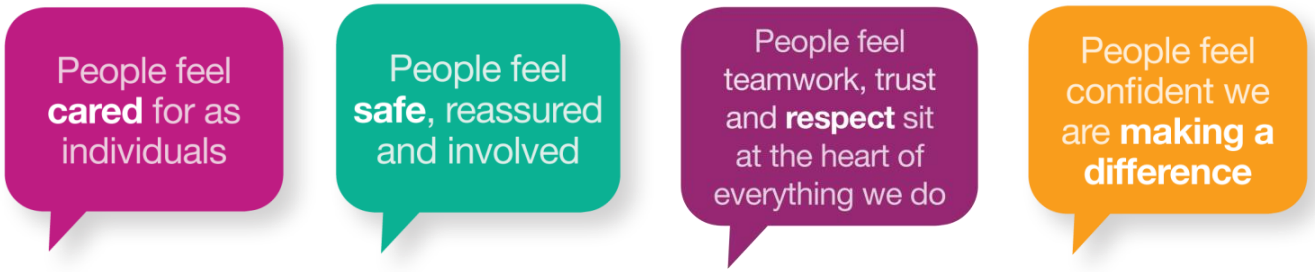
East Kent Hospitals University NHS Foundation Trust

BOARD OF DIRECTORS MEETING – THURSDAY 4 JULY 2019

Please find attached the agenda for the next Board of Directors meeting. The meeting will take place in the **Board Room, William Harvey Hospital, Kennington Road, Willesborough, Ashford, Kent, TN24 0LZ**, commencing at **9.45 am to 12.30 pm**.

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



AGENDA

19/

OPENING MATTERS				
052	Chairman's welcome		**09:45**	Acting Chair
053	Apologies for Absence			
054	Declaration of Interests			
055	Minutes of Previous Meeting held on 6 June 2019			
056	Matters Arising from the Minutes on 6 June 2019			
057	Chair's Report	**Discussion**	**10:00** **10 mins**	Acting Chair
058	Chief Executive's Report	**Discussion**	**10:10** **10 mins**	Chief Executive
Getting to good	**Improve quality, safety and experience, resulting in Good and then Outstanding care**			
059	Staff Experience Story	**Discussion**	**10:20** **20 mins**	Interim Chief Nurse and Director of Quality/ Deputy Medical Director

We care

NHS East Kent Hospitals University NHS Foundation Trust

060	Medical Director Reports		**10:40** **10 mins**	Deputy Medical Director
	060.1 Medical Director's Infection Control Report	**Discussion**		
	060.2 Board Assurance for Management and Oversight of Investigation and Disciplinary Procedures relating to Doctors	**Decision**		
061	Quality Committee - Chair Report • Deep Dive Risk CRR28: Lack of timely recognition of serious illness in patients presenting to the Emergency Departments (EDs)	**Approval**	**10:50** **5 mins**	Chair Quality Committee – Barry Wilding
062	Care Quality Commission (CQC) Update	**Discussion**	**10:55** **10 mins**	Interim Chief Nurse and Director of Quality Deputy Medical Director

A great place to work

Making the Trust a Great Place to Work for our current and future staff

Right skills right time right place

Developing teams with the right skills to provide care at the right time, in the right place and achieve the best outcomes for patients

063	Strategic Objectives 2019/20 • A great place to work • Right skills, right time, right place	**Discussion**	**11:05** **5 mins**	Acting Director of HR
064	Strategic Workforce Committee – Chair Report	**Approval**	**11:10** **5 mins**	Chair Strategic Workforce Committee – Jane Ollis
	TEA/COFFEE BREAK		**11:15** **10 mins**	

Healthy finances

Having Healthy Finances by providing better, more effective patient care that makes resources go further

065	Finance and Performance Committee – Chair Report • Finance Report	**Approval**	**11:25** **5 mins**	Chair Finance and Performance Committee – Sunny Adeusi

We care

NHS East Kent Hospitals University NHS Foundation Trust

Higher standards for patients

Improve the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all times

066	Corporate Reporting		**11:30** **30 mins**	
066.1	Integrated Performance Report	**Discussion**		Chief Executive / Executive Team
066.2	Full Corporate/Highest Mitigated Strategic Risks Report	**Discussion**		Interim Chief Nurse and Director of Quality/ Executive Team

Delivering our future

Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services

067	Programme Initiation Document (PID)	**Discussion**	**12:00** **10 mins**	Chief Executive Director of Strategic Development and Capital Planning/Deputy Chief Executive

CLOSING MATTERS

068	Any other business	**12:10**
069	**QUESTIONS FROM THE PUBLIC**	**12:15** **15 mins**

Date of Next Meeting: Thursday 12 September 2019 in the Board Room, Kent and Canterbury Hospital, Canterbury.

The public will be excluded from the remainder of the meeting due to the confidential nature of the business to be discussed.

Getting to good | Higher standards for patients | A great place to work | Delivering our future | Right skills right time right place | Healthy finances

We care

REGISTER OF DIRECTOR INTERESTS – 2019/2020 FROM MAY 2019

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) **(4)**	Appointed 1 April 2018
ADEUSI, SUNNY	Non Executive Director	None	1 November 2015 (Second term)
ASHMAN, ANDREA	Acting Director of HR	None	1 November 2018 (Acting)
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)
HALLUMS, AMANDA	Interim Chief Nurse and Director of Quality	Trustee of St Francis Hospice **(1)**	1 April 2019 (Interim)

REGISTER OF DIRECTOR INTERESTS – 2019/2020 FROM MAY 2019

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
LE BLANC, SANDRA	Director of HR	Justice of Peace (East Kent) and I am a specialist advisor for the CQC **(4)** Member – Scheme Advisory Board for the NHS Pension Scheme **(4)**	Appointed 1 September 2014
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) **(1)**	1 July 2017 (First term)
MARTIN, LEE	Chief Operating Officer	None	Appointed 1 August 2018
OLLIS, JANE	Non Executive Director	The Heating Hub **(1)** Board Member of the Kent Surrey Sussex Academic Health Science Network (AHSN) **(1)** Director of MindSpire **(1)** Non Executive Director of Community Energy South **(1)** Vice President of the British Red Cross in Kent **(4)**	8 May 2017 (First term)
PALMER, KEITH	Non Executive Director	Non Executive Director of EKMS **(1)** Non Executive Director of 2Gether Support Solutions **(1)** Managing Director of Silverfox Consultancy Ltd **(1)** Sole shareholder of Silverfox Consultancy Ltd **(3)** (Silverfox Consultancy Ltd no longer trading – closure notice process commenced with Companies House)	1 January 2017 (First term)
REYNOLDS, SEAN	Non Executive Director	Trustee of Building Heroes **(1)** Interim Chair of EKMS **(1)**	20 August 2018 (First term)

REGISTER OF DIRECTOR INTERESTS – 2019/2020 FROM MAY 2019

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	None	Appointed January 2004
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)** Trustee of Epilepsy Society **(4)**	1 March 2018
STEVENS, PAUL	Medical Director	CQC Adviser **(4)** NICE Chair, Chair of the Kidney Disease Guideline and Quality Standards Groups **(4)** Executive Member of Kidney Disease Improving Global Outcomes **(4)** Non Executive Director of Beautiful Information Limited **(1)**	Appointed June 2013
WILDING, BARRY	Senior Independent Director	Trustee of CXK, a Charity in Ashford inspiring people to thrive **(4 & 5)**	11 May 2015 (Second term)

REGISTER OF DIRECTOR INTERESTS – 2019/2020 FROM MAY 2019

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

The Trust has a number of subsidiaries and has nominated individuals as their 'Directors' in line with the subsidiary and associated companies articles of association and shareholder agreements

2gether Support Solutions Limited:
Keith Palmer – Non-Executive Director in common
Alison Fox – Nominated Company Secretary

East Kent Medical Services Limited:
Keith Palmer – Non-Executive Director in common
Nic Goodger – Nominated Director
Heather Munro – Nominated Director
Alison Fox – Nominated Company Secretary

Healthex Limited:
Elisa Llewellyn – Nominated Director
Bernard Pope – Nominated Director
Alison Fox – Nominated Company Secretary

Beautiful Information Limited:
Philip Cave, Nominated Director
Paul Stevens, Nominated Director
Alison Fox, Nominated Company Secretary

Categories:

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

UNCONFIRMED MINUTES OF THE NINETY-THIRD MEETING OF THE BOARD OF DIRECTORS THURSDAY 6 JUNE 2019 AT 09:45 AM BOARD ROOM, WILLIAM HARVEY HOSPITAL, ASHFORD

PRESENT:

Ms Jane Ollis	Acting Chair	JO
Mr S Adeusi	Non-Executive Director	SA
Mrs A Ashman	Acting Director of Human Resources	AA
Mr P Cave	Director of Finance and Performance	PC
Mrs W Cookson	Non-Executive Director	WC
Ms A Hallums	Interim Chief Nurse & Director of Quality	AH
Mr N Mansley	Non-Executive Director	NM
Mr L Martin	Chief Operating Officer	LM
Mr S Reynolds	Non-Executive Director	SRe
Ms L Shutler	Director of Strategic Development and Capital Planning/ Deputy Chief Executive	LS
Dr P Stevens	Medical Director	PS
Mr B Wilding	Non-Executive Director	BW

IN ATTENDANCE:

Miss C Betts	Patient relative (for minute number 19/41)	CB
Dr P Brighton	Frailty Consultant/Harmonia Dementia Lead (for minute number 19/49)	PB
Ms J Christmas	Deputy Chief Nurse & Deputy Director of Quality (for minute number 19/41)	JC
Mrs A Fox	Trust Secretary	AF
Ms C Judge	Interim Matron (for minute number 19/41)	CJ
Miss S Robson	Board Support Secretary	SR
Dr J Seeley	Geriatric Medicine Registrar (for minute number 19/49)	JS
Mrs N Yost	Director of Communications and Engagement	NY

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Dr J East
Ms G Gordon
Mrs C Heggie
Mr J Ransley

MINUTE NO.		ACTION
19/34	**CHAIRMAN'S WELCOME**	

The Chair welcomed attendees to the meeting. Noting the celebrations taking place regarding the 75th anniversary of the D-Day landings and that SRe would be attending an event that day representing the Royal Air Force (RAF).

AH extended condolences on behalf of the Trust and the Board in relation to the sad news of the death of an EKHUFT member of staff, Christine Pettit, who had been taken ill suddenly a few week's previous. This staff member worked as a Senior Nurse at Queen Elizabeth the Queen Mother Hospital (QEQMH) for over 30 years and acknowledged her contribution, hard work, support and commitment to the NHS and the Trust. She had been a very popular and valued member of staff and would be sadly missed. Her funeral was being held that day and staff had put themselves forward to work on their day off to cover the Fordwich Ward, allowing the ward staff to attend her funeral.

