing difficulties (dysphagia).

1.1.3 Currently the Trust is only able to offer instrumental diagnostic assessment at K&CH (via videofluroscopy).

1.1.4 These FEES scopes will prevent the need for patients to transfer from EKHUFT sites to K&CH.

1.1.5 This equipment will provide earlier and accurate identification of the dysphagia, guiding individually tailored treatment, and will enable all patients to access instrumental swallow assessment.

1.2 Spot Screeners

1.2.1 The Committee received, considered and approved this application for funding.

1.2.2 Spot vision screeners enable the quick and easy detection of the need for glasses in patients from 6 months to adulthood.

1.2.3 This equipment can screen both eyes at once, can be performed from a non-threatening distance, and does not require the use of eye drops.

1.2.4 These vision screeners will provide consistent approach across all the Trust sites.

1.3 Intensive Therapy Unit (ITU) Staff and Patient Facilities Works

1.3.1 The Committee received and considered this application for funding.

1.3.2 This was around the provision of facilities works to the ITU relatives waiting room and associated works.

1.3.3 The Committee acknowledged the importance of providing a suitable, calm and pleasant environment for relatives and visitors. This proposal will ensure that people feel as comfortable as possible

when visiting loved ones.

1.3.4 The Committee approved this funding but agreed that this proposal be undertaken as part of the current ward room improvements within the 'breaking bad news' room facilities. If it was not possible for these costs to be incorporated within those improvement works funding, the application would be re-presented to the Committee for approval.

1.4 MRI Compatible Ventilator, Patient Monitor and Infusion Pump

1.4.1 The Committee received, considered and approved this application for funding. This is being recommended to the Board for approval.

1.4.2 This application is for the purchase of MRI conditional equipment at the QEQM site to enable the safe imaging of ventilated critical care patients.

1.4.3 Currently all ventilated patients require transfer to K&CH.

1.4.4 ITU staff are required to transfer with the patient and this requires reliance on the ambulance service.

1.4.5 Equipment can be used from neo-natal to adult.

1.4.6 This equipment will enable prompt treatment decision.

1.4.7 The Board is asked to approve this funding of MRI compatible ventilator £31k, patient monitor £60k and infusion pump £22k.

1.5 Dementia Village

1.5.1 The Committee received and considered an application for additional funding to support the provision of a dementia care facility at Buckland Hospital.

1.5.2 The Committee agreed that this needed to be funded from the Trust's capital. It would be explored for specific funding to be sought from various charities.

2 Finance Report

2.1 The Committee discussed and noted a report on the current financial position and income and expenditure of the East Kent Hospitals Charity, that included the following key elements as at 30 June 2018:

2.1.1 The Charity fund balances of £3.1m.

2.1.2 Income of £0.2m.

2.1.3 Expenditure had been £0.3m.

2.1.4 Cash position of £1.1m.

2.1.5 Investments were £2.4m.

3 Prioritisation Plan and Charity Funding Plan

3.1 The Committee received and discussed these two plans.

3.2 The Committee reviewed and discussed the equipment and projects for consideration for future applications for Charity funding.

3.3 The Committee agreed the planned Charity Funding for 2018/19.

3.4 The Committee approved the charitable funds to be split, £1m for medical equipment, £300k for estates and £200k for staff and wellbeing, and recommended this for approval by the Board.

4 2gether Support Solutions

The Committee received a verbal briefing of the impact of 2gether on the Charity. In relation to the majority of the Trust's property and equipment being transferred to 2gether on 1 October. There would be no change in terms of the operation of the equipment.

5 **Devereux Trust (Charitable Property)**

The Committee received and discussed an update report regarding the Devereux Trust Charitable Property and agreed the next steps in relation to the best interests of the tenant. The Committee will receive assurance annually that the Trust's obligations have been fulfilled.

6 **Appeal and Fundraising Update**

6.1 The Committee received and noted an update report of the current fundraising activities of the Charity. This included:

6.1.1 The dementia appeal fundraising total of £128,500k.

6.1.1.1 The Charity has been awarded the Charity of the Year for the Kentish Gazette (Canterbury, Faversham, Herne Bay, Whitstable area).

6.1.1.2 Tim's Big Swim raised £500 in sponsorship.

6.1.1.3 Minster Women's Institute chose to support the Appeal as their charity of the year, and presented £166, with the promise of more fundraising to follow.

6.1.1.4 The Appeal was the beneficiary of Lofty Fest 2018, a one-day music festival in Ashford. The event raised £700.

6.1.1.5 The Greenhill Senior Citizens Club picked the Appeal as their charity of the year and presented £1,000.

6.1.2 The Twinkling Stars Project: the suite received its official opening on 26 August, and previous donors were invited to the opening to show them how their funds had been spent.

6.1.3 The founder of Fever Pitch - Football for Funding held an event that raised an impressive £22,295. Quotes for the refurbishment of the Counselling Room have been agreed by the Maternity Team and Estates.

6.1.4 The Tiny Toes giving page has topped £33k.

6.1.5 Charity of the Year: Ashford Borough Council has chosen Padua Ward as their Charity of the Year 2018/19 (this is on the back of "Tiny Toes" being the Charity of the Year 2017/18).

6.1.6 Vitality 10km race in London (28 May): The individual that claimed the Charity place ran for ITU at the WHH and raised £900.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Charity has to remain financially stable and cannot over commit to projects that could lead to an overreach of funding capacity. The Committee oversees the financial position and activities to ensure the Charity achieves its strategies and objectives.
LINKS TO STRATEGIC OBJECTIVES:	The broad objectives of the Charity link to all the strategic objectives of the Trust. **Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	No

RESOURCE IMPLICATIONS:	Not applicable
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is being asked to:

i) discuss and note the report;
ii) approve the funding of MRI compatible ventilator £31k, patient monitor £60k and infusion pump £22k;
iii) approve as set out in the Prioritisation Plan and Charity Funding Plan, for the charitable funds to be split, £1m for medical equipment, £300k for estates and £200k for staff and wellbeing.