CHAIR'S INITIALS ……

ACTION: Extend thanks on behalf of the Board and the Trust to the staff that worked on their day off to cover the Fordwich Ward at Queen Elizabeth the Queen Mother Hospital (QEQMH). Allowing the ward staff to attend the funeral of their colleague. AH

19/35 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Professor Stephen Smith (StS), Chair.

19/36 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

19/37 **MINUTES OF THE PREVIOUS MEETING HELD ON 9 MAY 2019**

SA raised that he had been present at the previous meeting as was SAc and they were not noted as being present in the minutes.

PS highlighted an amendment at the bottom of page 5 within minute number 19/25 – Medical Director's Mortality Report within the penultimate sentence. The accurate wording should read '18% where the primary diagnosis was not sepsis'.

The Chair noted incorrect names referenced on pages 11 and 12 within minute number 19/33 – Questions from the public. The first three questions should be recorded from Ms Gordon and the fourth question from Mrs Heggie.

DECISION: The Board **APPROVED** the minutes of the previous meeting held on 9 May 2019 as an accurate record with the amendments detailed above.

19/38 **MATTERS ARISING FROM THE MINUTES ON 9 MAY 2019**

Action B/009/19 – Integrated Performance Report. The Board noted that this was work in progress and an update would be provided at the July Board meeting.

DECISION: The Board discussed and noted the updates provided, those for future Board meetings and **APPROVED** the actions for closure.

19/39 **CHAIR'S REPORT**

The Chair commented that a positive and productive meeting had been held with the Council of Governors, and acknowledged the valuable contribution from the Governors. It was noted that there were currently two Governor vacancies and elections would be held for these roles shortly. A number of planned membership engagement events had been scheduled as well as the development of improving the flow of communications regarding what was happening within the Trust and also around gathering information and being a voice from the local communities. The Council would be discussing in greater depth at their August meeting an analysis of the results of the annual Council and Council Committees effectiveness review. There would also be focus on the indicators that the Council would be looking at for the year ahead.

The Chair reported that she had attended the cremation along with a number of EKHUFT colleagues of Mr John Smith. Acknowledging he had been a remarkable man and had lived a very full and enriched life.

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

19/40 **CHIEF EXECUTIVE'S REPORT**

SAc commented on the National campaigns and awareness regarding Mental Health day and Dementia week in May. At a recent Chief Executive's and Chair's meeting, the Chief Executive of the Kent and Medway NHS and Social Care Partnership Trust (KMPT) had discussed a more collaborative programme of work for mental health. The Trust had in place mental health liaison teams at QEQMH with the provision of 24/7 support, and also at William Harvey Hospital (WHH) that was currently not supported 24/7 but work was on-going to extend this support. She had recently visited the team at WHH to hear about the work they were doing and also to discuss their aspirations for future work, particularly in relation to providing training to EKHUFT staff around supporting them in managing patients with mental health and challenging behaviours. This team had been involved in the training of the eight Healthcare Assistants in the Emergency Departments (EDs), appointed to support patients with mental health that presented at the EDs. This is part of the Trust's approach around improving mental health services, ensuring appropriate support for patients and developing the range of skills required in the hospitals to meet patient needs as well as the management of the complexities that some patients present with.

LM reported that a mental health work programme had been developed for the year, identifying five key areas for priority, particularly around increasing support in the community services to enable patients to be supported and managed within the community.

SAc had visited the three wards in QEQMH, WHH and the Kent and Canterbury (K&CH) that care for people living with dementia. In relation to the work being done by the dementia team and promoting Dementia week. She had been impressed with the work of the staff, particularly on Invicta Ward at K&CH, who were really patient focussed. Wherever possible staff normalised care and had put arrangements in place for students from a local beauty college to provide treatments for patients. Supporting a homely environment where patients felt personally looked after and promoted awareness within the community. She also visited Harmonia (Dementia Village) in Dover. It was noted that throughout the Trust it recognised the National connection between the forget-me-not flower with those living with dementia, ensuring awareness and staff were attentive to the specific needs of these patients. The Human Factors training provided throughout the Trust covered dementia, learning disabilities and vulnerable adults.

AH stated that the Trust would be including Dementia training as a mandatory requirement for staff. Mental health training within the ED had now been incorporated in the induction training for all staff. The Trust was also looking at identifying staff interested in becoming mental health first aiders.

SRe raised the benefit of Board members receiving mental health training.

PS reported that he had raised and continued to raise the need for psychological counselling with the Clinical Commissioning Groups (CCGs). A programme of work was in place around improving psychological support for patients discharged from

Intensive Therapy Unit (ITU) as well as their relatives and carers, and also support to parents who had lost children through a neonatal death.

The Board noted that SAc and PC had recently met with NHS Improvement (NHSI) around engaging with the new team, discussions included the Trust's capital requirements and the investment needs. In particular focussing on the business cases put forward in relation to the estate, backlog maintenance and infrastructure. NHSI took on board the issues presented emphasising that capital funding provision was limited.

In relation to the Sustainability and Transformational Partnership (STP) work continued around developing arrangements for working as an integrated care partnership. Current focus was around how the GPs, as providers would work as part of the provider network with the development of primary care networks (PCNs), in relation to primary care working collaboratively.

SAc and the Medical Director welcomed Dr Katherine Henderson, President Elect from The Royal College of Emergency Medicine to the QEQMH on International Emergency Medicine Day (27 May 2019). She had met with ED staff to understand the pressures faced on a day to day basis. It was noted that there were currently discussions Nationally around whether the Accident & Emergency (A&E) targets should be changed, which Dr Henderson was involved with.

In response to a question raised by WC regarding whether feedback had been received following the ED visit. SAc reported that feedback had been received that day, noting the collaborative work with the provision of GP support, issues around patient flow and congestion, concern raised regarding the total time patients were in the ED whilst waiting to see a physician and the delays in waiting for a decision from a physician to admit to hospital and the management of this.

ACTION: Arrange for the Board to receive Mental Health training. AA

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

19/41 **PATIENT EXPERIENCE STORY**

CB tabled photos of her father to Board members for them to visualise the patient described in this experience story. She explained the experience that she and her father went through and gave an overview of her father's character. They had a close relationship and had great communication, she emphasised that communication was a key element for everyone whether being verbal or non-verbal. She highlighted that the communication element broke down within the care package for some elderly patients when in hospital, and on occasions was forgotten, overlooked and sometimes even disregarded. This was the main element within this story and the complaint submitted.

CB stated that the results of a CT scan were not discussed with her father, his family or outside agencies as soon as these were available, which resulted in poor discharge decision and inadequate care provided when discharged, around occupational therapy support and assessing the home environment and whether her father was able to look after himself. The family would have made a different decision for discharge if they had been notified. She explained the treatment her father received and the lack of information given to her father or his family.

CB explained the inappropriateness when they were advised of the cancer diagnosis by a registrar who did not give due attention to her father or his family, and the importance that this news be delivered in a considered and compassionate way. There had also been an incident of discussions in an inappropriate environment with Faversham Cottage Hospital (FCH) regarding a Do Not Resuscitate (DNR) directive. Her father had had a lengthy delay waiting to be re-admitted to K&CH from (FCH) of 14 hours. They also experienced long waits in A&E with lack of provisions for patients, e.g. food and drink, as well as transfers to other wards in the hospitals that were undertaken after mid-night.

The Chair thanked CB for attending the Board meeting and extended apologies for their negative experience and that the care received had not been at the standard that it should have been. The Board acknowledged the need to ensure improvements in communications with patients and carers.

PS reiterated the Trust's responsibility ensuring that all the points raised by CB were addressed to ensure that no other patient had the same experience. He acknowledged the importance of improving communication, particularly in relation to 'checking and understanding' around making sure people understood their diagnosis and took this on board, were made aware of the investigations that would be undertaken and the actions on receipt of results, as well as keeping the patient regularly updated.

AH reported that the Trust was developing training around breaking bad news. The structure of the discharge team had been changed to ensure an improved and much smoother process for patient discharges. As well as ensuring that discussions regarding discharging patients took place as early as possible.

AH confirmed that lessons had been learnt, the findings from this complaint had been shared with the ward staff, the discharge team and the staff in urgent and emergency care. A process had been identified flagging frail patients, end of life patients or patients with on-going investigations to be promptly transferred from ED to the observations wards or the hot floor Acute Medical Unit (AMU). JC explained that the Trust was exploring the possibility of a video being development for staff training purposes. There was also engagement with EKHUFT's Patient Involvement Group.

WC commented that this had been multi-disciplinary, multi-agency and multi-pathway. It was important that the Board be kept informed of the action put in place around the identified themes for communication, to be assured that changes had been put in place and that these issues had been addressed. The Board acknowledged the importance of good communication and listening to patients and their families.

SAc emphasised the importance that complaints that were multi-agency were shared with partners around implementing improvements and sharing lessons learnt. Also that staff were focussed on being attentive to the needs of patients and that the appropriate procedures were followed, e.g. receiving the cancer diagnosis by an appropriate senior clinician in the presence of a specialist nurse.

ACTION: Provide a verbal update to the Board in September on the progress of the actions taken forward across all the clinical specialities. Around the lessons — AH

learnt from the Mr B Patient Experience Story (End of Life), in relation to improving communications with patients and their families.

The Board discussed and **NOTED** the Patient Experience Story report, the key themes and actions.

19/42 **QUALITY PRIORITIES:**

- **MEDICAL DIRECTOR'S REPORT**
- **CHIEF NURSE AND DIRECTOR OF QUALITY REPORT**

The Chair introduced these reports that were around the key metrics regarding patient safety for the Board to review and discuss.

PS reported that the reports presented detailed a breakdown of incidents reported on three key quality areas of focus for the Trust to improve that were linked to the Trust's strategic objective 'Getting to Good'. These were in relation to medicines management; identification, treatment and support of patients at high risk of deterioration; and inpatient falls. Looking at key themes and the aimed objectives along with the actions to address this.

WC highlighted that the Trust was below the National average in relation to harm related to medicine management incidents and whether there were any trends around specific medications or wards where the Trust was focussing its improvement actions. PS confirmed that there were specific actions around medication e.g. related to insulin, some of which had been completed and others on-going. Electronic prescribing would have a significant positive benefit and this was due to be implemented later in the year.

PS responded to a question raised by WC regarding the management of deteriorating patients and assurance of adherence to Vital Pac protocols across EKHUFT. He confirmed that audits were regularly undertaken in relation to observations on Vital Pac, new scores and actions taken as a result of new scores and that these protocols were being adhered to. AH reported that Vital Pac would be introduced within the Children's services (in Children's ED and in the Children's wards) within the next few months.

AH stated that in relation to the report regarding falls around improving the falls rate for 2019/20, noting that the overall rate across the inpatient sites for the previous year was 5.05 falls per 1000 occupied bed days compared with 5.34 the year before. There had been an increase in falls at K&CH and this was an area of focussed work, acknowledging that patients were frail and elderly. Compliance against the falls risk assessment was currently 85% and she expected this to be improved with the aim to achieve around 90% and above.

AH commented that the Trust would continue to work to achieve the Commissioning for Quality and Innovation (CQUIN) standard for falls and actions had been identified and being taken forward as detailed in the report. This would be supported by having in place a multi-disciplinary team approach to falls that was nurse led with nursing focus. The work of the Falls Steering Group would be reviewed along with their Terms of Reference (ToR). The Trust also took part in the National Audit of Inpatient Falls (NAIF) around reviewing risk assessments, the provision of immediate care and these being graded of the level of harm. A deep

dive would be undertaken to identify the areas to be targeted to support a reduction in the number of falls.

SAc reported that these would be monitored by the Quality Committee (QC) around progress against these priorities and the associated metrics, providing assurance of the required focussed work with agreed actions and milestones, the improvements being made and the impact. Progress would also be provided as part of the quarterly report presented to the QC on the Board Assurance Framework (BAF) and Annual Priorities. Feedback from the QC would be provided in the QC Chair reports to the Board.

The Chair raised the suggested actions listed in the Medical Director's report and queried where these would be addressed and monitored. PS confirmed that these would be monitored by the Patient Safety Committee (PSC) and reported to the QC. He highlighted one of the actions with a resource implication regarding the provision of seven day clinical pharmacy services and a business case had been submitted for approval via the required governance structure.

PS commented on the National ReSPECT programme that was regarding the escalation of care programme that had been adopted by the majority of NHS organisations. This presented a potential resource implication as there was currently a block within the Community Trust who had their own escalation process, this was being addressed through the STP as well as raising with the trust's Medical Director.

The Board would receive a report at the next meeting on the Strategic Objectives 2019/20 covering; A great place to work; and Right skills, right time, right place.

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

19/43 **MEDICAL REVALIDATION REPORT**

The Board received a report providing an overview of the revalidation process around how doctors were regulated, aimed at improving the quality of care provided to patients and improving patient safety, as well as maintaining public confidence in the medical system. Providing assurance that clinicians in post providing care had the required skills and competencies. Annual appraisals were part of the five year revalidation and the Trust had in place a series of escalation processes associated with any failures to complete annual appraisals.

PS reported that the appraisal rate had dipped slightly but confirmed that the Trust's process was vigorous. He commented that where an appraisal had been completed but the appraisal output form had not been signed off, this was not accepted as a completed appraisal until the form was signed off. The Trust's performance was good compared to other trusts. It was noted that there might be valid reasons for non-completion in relation to maternity leave or sickness leave.

The Board noted the recommendations to the General Medical Council (GMC) as detailed in the report. PS explained that the responsibility was with the GMC for withdrawal of a licence for a doctor to practice and suspending the licence to practice. The Trust was able to restrict a doctor's practice and regularly reports regarding the restrictions would be provided to the Trust's Chief Executive.

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

19/44 **QUALITY COMMITTEE (QC) – CHAIR REPORT**

BW reported that the new format of the QC meetings continued to work well and at each meeting there was a focussed discussion on either three or four of the Care Group Quality and Risk reports rather than all seven.

WC raised the format in which the risk register report was currently presented to the QC, which was not reflective of the work being done around risk management throughout the Trust. It was noted that there had been significant work undertaken to revise the format of future reports and that this would be presented in August.

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

19/45 **CARE QUALITY COMMISSION (CQC) UPDATE**

AH confirmed that the report had been presented to the QC in May and provided an update on the current status of the paediatric improvement plan as well as the overall Trust's CQC improvement plan. The information within these plans had been updated to reflect the discussions at the meetings with the Care Groups and the Paediatric Taskforce. As a result of assurance around progress against the plans and the closure of actions.

AH explained that in relation to the actions that had not commenced, these were regarding the mock CQC inspection that took place with NHSI. The report following this inspection was received in March and as a result additional actions were put in place.

AH reported that monthly meetings were held with the Care Groups to monitor progress against the improvement plans. A reporting template had been developed that would be required to be completed in advance of these meetings to ensure these were productive and the appropriate assurance was received. These reports would be presented to the Getting to Good Steering Group that the Trust had recently set up. NM raised concern that a number of these Care Group meetings had been cancelled and emphasised the importance of these meetings taking place. AH confirmed that a strong message had been relayed that under no circumstances should these meetings be cancelled and it be escalated if there was a possibility of any cancellations. It had been acknowledged that it was important for meetings be scheduled avoiding any peak operational pressure periods.

AH stated that an End of Life (EoL) engagement visit took place on 22 May, positive informal feedback had been received from NHSI/NHS England (NHSE) who had been impressed with the presentations from the Cancer and the Clinical Support Services Care Groups. A number of suggested actions were identified from this visit. The improvement plans were complemented by the Trust carrying out CQC self-assessments and routine quality reviews.

It was noted that where evidence had not been received for an action previously marked complete, the action had been changed from complete to overdue. This had resulted in a high number of overdue actions (67%) and many of which reflected that evidence had not been received rather than actions that were

incomplete.

The Board noted that the CQC Insight report published on 23 April indicated the Trust's overall performance was stable. AH reported that she had seen steady improvements in performance over the last couple of months. This had been evident following an NHSI visit to the ED and Children's Services at QEQMH and the improvement was palatable.

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

19/46 **NOMINATIONS AND REMUNERATION COMMITTEE (NRC) - CHAIR REPORT**

WC reported that all the Non-Executive Directors, Chairman, Chief Executive and Director of HR attended these meetings.

The Board **NOTED** the NRC report.

19/47 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR REPORT**

- **FINANCE REPORT**

SA reported that financial performance in Month 1 had started well with regards to income and expenditure and was slightly better than plan of £100k. In relation to progress against the 2019/20 Cost Improvement Programme (CIP) target of £30m, a total of £18.7m projects had progressed to 'green' stage. This was slightly behind the plan at the same time the previous year and there needed to be focus around progressing projects that were amber or red to green.

It was noted that agency spend was being monitored by the FPC and a positive reduction in expenditure had been achieved. Assurance was received that on-going focus would be maintained to ensure continued reduction in agency usage and costs. The Board noted the importance of progressing the Trust's recruitment plan that was a key element in supporting the reduction of agency costs. AH confirmed that assurance was provided in the monthly safe staffing report presented.

The FPC recommended for Board approval the contract variations between the Trust and its wholly owned subsidiary 2gether Support Solutions (2gether) Limited regarding further service transfers into the Operated Healthcare Model and Estate Managed Service (EMS). These totalled £4,943,522 and were already included within the annual plans and budget.

NM queried what cost benefit there would be to the Trust in relation to this service transfer. PC confirmed the cost benefit was approximately £270k.

The Board noted that the FPC had approved the Operational Framework that was around having controls in place to manage performance across the Care Groups. Where focus was required to improve performance consideration would be made in relation to placing Care Groups into Internal Special Measures. This would ensure the provision of the necessary focussed support to achieve the required improvements.

DECISION: The Board discussed the FPC Chair Report and **APPROVED** the

Operated Health Care Facility (2gether) contract variation.

19/48 **CORPORATE REPORTING**

19/48.1 **INTEGRATED PERFORMANCE REPORT (IPR)**

SAc provided an overview of performance in April against the constitutional standards and access targets, performance was steady against the A&E 4 hour wait target. Improvement against the NHSI trajectory of 76.4% was not at the level expected and was 77.13%, representing a 1% decrease in performance compared to the previous month of 78.2%. This was mainly due to patient flow through the hospital.

In respect to the clinical standards the Clinical Directors had been asked to review and discuss this in relation to refocusing where the clinical standards should be, e.g. around the time for senior clinical review. It was hoped that this review would result in positive refinements in patient pathways and a positive impact on improving performance against the A&E 4 hour wait target. This would also support improvements in other areas as well as patient safety and focus on being attentive to individual patient needs. LM reported that the Trust had seen an increase in patients presenting to A&E of 6%, which was equating to approximately 17% admission increase. This was being reviewed to identify the reasons for this increase e.g. whether due to lack of capacity in being seen by local GPs or increase in elderly patients presenting.

SAc reported that with regards to performance against the 18 weeks referral to treatment (RTT) standard remained really good at 79.15% against the trajectory of 78.00%. The number of patients waiting over 52 weeks for treatment had reduced to 3. The reported waiting list size was 45,867 and the overall backlog position had reduced to 9,564, the Trust was working hard to continue to reduce this backlog. LM highlighted the improvement regarding the time to first new out-patient appointment, which a year ago had been up to 42 weeks with a total number of patients on the waiting list of 54,000, this had now reduced to approximately 46,000. There was an out-patient strategy and steady progress was being maintained, it was anticipated that in the next 10 weeks this would be further reduced to 12 weeks across all specialities.

SAc stated that against the cancer 62 day GP RTT standard performance was poor at 78.78% against the improvement trajectory of 85.52%. The standard had been met against the 6 week referral to diagnostic with a compliance of 99.29%. There had been issues within diagnostics due to the breakdown of an MRI scanner and also a CT scanner, as a result achievement of compliance had been challenging. LM highlighted that as a result of these breakdowns approximately 250 patients had been displaced from their appointments. The radiology staff had worked extremely hard to ensure these patients received timely care and that the diagnostic standards were achieved. He extended thanks to all the radiology staff. He emphasised that staff had worked extremely hard to improve performance against the cancer standards.

LM reported that a deep dive had been undertaken within Urology and the outcome report had been very postivie around the changes implemented and the improvements.

KP raised the issue regarding patient experience and patient safety performance,

which had dropped and queried whether this could be identified to any specific areas. SAc commented that with regards to the complaints received the issues were linked to congestion and patient flow, particularly within A&E. AH stated that common themes had been identified in specific wards in relation to falls and pressure ulcers (PUs), and these were being addressed directly with those wards.

WC raised that falls was a key quality priority area of required improvement and had concern regarding the decrease in performance in the month. AH stated that there was a link with staffing regarding where there were higher numbers of temporary staff and action was being taken to ensure a better balance around the provision of substantive and temporary staff. SAc commented that the number of Delayed Transfers of Care (DToC) had doubled since December that was having a negative impact on patient flow, the Trust was aware of the reasons for this and these were being addressed. The number of DToCs was likely to be the main reason for the increase in falls, as ward staff were encouraging patients to get out of bed to maintain mobility. It was also challenging for the ward staff around managing these patients who were not acutely ill and were waiting to be discharged to the community. LM commented that it was being looked at for the Heads of Nursing to undertake a review of these patients to identify whether there had been any experience of potential harm.

WC highlighted that there had been a significant increase in sickness absence. AA confirmed that a deep dive had been undertaken within the Care Groups that had identified a large number of incidents of coughs, colds and flu symptoms within staff that worked in the clinical areas who were unable to report to work. The HR Business Partners (HRBPs) were currently reviewing the information from this deep dive to identify whether there were any systematic issues that needed to be addressed.

NM raised the cancer access standards and provided an example of a case that he had been made aware of regarding a single mother that had been referred for a cancer diagnosis. She had waited over five weeks with no progress, this resulted in her GP making a referral to The Royal Marsden Hospital and within a few weeks had been seen and received treatment. She had been distressed with the delay in being seen and receiving treatment as well as lack of communication regarding progress with her referral. LM stated that it would be beneficial to be made aware whether this referral had been on the appropriate pathway for cancer patients and further information regarding the GP so that this case could be investigated. He confirmed that all cancer referrals from GPs were now electronic ensuring these were dealt with promptly and that within the last four months all patients referred on a cancer pathway had been given an appointment within 48 hours.

SRe reported a positive patient story regarding a cancer referral confirming that an e-mail had been received within 48 hours, a consultant appointment within 10 days and surgery within three weeks.

PC reported that achieving the Trust's CIP was a key expenditure area that needed to be delivered and currently £19m schemes were green, £6.7m were amber and the majority of these were close to being green. Fortnightly check and challenge meetings continued to be held with the Care Groups to maintain focus on progressing CIP projects and identifying potential projects. Progress was monitored through the monthly Executive Performance Review meetings with each of the Care Groups.

BW highlighted an anomaly regarding the HR metrics in relation to statutory training data that showed over 100%, which needed to be looked into and also to understand the validation process. AA reported that she had raised this issue and this had been incorrect, the IPR had since been revised to reflect the current position of 95.8%.

ACTION: Review and identify whether the incidents and issues (e.g. around falls, pressure ulcers) relate to the cohort of non-acutely ill patients in hospital that had been assessed as fit to be discharged to the community. AH

ACTION: Following an anomaly identified regarding the HR metrics in relation to statutory training data showing over 100%. Ensure a review is undertaken of the validating process for populating the IPR for all the metrics. Provide assurance to the Board that appropriate validation had taken place. PC

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

19/48.2 **FULL CORPORATE RISK REPORT AND DEEP DIVE REVIEW OF CRR 65**

AH stated that there had been discussions at the May QC meeting regarding a further deep dive into CRR 28 - Lack of timely recognition of serious illness in patients presenting to the EDs. It was agreed that a deep dive report on this risk would be presented to the next meeting at the end of June.

AH confirmed that the report presented to the Board included the deep dive into the risk CRR 65 - Risk of prosecution by the CQC for a breach of parts 20(2)(a) and 20(3) of the Duty of Candour (DoC) regulation without first serving a Warning Notice. The Trust identified this risk in February 2018 as there had been concerns regarding poor and inconsistent Trust-wide compliance with DoC. It was noted that the CQC could levy a fine and it was also a criminal offence for non-compliance against the DoC regulations. In January 2019 Bradford Teaching Hospitals NHS Foundation Trust had been issued with the first fine from the CQC under these regulations.

AH explained that at the time of this risk being identified the Trust's performance had been poor with compliance at 37% for the initial letter and 20% for the investigation findings letter. Compliance against this was formally monitored and reported through the quarterly Patient Experience and Claims report presented to the Patient Safety Committee (PSC) and QC. Following identification of this risk a number of mitigating actions were put in place as detailed in the report, which included training, policies and processes updated. A DoC guardian was appointed to oversee compliance and progress against the individual Care Group action plans.

AH reported that the Trust's Internal Auditors recently undertook an audit on compliance, this reported a positive outcome as compliance had improved significantly. This identified compliance with the initial letter was now at 91% and 75% for the investigation findings letter. Two Care Groups were underperforming and focussed work was needed to improve their compliance to meet the Trust's expectations.

AH stated that a DoC report was presented and discussed at the PSC meeting held the previous day. It was agreed that DoC compliance would be monitored on a weekly basis, and this would be via the weekly Serious Incident (SI) review

meeting. This would ensure focussed monitoring to support a continued improvement of compliance with the aim to achieve 100%.

The Board noted that the Trust had in place appropriate policies and procedures and emphasised the importance that these were followed and adhered to by staff. Around promoting staff awareness and staff training.

PS commented that DoC training was provided as part of the Clinical Leads Development Programme, this was also covered within the Trust's Induction programme.

ACTION: Provide the Board members with the link on the Trust's internal website to view the presentation regarding Duty of Candour (DoC). Provided as part of the Clinical Leads Development Programme, the Trust's Induction programme and used across all Care Groups for staff training in relation to DoC. PS

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

19/49 **HARMONIA (DEMENTIA VILLAGE) UPDATE**

The Chair noted that the report updated the Board on the strategic view of how the Trust supported people with dementia around the vision for this future development in providing a rich environment for people to live healthy and happy lives.

PB explained that with planning to manage the potential expected high and increasing population of people living with dementia (PLWD), a number of staff representatives from the Trust visited a number of healthcare providers in Belgium and Holland. This was around studying their approach to the care of PLWD around lessons learnt and what could be implemented by the Trust. One of these facilities was a purpose built dementia village and a key aspect was the importance of PLWD having an environment that was homely with community provisions around a café and restaurant areas.

PB stated that following the visit a site was identified behind the Buckland Hospital in Dover, housing that was owned by the Trust for this development. The Trust submitted a bid for the CASCADE project to the European Interreg 2 Seas[1] fund, who would be providing 60% of the project funding, and 40% provided by project partners. The project officially commenced on 7 April 2017 and would run for four years. This development was around the CASCADE model that focussed on key elements e.g. home is best, person centred care, de-stigmatisation of dementia as a condition, education of patients, carers, public and staff, and how to support people to live life to the full.

PB reported that the development would comprise six five bedroom properties, in addition to the bedroom and bathroom facilities, there would be the provision of a living area, and kitchen dining area along with a lift. The focus of the model of care would be around the provision of normality and person centred care, reducing the risk of escalating behaviours, and providing wellness within a healthcare setting. This model would also include the use of monitoring technology around the individual's care needs, learning what were the normal requirements for each individual and providing a trigger when there was something outside the norm. This would prompt a clinical review aimed at reducing any risks of health

[1] https://www.interreg2seas.eu/en/CASCADE

escalation. This development was around integration within the community and would include services for the public to visit with the provision of a community hub with a café. Aimed at encouraging and supporting positive relationships to enhance the lives of PLWD. Along with multi-purpose training rooms for use by residents and the public. The upper level of the development would provide six guest houses, allowing partners and families to stay with their loved ones. The Board were shown photos of what the developed site would look like on completion.

PB stated that the model would be provided as a dementia nursing care model, staffed 24/7 with PLWD living in their own individual homes. The drive for this development was to provide excellent care within an affordable service to local people and the local authorities. The first house would be completed within the next few weeks and would enable testing of the facility, the environment and the technology with service users. It was anticipated that the site would be handed over in August with the aim to open in the Autumn.

JS commented that the network and system surrounding PLWD was complex and involved numerous organisations from NHS, social care and the voluntary sector. This provided challenges to PLWD, a World Café event was held (a system wide workshop), to understand the experiences of PLWD and their carers and all sectors of care, social care and charities. This identified a mandate for an integrated model of care and key areas to focus on.

NM provided an example of the positive impact on PLWD with having the provision of care whilst being able to remain living in their own home environment.

PC enquired regarding progress to recruit staff and patients who wished to take up accommodation in the development. Recruitment to the Manager role of Harmonia was in progress and interviews would take place in the next couple of weeks. Once an appointment was made the CQC registration process could be commenced to register Harmonia as a separate entity as a care home. On-going funding would be provided by the clients of Harmonia.

The Board extended thanks to all the staff involved in developing this project, acknowledging their hard work and commitment in taking this forward.

The Chair expressed interest in providing the opportunity to the Board members and Governors to visit the site and the development later on in the year.

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

19/50 **ANY OTHER BUSINESS**

There were no other items of business raised for discussion.

19/51 **QUESTIONS FROM THE PUBLIC**

Mrs Heggie enquired about the reference made with regards to 2gether taking over the module theatres. PC explained that this was regarding the two module theatres at the K&CH and that this was a contractual relationship in relation to 2gether running this facility around the maintenance of these facilities, e.g. cleaning. The Trust would remain operations of the internal functions within the theatres.

Mrs Heggie highlighted the patient story and emphasised an on-going issue regarding patient discharges and lack of communication. She accepted the challenges around liaising with numerous partners and reliance on transport being available. She highlighted that the patient story presented had been on-going since 2017 and raised concern that there had been no improvement. She emphasised the importance of ensuring the right processes were in place and the importance that there be improvement within this area. She raised an example of a similar patient experience and the negative impact on patients. The Chair confirmed that the Board was sighted of these issues and that these were being addressed and changes were being implemented.

Ms Gordon asked a question regarding the Chief Executive's report regarding the A&E 4 hour waiting time target and the comment that NHSI were looking at amending this measurable target around the total amount of time patients remained in A&E for treatment. In relation to measuring how the system was managing demand. SAc commented that at the current time it was felt that the 4 hour waiting time target did not fully reflect the issues and risks that patients were experiencing. Also that this did not reflect the patients that were being seen who had significant medical complexities and the increase in elderly patients presenting to A&E. Discussions were taking place centrally. Around looking at simple measures around the total time patients were in A&E and the time it took for them to be seen by a doctor. It would take a little time for new measures to be announced. It was likely that a couple of measures would be put in place, one around the total time spent in A&E.

Mrs Heggie raised the discussion regarding DoC and that in respect to staff disciplinary hearings that staff should have read and made themselves aware of the policies in place. SAc explained that professional members of staff had an individual responsibility to ensure that their training was up to date, and as an organisation EKHUFT had a responsibility for ensuring the provision of support and facilitating training and raising staff awareness.

The public were excluded from the remainder of the meeting due to the confidential nature of the business to be discussed.

The Chair closed the meeting at 12.45 pm.

Date of next meeting in public: Thursday 4 July 2019 in the Board Room, William Harvey Hospital, Ashford.

Signature _____

Date _____

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**MATTERS ARISING FROM THE MINUTES ON 6 JUNE 2019**
BOARD SPONSOR:	**CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: PUBLIC BoD ACTION LOG** **APPENDIX 2: ASSURANCE PROCESS FOR INTEGRATED PERFORMANCE REPORT (IPR)**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

The Board is asked to consider and approve the actions noted below for closure:

Action No.	Action	Target date	Action owner	Status	Progress Note (to include the date of the meeting the action was closed)
B/002/19	Continue to include in future reports the comparison in acute trust data regarding healthcare associated infection (HCAI) numbers and rates.	Jul-19	PS	to Close	Included in report presented to the July 2019 Board covering healthcare associated infections (HCAIs). **Action for agreement for closure at 4 July 2019 Board meeting.**
B/012/19	Extend thanks on behalf of the Board and the Trust to the staff that worked on their day off to cover the Fordwich Ward at Queen Elizabeth the Queen Mother Hospital (QEQMH). Allowing the ward staff to attend the funeral of their colleague.	Jul-19	AH	to Close	Thanks extended via e-mail to Senior Matrons and Matrons. **Action for agreement for closure at 4 July 2019 Board meeting.**

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B/015/19	Review and identify whether the incidents and issues (e.g. around falls, pressure ulcers) relate to the cohort of non-acutely ill patients in hospital that had been assessed as fit to be discharged to the community.	Jul-19	AH	to Close	Review does not demonstrate that this cohort of patients are at greater risk. **Action for agreement for closure at 4 July 2019 Board meeting.**
B/016/19	Following an anomaly identified regarding the HR metrics in relation to statutory training data showing over 100%. Ensure a review is undertaken of the validating process for populating the IPR for all the metrics. Provide assurance to the Board that appropriate validation had taken place.	Jul-19	PC	to Close	Briefing regarding Assurance Process for Integrated Performance Report attached to actions table (Appendix 1). **Action for agreement for closure at 4 July 2019 Board meeting.**

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B/017/19	Provide the Board members with the link on the Trust's internal website to view the presentation regarding Duty of Candour (DoC). Provided as part of the Clinical Leads Development Programme, the Trust's Induction programme and used across all Care Groups for staff training in relation to DoC.	Jul-19	PS	to Close	Link to the page on the Trust's internal website circulated to Board members along with a presentation provided to Trust staff regarding DoC. **Action for agreement for closure at 4 July 2019 Board meeting.**	

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The Board may lose sight of progress of key actions if the action list is not properly updated and maintained. The Trust Secretariat ensures there is an efficient process for maintaining the action list.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None

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SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the progress updates on open actions, and **APPROVE** the actions for closure as detailed above.

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Action No.	**Date of Meeting**	**Min No.**	**Item**	**Action**	**Target date**	**Action owner**	**Status**	**Progress Note (to include the date of the meeting the action was closed)**
B/002/19	04.04.19	19/008	Medical Director's Report	Continue to include in future reports the comparison in acute trust data regarding healthcare associated infection (HCAI) numbers and rates.	Sep-19	PS	to Close	Included in report presented to the July 2019 Board covering healthcare associated infections (HCAIs). **Action for agreement for closure at 4 July 2019 Board meeting.**
B/009/19	04.04.19	19/014.1	IPR	Review the Trust's process in relation to forecasting and how this is reported in the IPR, to identify whether any improvements can be made.	Jul-19	PC	Open	The financial forecast for finance is included in the Board Finance report and the key operational target forecasts are reviewed at the Finance and Performance Committee (FPC). However, the IPR does not include forecasts. This will be reviewed over Q1 2019/20 with a progress update in Q2, a forecast column can be added but will not be relevant for all metrics so key targets will be initially reviewed. Meeting being held on 28 June with the Head of Corporate Information and Assurance, Head of Information and Chief Operting Officer to discuss the metrics, forecast, narrative, to shape the IPR. Following this meeting a further meeting will be held on 8 July, which will include representation from Non-Executive Directors and the Trust Secretary to review the IPR.
B/012/19	06.06.19	19/034	Chairman's Welcome	Extend thanks on behalf of the Board and the Trust to the staff that worked on their day off to cover the Fordwich Ward at Queen Elizabeth the Queen Mother Hospital (QEQMH). Allowing the ward staff to attend the funeral of their colleague.	Jul-19	AH	to Close	Thanks extended via e-mail to Senior Matrons and Matrons. **Action for agreement for closure at 4 July 2019 Board meeting.**
B/013/19	06.06.19	19/040	Chief Executive's Report	Arrange for the Board to receive Mental Health training.	Aug-19	AA	Open	**Action for future Board meeting.**

B/014/19	06.06.19	19/041	Patient Experience Story	Provide a verbal update to the Board on the progress of the actions taken forward across all the clinical specialities. Around the lessons learnt from the Mr B Patient Experience Story (End of Life), in relation to improving communications with patients and their families.	Sep-19	AH	Open	**Action for future Board meeting.**
B/015/19	06.06.19	19/048.1	Integrated Performance Report (IPR)	Review and identify whether the incidents and issues (e.g. around falls, pressure ulcers) relate to the cohort of non-acutely ill patients in hospital that had been assessed as fit to be discharged to the community.	Jul-19	AH	to Close	Review does not demonstrate that this cohort of patients are at greater risk. **Action for agreement for closure at 4 July 2019 Board meeting.**
B/016/19	06.06.19	19/048.1	Integrated Performance Report (IPR)	Following an anomaly identified regarding the HR metrics in relation to statutory training data showing over 100%. Ensure a review is undertaken of the validating process for populating the IPR for all the metrics. Provide assurance to the Board that appropriate validation had taken place.	Jul-19	PC	to Close	Briefing regarding Assurance Process for Integrated Performance Report attached to actions table (Appendix 2). **Action for agreement for closure at 4 July 2019 Board meeting.**
B/017/19	06.06.19	19/048.2	Full Corporate Risk Report and Deep Dive Review of CRR 65	Provide the Board members with the link on the Trust's internal website to view the presentation regarding Duty of Candour (DoC). Provided as part of the Clinical Leads Development Programme, the Trust's Induction programme and used across all Care Groups for staff training in relation to DoC.	Jul-19	PS	to Close	Link to the page on the Trust's internal website circulated to Board members along with a presentation provided to Trust staff regarding DoC. **Action for agreement for closure at 4 July 2019 Board meeting.**

19/056 – Matters Arising Appendix 2

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**ASSURANCE PROCESS FOR INTEGRATED PERFORMANCE REPORT (IPR)**
BOARD SPONSOR:	**DIRECTOR OF FINANCE & PERFORMANCE MANAGEMENT**
PAPER AUTHOR:	**HEAD OF CORPORATE INFORMATION, DATA QUALITY & ASSURANCE**
PURPOSE:	**FOR INFORMATION**
APPENDICES:	**APPENDIX 1: IPR ASSURANCE FLOW DIAGRAM**

BACKGROUND AND EXECUTIVE SUMMARY

Following discussion at the Executive Management Team (EMT) and Board, it was requested that assurances were made as to the robustness and integrity of data presented within the Integrated Performance Report (IPR). Additionally, it was asked as to what validation process is undertaken prior to final release.

The purpose of this paper is to confirm the current process for assuring the correctness of data presented within the IPR, and to ensure that full assurance is in place.

Please see Appendix 1 below for the full Assurance Flow Diagram.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The risk of lack of assurance processes around the IPR is that data will be published incorrectly.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.**
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	N/A
RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	N/A
SUBSIDIARY IMPLICATIONS:	N/A

19/056 – Matters Arising Appendix 2

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to note the assurance process of the IPR.

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Appendix 1 – Integrated Performance Report (IPR) Assurance Flow Diagram

Integrated Performance Report (IPR) Assurance

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- Data collection
- Publish on Scorecard
- Sense check numbers reported in-line with expectations & question accuracy of data sourced via manual data

- Produce IPR packs and check variance against previous pack
- Note caveats and warnings in distribution email

- Investigate any known anomalies and fix
- Domain leads to check through pack and ensure their data is reflective of their service
- If issues, lead will report anomaly to get investigated.
- Commentary written by Leads

- Checks for commentary received, chase and full pack to be produced
- On production, pack to be checked again, ensuring any known issues are fixed and data reconciles with other reporting mechanisms
- Sense check of pack before final publication

- Distribute final IPR pack
- On-going work to ensure automation of data and assurance checks in place

Simon Bailey | Head of Corporate Information, Data Quality & Assurance

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East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**CHAIR'S REPORT**
BOARD SPONSOR:	**ACTING CHAIRMAN**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Introduction

The purpose of this report is to:

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

Key Events:

1. Acting Chairman

1.1 In my capacity as the Deputy Chairman, in the absence of the Chairman having a surgical procedure and his planned sickness absence. I have provided Acting Chairman cover over the last two months, I am pleased to report that his recovery has gone well and Stephen Smith, Chairman, will be returning the week following the July Board meeting.

2. Donation by the League of Friends of an Operating Microscope at Kent & Canterbury Hospital (K&CH)

2.1 Thanks to a generous donation by the Hospital's League of Friends, a new state-of-the-art operating microscope has been purchased. This will allow ear, nose and throat (ENT) surgical teams at K&CH to carry out operations in the inner ear instead of having to send patients to William Harvey Hospital (WHH).

2.2 This microscope allows surgeons to operate accurately inside the ear, maximising precision and minimising invasion into the ear canal. Also enabling the surgical teams to work to the highest standards for the Trust's patients.

2.3 I would like to take this opportunity to extend thanks to all of our Hospital League of Friends and members for their continued tireless hard work in raising funds that is much appreciated.

Key Visits undertaken during the month of June

3. Maternity Services at William Harvey Hospital (WHH)

3.1 I visited our Maternity Services at WHH with the Head of Midwifery & Nursing, whose highly professional and caring team do an amazing job supporting mother's and safe delivery of over 7,000 babies each year across the Trust. I saw the newly re-furbished Padua Ward, the Delivery Suite and also reviewed the Perinatal Mortality Review Tool and took assurance around the standardised high quality reviews that are undertaken to understand why a baby has died and whether there are any lessons to learn to save future lives.

4. Clinical Coding

4.1 I met with the Head of Clinical Coding and the Clinical Coding Manager at the WHH to gain an appreciation of the complex process that sits behind the clinical coding of every patient episode. The Clinical Coding Manager provided an overview of the coding process and I was deeply impressed with the care and attention to the depth of coding and challenges in dealing with the volume of work (last year we processed on average 230,000 episodes which equates to approximately 10,900 episodes per Whole Time Equivalent (WTE) coding analyst per annum), scrutinising the clinical documentation for co-morbidities and other relevant health related and social factors.

5. Radiology

5.1 I also attended an exciting evening with our radiologists led by the Clinical Support Services (CSS) Clinical Director and CSS Operations Director from Allied Health Services, exploring opportunities for artificial intelligence to support work flow and image recognition, to ensure patients get timely interpretation of their images, work flow processes are efficient and our team can manage the increasing demand for their services (10% per annum) in light of a national shortage of radiologists. During 2018/19 radiology completed a total of 600,000 examinations, broken down as noted below:

5.1.1 CT – 85,000;
5.1.2 MRI – 85,000;
5.1.3 Ultrasound – 99,000;
5.1.4 Plain film x-ray – 300,000.

Council of Governors Update:

6. Council of Governors Elections

6.1 The elections for public governors to represent the Ashford, Dover, Folkestone & Hythe, Thanet and Canterbury constituencies, as well as two staff governor vacancies, will commence on 24 July when the Notice of Elections will be published. The process will conclude on 19 September with the Declaration of Results. Two newly elected public governors will commence in post immediately as they are filling existing vacancies in Ashford and Folkestone & Hythe; the remainder will start their term of office on 1 March 2020.

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7. Joint site visits

7.1 One visit took place on 10 June at the K&CH. The team visited the Speech and Language Department, Rheumatology, the Elective Orthopaedic Centre, Neurosciences and both the Colposcopy and Age Related Macular Degeneration outpatient clinics. The enthusiasm shown by all the teams visited was inspiring and their passion for the services they deliver clearly evident. Staffing challenges were mentioned by several of the teams, along with their determination to resolve these. The Speech and Language Therapy staff in particular were very pleased with the service developments they had been able to make now that the staffing was at full strength.

8. Council Engagement with members and the public

8.1 A group of three governors held a 'Meet the Governor' session at the Queen Elizabeth the Queen Mother Hospital (QEQMH) on 18 June and spoke to over 20 people. A lot of the feedback was positive, although two people raised concerns about end of life care and they were assisted to take these to the Trust's Patient Experience Team to be addressed. The Governors also received a number of questions about the Stroke Care plans.

The next round of the evening Members Meetings take place in July with sessions on Paediatrics at WHH and QEQMH and Urology at K&CH. These sessions are well worth attending and details can be found on the website.

Non-Executive Directors' Commitments:

A brief outline of the Non-Executive Directors' commitments are noted below:

Non-Executive Directors	13 June – Interview Panel Member for the appointment of a Finance Director, 2gether Support Solutions (2gether) 21 June - Interview Panel Member for the appointment of a Non-Executive Director (Finance), 2gether

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.

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LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	None
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the report.

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19/058

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**BUSINESS SUPPORT OFFICER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: LATEST PUBLICATIONS AND RESOURCES**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month's report covers the following:

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

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks around Emergency Department (ED), Financial Recovery are covered in more detail elsewhere on the Board agenda.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	ED, Financial Recovery, Clinical Strategy all link to the strategic risk register.
RESOURCE IMPLICATIONS	None

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COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDARY IMPLICATIONS	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the report.

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Chief Executive Report

CEO Activity and Events

System Transformation Partnership (STP) Development

The Kent and Medway STP will develop into the heralded Integrated Care System (ICS) and develop this direction with all willing partners ahead of any primary legislation. Related development and implementation of integrated care partnership (ICP) as well as Primary Care Networks (PCN) has also commenced. Further detail is in the Board papers today.

During the first quarter of 2019/20 the Trust and Clinical Commissioning Groups (CCGs) have been developing working relationships to improve the finances and healthcare delivery on a system basis. To enable this to happen it is proposed that the concept of the aligned incentive contract which the Trust signed in April is extended for a period of five years and that there is a merger over the next year of the Programme Management Offices. These two actions will allow both parties to focus on improving healthcare pathways with neither party being adversely affected by the financial impact of the change. The Director of Finance and Performance has a more detailed paper explaining for the Board.

NHS Confederation 2019

I attended the NHS confederation 2019 annual event and was asked to present on 2 panels, mainly focused around primary and secondary care working together, with the Queen Elizabeth the Queen Mother Hospital (QEQMH) and the Acute Response Team (ART) in Thanet as the point of reference; and preparation for the EU exit which I did with Professor Keith Willet.

The NHS Interim People Plan was well received and there was great encouragement given the profile it has via Baroness Harding. There was a strong steer towards greater inclusion and the value on our Black Minority Ethnic (BME) workforce. We were also encouraged to use Associated Non-Executive Directors (NEDs) to help and support in this regard.

There were deep concerns regarding the availability of capital and the profiling of the 5 year settlement.

NHS Employers Policy Board, of which I am a member, occurred the day before Confederation. This included a positive update on the British Medical Association (BMA) and NHS Employers agreement for the Junior Doctors contract dispute, since then the offer has been accepted.

We also spent some time on the concerns related to pensions and how doctors in particular are being affected. However, other long serving and senior staff will also be impacted negatively. Many Trusts are now being seriously affected by senior doctors retiring or reducing their commitment to additional sessions.

Nuffield Event

The Executive Team from the Trust and Clinical Commissioning Group (CCG), hosted colleagues from the Nuffield in which Dr Louella Vaughan and Nigel Edwards discussed their research and examples of providing acute medical care in more isolated and distant hospitals. Their recent report recognises that smaller hospitals serve a million patients daily

but are facing increasing challenges in delivering effective acute medical services in the context of growing patient numbers, an increasingly complex mix of cases arriving for care, workforce shortages, changing societal expectations and severe restrictions in funding growth.

Neonatal Nutrition Seminar

I was invited to open the annual Neonatal and Paediatric Seminar which this year was focused around nutrition. Medical, nursing and therapy staff had the benefit of expert external presentations as well as internal examples of exceptional working.

Gastro Team Development Event

I was delighted to be asked to open this event which was focused on gastroenterology and endoscopy clinical teams developing their relationships and team work. Discussions included the issues and challenges of delivery of educational and quality standards within the teams.

Radiology Departmental Digital Discovery

The acting Chairman and some of the Executives joined colleagues from the radiology department who had a get together to discuss their challenges and the part technological innovation and development could play in meeting those challenges. Artificial Intelligence (AI), machine learning, decision support and workflow management were all on the agenda as well as flexible working which is far more available in radiology that other specialties. A number of companies presented their current innovations.

Kent & Medway Medical School (KMMS) Update

We had our third EKHUFT KMMS academic committee meeting chaired by the acting Chairman, Jane Ollis. The committee is working with hospital specialities to develop joint posts both in education and research. Specialities that have been targeted for these posts include the emergency department, stroke, frailty, sleep medicine and diabetes medicine.

The Dean, Professor Chris Holland has appointed five senior mainly full-time posts – all appointments were external candidates. In the Autumn it is planned that a further nine part-time posts will be appointed to and it is hoped that several EKHUFT consultants will apply.

All Trusts have undertaken to support and fund posts in support of KMMS. The KMMS medical school recently achieved stage 4 General Medical Council (GMC) accreditation and remains on time for a September 2020 start.

Trust Seal Activity

- Deed of Variation – lease of land and buildings at Kent & Canterbury Hospital (K&CH) between EKHUFT and 2gether Support Solutions Ltd.

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Appendix 1: Publications and Policy Developments of Note

NHSI and NHSE

Health and Care Innovation Expo 2019

The agenda for Health and Care Innovation Expo 2019 is now available. Register to hear from high profile speakers such as Chief Executive of NHS England Simon Stevens, NHS Chief People Officer Prerana Issar, and Secretary of State for Health and Social Care Matt Hancock. They'll be focusing on the most important challenges and developments across health and social care such as delivering a new People Plan and the vital role of networks in delivering the NHS Long Term Plan.

All public sector staff can register free via the Expo website using code EXPO19.

Interim NHS People Plan

The Interim NHS People Plan, developed collaboratively with national leaders and partners, sets a vision for how people working in the NHS will be supported to deliver care and identifies the actions we will take to help them.

Some actions will make a rapid difference in 2019/20, and some will lay the groundwork to grow the NHS's workforce, support and develop NHS leaders and make our NHS the best place to work.

This is the beginning of a new way of working. Our Chief People Officer Prerana Issar will shortly launch a partnership exercise — for leaders and people across the health and care system — to set the conditions for an improved working culture throughout the NHS.

https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan

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REPORT TO:	**BOARD OF DIRECTORS (BOD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**STAFF EXPERIENCE STORY: I CAN – HELPING PATIENTS BE ACTIVE AND INDEPENDENT**
BOARD SPONSOR:	**INTERIM CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

We all want our patients to leave hospital as early, healthy and as independent as possible. However, in the UK 35% of 70-year-olds and 65% of 90-year-olds decondition during a hospital stay. Ten days in a hospital bed leads to the equivalent of 10 years of ageing in the muscles of people over 80 – risking falls, reduced confidence and increased dependency on others.

In EKHUFT, at any one time, we have 300 patients who are medically fit for discharge. So this year we're focusing on how we can make a positive difference for these patients - how we can help them keep mobile and active, and prevent deconditioning while they are in hospital.

There are great examples of staff from all over the Trust making small, positive changes to encourage patients to be more active and be independent in daily tasks like washing and dressing. Staff have been sharing what they're doing at the Team Talks, in the nursing conference and through Trust communications. Examples include memory lane café's and reminiscence boxes for dementia patients, lunch clubs and cinema clubs, and children coming onto the wards to spend time with patients.

This month's patient/staff story is to tell the Board about some of these initiatives and the difference they are making to patients.

The Trust has launched I Can, to promote the work of staff and engage more colleagues to adopt a similar approach with their patients. We want every member of staff and every ward to feel they can make a difference and give this personalised care to every patient. Every ward has different needs and different solutions, so we want to support and empower staff to develop the right solutions for their patients.

Some patients need extra help to retain their mobility and independence, and so as part of this work, ward teams are developing 'enablement spaces' on each medical ward at Kent & Canterbury Hospital (K&CH) and a specialist enablement ward at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM), dedicated to enabling patients to reach their potential safely. The enablement areas will give wards back the space to keep patients stimulated, motivated, active and socially interactive.

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The Trust is also putting a dedicated acute frailty service into the 'front door' at WHH and QEQM to help prevent avoidable admissions, as well as making more use of the 'Hospital at Home' service to get people home earlier if they can be treated outside hospital.

The ambition of I Can is to make sure patients can leave hospital earlier, healthier and as independent as possible, and make sure more patients are able to go back to their own place of residence.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	None
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	No
RESOURCE IMPLICATIONS:	Within current resources
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None to date
SUBSIDIARY IMPLICATIONS:	No

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the ways in which staff are making a difference to their patients and helping them be active and independent.

19/060.1

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**MEDICAL DIRECTOR'S INFECTION CONTROL REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

This report details performance in relation to Healthcare Associated Infections (HCAIs), significant infection control incidents/outbreaks and anti-microbial stewardship. The report also concludes with a suggested approach to the forthcoming influenza season.

HCAIs can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile). We also consider methicillin-sensitive Staphylococcus aureus (MSSA) and certain gram negative infections such as Escherichia coli (E.coli). Anti-microbial stewardship is a key component of infection prevention and control both for the role that good anti-microbial stewardship plays in prevention of C. difficile but also importantly because of emerging anti-microbial resistance.

HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

1. C. difficile
   The trajectory set by the Department of Health (DH) for this financial year is a total of 95 cases. This is a combined hospital onset healthcare associated (defined as detection 48 hours or more after admission) and community onset healthcare associated (defined as detection less than 48 hours after admission but previous admission within 4 weeks). Up to the 24 June 2019 this financial year we have reported 13 cases under the new system of reporting. This is inside the DH trajectory.

2. MRSA and MSSA
   Up to the 24 June we have had no MRSA bacteraemias. There have been 7 MSSA bacteraemias, a rate of 8.3/100,000 occupied bed days. Comparatively the rate for other trusts in the South of England varies from 1.24 to 28.2.

3. E.coli
   Up to the 24 June there have been 20 hospital onset E. coli bacteraemias, a monthly rate of 5.9/100,000 occupied bed days. Comparatively the rate for the South of England varies from 1.52-8.67 (mean 4.9). There have been 96 community onset E. coli bacteraemias, a monthly rate of 28.4, the range through the South of England is 10.0-44.7 (mean 25.3).

4. Incidents/outbreaks
   In May 2019 there was an outbreak of measles confined to the community in Canterbury.

   Following the national alert concerning contamination of food products supplied to NHS organisations the Trust had one confirmed case of Listeriosis associated with sandwiches supplied by the Good Food Chain. There have been no further cases.

5. Anti-microbial stewardship
   The goals of antimicrobial stewardship (AMS) are to improve patient outcomes, improve patient safety, reduce antimicrobial resistance and reduce healthcare costs through the appropriate selection and administration of antimicrobial agents. The evidence shows that implementation of good AMS reduces C. difficile colonisation or infection, is associated with decreased MRSA and resistant organism isolation rates and reduces healthcare costs. To help drive this there are a number of Commissioning for Quality and Innovation (CQUINs) and audits related to AMS described in the AMS section below. Overall performance in this area has a lot of improvement to make but a baseline has been established against which progress can be measured.

6. Influenza
   The indications are that the flu season this year will be quite severe and preparation should therefore begin as rapidly as possible. It is recommended that the value of point of care testing for influenza be explored now in order to be able to introduce this in the Emergency Departments (EDs) prior to the flu season.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Poor infection prevention and control is a risk to the health of patients, staff and visitors and represents a reputational risk for the organisation. Actions to mitigate these risks include sustained implementation of the Trust's infection prevention and control action plan and full participation in the Kent & Medway infection prevention and control collaborative. Portents from the Australian influenza season indicate a high risk of a severe influenza season for the UK this year. This requires early implementation of the vaccination program and exploration of point of care testing for rapid identification of flu presenting to the emergency departments.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.**

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	• **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR1 Failure to maintain the quality and standards of patient care. CRR47 Inability to prevent deterioration in the number of healthcare associated infections.
RESOURCE IMPLICATIONS:	A review of the antimicrobial stewardship resource may have significant staff implications. Introduction of influenza point of care testing has a resource implication of £76000 for a 5 year programme including approximately 2,000 tests per year, all training, technical support and internal quality control costs.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Quality Committee (in part).
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to receive and discuss the report and to support the Quality Committee in monitoring improvement work.

The Board is also asked to note the high risk of a bad influenza season for this year.

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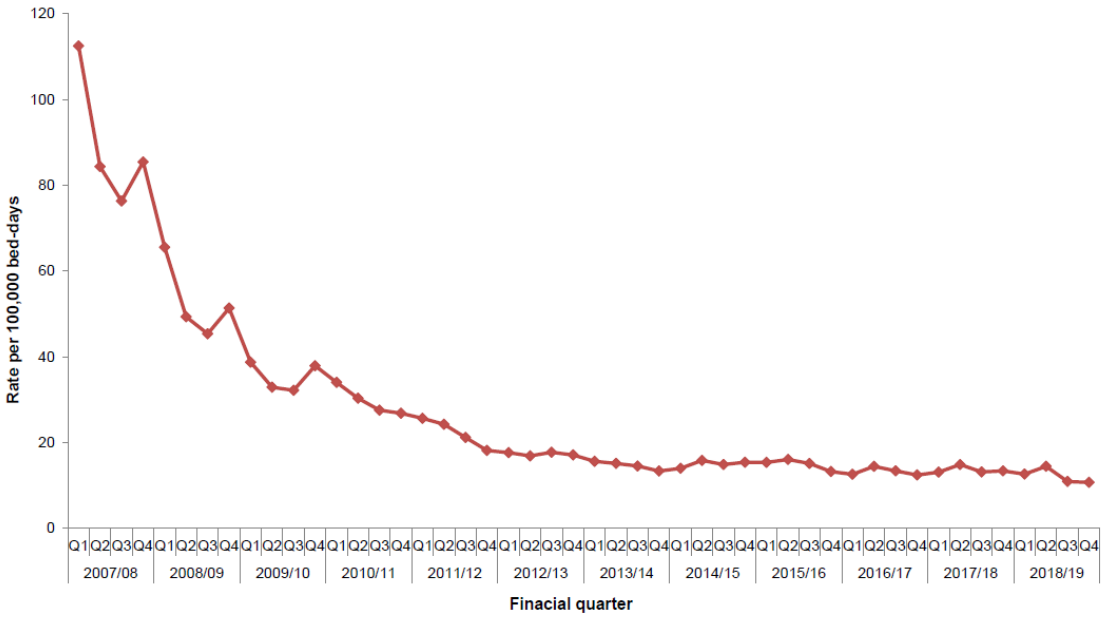
1. Clostridium difficile

C. difficile is a bacterium found in people's intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies). C. difficile causes disease when the normal bacteria in the gut are disadvantaged, usually by someone taking antibiotics. This allows C. difficile to grow to unusually high levels enabling toxin producing strains to reach levels leading to mild to severe diarrhoea.

C. difficile is the biggest cause of infectious diarrhoea in hospitalised patients. You can become infected with C. difficile if you ingest the bacterium through contact with a contaminated environment or person. People who become infected with C. difficile are usually those who have taken antibiotics, particularly the elderly and people whose immune systems are compromised. There is also an association with drugs that reduce the amount of acid produced by the stomach (proton pump inhibitors, for example omeprazole).

Nationally since the initiation of C. difficile monitoring in 2007 there has been a sustained reduction in hospital onset healthcare associated cases as shown in the graph below.



For the last 2 years all trusts have also submitted data concerning community onset cases. Although the overall number of C. difficile cases has decreased the proportion of community onset cases has increased. It is recognised that C. difficile in the community will be associated with hospital onset infection and in order to increase focus on further prevention from the beginning of this new financial year trusts have been required to alter the definition of hospital onset C. difficile to include all cases detected 48 hours or more after admission (previously 72 hours or more) **and** those cases detected less than 48 hours after admission who had previously been hospital inpatients in the preceding 4 weeks.

The DH set trajectories for trusts for C. difficile each financial year which are partly based on the previous year's data but also on population characteristics. EKHUFTs total number of cases for this year using the new definition for reporting is 95, a rate of 27.9 per 100,000 occupied bed days. By way of comparison the rates for our neighbouring Trusts range from 18.40 to 26.20.

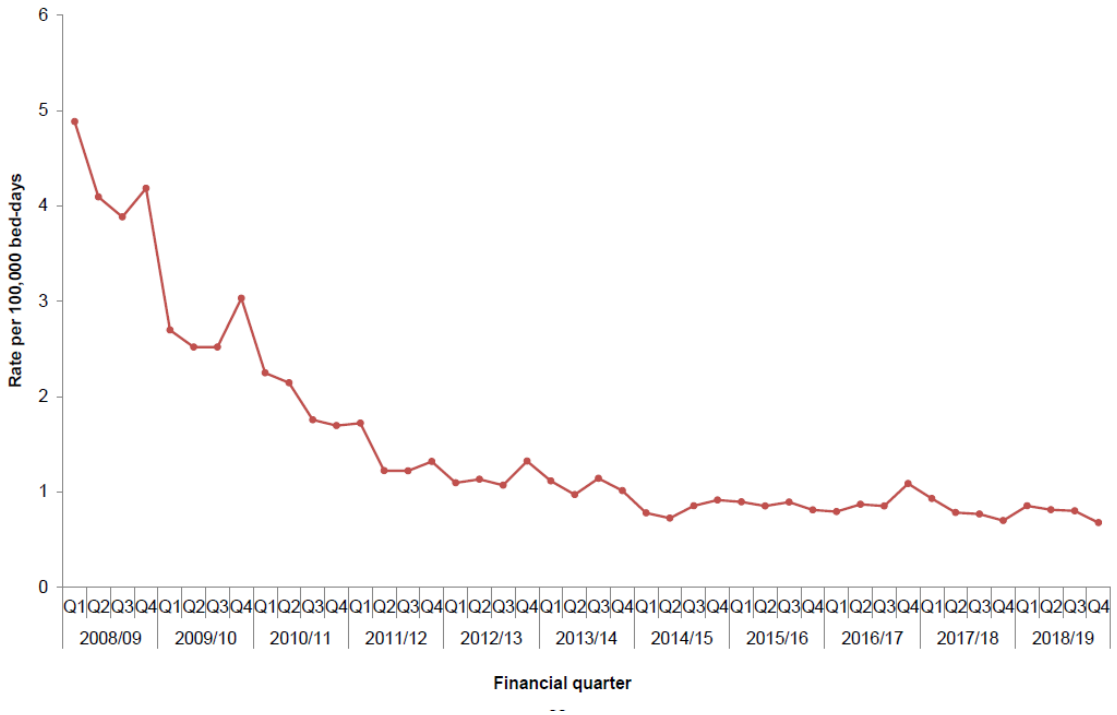
Year to date we are within the DH trajectory.

Actions to continue to maintain this include attention to basic infection control practices within the Trust combined with actions to improve anti-microbial stewardship (see below). Clinical case reviews will be undertaken for each C. difficile case to determine whether it was linked to any lapses in care related to the care and treatment of the patients, in or out of the hospital setting and identify any patient safety issues or learning. We are also working with our partners in the community and in primary care within a Kent and Medway collaborative to reduce all HCAIs and anti-microbial stewardship is a key focus out of hospital too.

2. MRSA/MSSA

MRSA is a type of bacteria that is resistant to several widely used antibiotics. MRSA lives harmlessly on the skin of around 1 in 30 people (MRSA colonisation) and is acquired either by touching someone who has it, sharing things like towels, sheets and clothes with someone who has MRSA on their skin, or by touching surfaces or objects that have MRSA on them. MRSA colonised people are therefore at risk from invasive infection when natural barriers to infection are breached through surgical procedures and insertion of indwelling catheters and cannulas. Invasive infection may then lead to bacteraemia (the presence of bacteria in the blood).

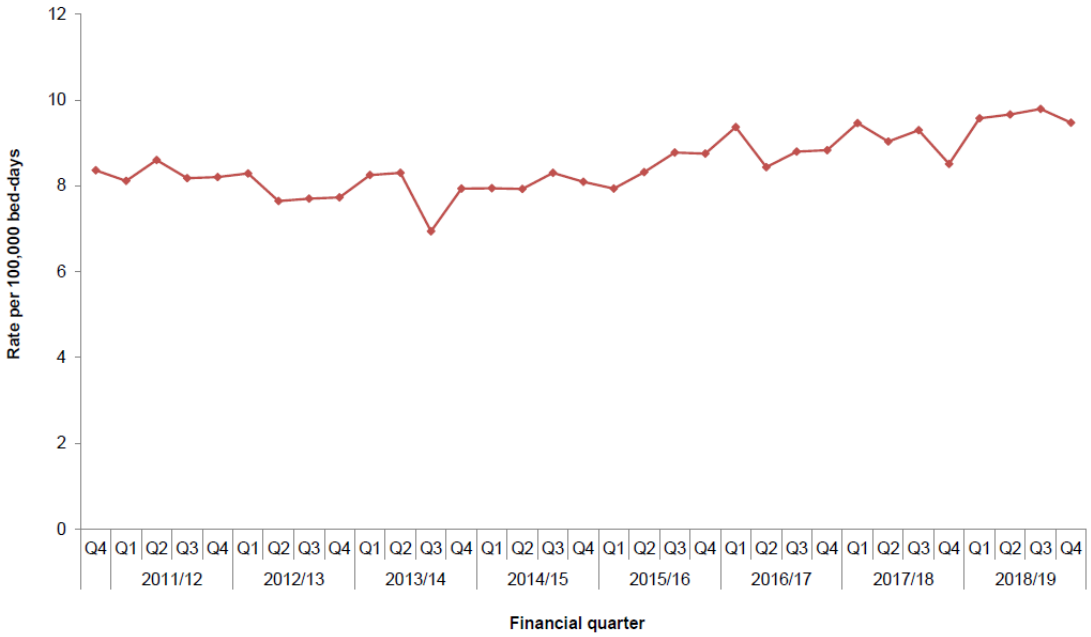
There has been a considerable decrease in the incidence rate of all reported MRSA bacteraemia since the enhanced mandatory surveillance of MRSA bacteraemia began in April 2007, shown in the graph below.



Our aim each year is to have no cases of MRSA bacteraemia and this has been achieved year to date.

MSSA also lives harmlessly on the skin and in the nose, but is found more commonly than MRSA and is present in approximately 30% of the population. MSSA colonised people have the same risks of invasive infection as those colonised with MRSA.

However, since the mandatory reporting of MSSA bacteraemia began in January 2011 there has been a general trend of increasing counts and incidence rates. These increases have been primarily driven by the increase in community-onset cases but hospital onset cases have also increased, shown in the graph below.



Year to date EKHUFT has reported 7 MSSA bacteraemias, a rate of 8.31/100,000 occupied bed days, a rate slightly below the national average of 9.5 for the last quarter of 2018/19.

3. Escherichia coli (E. coli)

E. coli are gram negative bacteria found in the environment, foods, and intestines of people and animals. E. coli are a large and diverse group of bacteria. Although most strains of E. coli are harmless, others can make you sick. There is renewed focus on reducing healthcare associated E. coli bloodstream infections because they represent 55% of all gram-negative blood stream infections. Approximately three-quarters of E. coli bacteraemias occur before people are admitted to hospital, reduction therefore requires a whole health economy approach.

Key healthcare-associated risk factors for E. coli bacteraemia include:

- indwelling vascular access devices (insertion, in situ, or removal);
- urinary catheterisation (insertion, in situ with or without manipulation, or removal);
- other devices (insertion, in situ with or without manipulation, or removal);
- invasive procedures (e.g. endoscopic retrograde cholangio-pancreatography, prostate biopsy, surgery including, but not restricted to, gastrointestinal tract surgery);
- neutropenia (neutrophil count <500/µL at time of bacteraemia;
- antimicrobial therapy within the previous 28 days;
- hospital admission within the previous 28 days.

The incidence rate of all reported E. coli bacteraemia has continued to increase each year since the initiation of mandatory surveillance of E. coli bacteraemia in July 2011, this is driven by the increase in the rate of community-onset cases. Hospital-onset

cases have been relatively stable. There is a strong seasonality to the incidence of all-reported E. coli bacteraemia cases, with the highest rates observed in July to September of each year.

Year to date EKHUFT has reported 20 hospital onset bacteraemias, a monthly rate of 5.9/100,000 occupied bed days. By comparison the monthly rates for trusts in the South of England vary between 1.52-8.67 (mean 4.9)/100,000 bed days. There have been 96 community onset E. coli bacteraemias, a monthly rate of 28.4/100,000 beds days, the range through the South of England is 10.0-44.7 (mean 25.3).

EKHUFT is part of the Kent & Medway collaborative aiming to reduce the number of gram negative bacteraemias by 50% by 2022 and E. coli is a key part of this.

Actions to reduce hospital onset E. coli bacteraemia are driven by the sentinel areas from the UK surveillance program:

- Reduction in urinary tract infection through targeting urethral catheter care and re-invigoration of the HOUDINI (Haematuria, Obstruction/Retention, Urology, Damaged skin, Input/Output, Nursing care, Immobility) bundle, reduction in recurrent urinary tract infection and promotion of hydration;
- Prevention of hepatobiliary infections through 'hot' cholecystectomy where indicated, better management of gallstone disease and prevention and treatment of surgical site infections;
- Enhanced surveillance and identification of neutropenia.

A similar programme of action is being undertaken to reduce community onset bacteraemias through the Kent & Medway Infection Prevention and Control (IPC) collaborative.

4. Incidents/Outbreaks

4.1 Measles

An outbreak of measles in May in the Canterbury area increased the likelihood of cases of measles presenting at our EDs prompting further education and awareness surrounding measles. Immunisation against measles is recommended for frontline healthcare workers but is not mandatory. Between 1 January 2018 and 31 October 2018, there were 913 laboratory-confirmed measles cases in England. This steep rise in cases (when compared to 259 lab-confirmed measles cases in 2017), was associated with outbreaks linked to importations from Europe that have led to some limited spread in the community, particularly teenagers and young adults who missed out on their MMR vaccine when they were younger. This latest outbreak in Canterbury was also related to importation and our geographical position as a Trust makes us particularly likely to see measles in adults presenting as emergencies.

Following the outbreak last year Occupational Health undertook a look back exercise and invited 2426 staff from frontline clinical areas to contact them for a measles status review. Occupational Health now hold data indicating that 32% of clinical/patient facing staff are immune to measles. We will continue to raise awareness to promote immunisation amongst our staff.

4.2 Listeria

Listeria is a family of bacteria that contains ten species. One of these, Listeria monocytogenes, causes the disease listeriosis in humans and animals. Although listeriosis is rare, the disease is often severe with high hospitalisation and mortality rates circa 13%).

Listeria is found in soil, plants and water. Animals, including cattle, sheep and goats, can also carry the bacteria. Consumption of contaminated food or feed is the main route of transmission to humans and animals. Infections can also occur through contact with infected animals or people. Cooking at temperatures higher than 65 °C kills the bacteria. However, Listeria can contaminate foods after production (for example contamination can occur after the food is cooked but before is packaged). Unlike many other foodborne bacteria, Listeria tolerates salty environments and can even multiply at cold temperatures (between +2°C and 4 °C). The hardiness of this bacteria, coupled with the high mortality rates in humans, makes safe food handling paramount to ensure public health.

On Sunday 26 May Public Health England (PHE) contacted the Trust to advise that certain sandwiches supplied to NHS trusts by the Good Food Chain might be contaminated with Listeria. This was as a result of 3 cases of Listeriosis (2 fatal) linked back to this supplier. The Trust immediately withdrew all sandwiches and reverted to onsite production, all food handling processes were reviewed. This was reported as an incident on our Datix system and local PHE were also informed on Monday 27 May 2019.

An exercise was conducted over the May Bank Holiday to identify as far as possible the patients who might have consumed an infected product. Those patients identified were all informed. A communication went to all doctors to be alert for the possibility of Listeria, particularly in any patients being readmitted within a 70 day time frame with symptoms that might suggest Listeriosis (the incubation period for Listeria varies from 2-70 days), and especially in any immunocompromised patients.

One patient was identified with blood culture positive Listeria infection. The patient had been an inpatient at the William Harvey Hospital (WHH) from 2 May 2019 to 29 May 2019 and was undergoing treatment with immunosuppressive therapy. Although allowed home on the 29 May 2019 on Thursday 30 May 2019 blood cultures taken on the 28 May 2019 were positive for Listeria, the patient was immediately called back to hospital and local PHE were informed. The Listeria was sent for genomic typing which proved to be the same as the Good Food Chain. The incident was added to the Datix report. Duty of Candour was completed by the Medical Director. The patient made a rapid response to treatment and was formally discharged from hospital again on the 6 June 2019. There have been no further cases locally. Nationally there have now been a total of 9 cases linked to this outbreak, 5 of them fatal.

5. Anti-microbial stewardship

Anti-microbial stewardship (AMS) within the Trust is led by a consultant microbiologist working closely with a senior pharmacist. AMS is a key part of IPC and involves:

- timely and optimal selection, dose and duration of an antimicrobial agent for the best clinical outcome for the treatment or prevention of infection;
- minimal impact on antimicrobial resistance and other ecological adverse events such as C. difficile.

The national priority given to AMS is underpinned by the “Reducing the Impact of Serious Infections” CQUIN, which the Trust is committed to. This is in 2 parts; the first part is an audit around appropriate use and a review of antimicrobial agents in sepsis. The audit considers combined performance of percentage of intravenous antibiotic prescriptions that had evidence of review between 24 and 72 hours PLUS review by an appropriate clinician PLUS a documented rationale for intravenous

prescription. The target for this CQUIN is an overall performance of 90%. Throughout the 4 quarters of 2018/19 there has been continued improvement helped by changes to drug charts prompting review. Final performance overall at the end of Q4 was 58% and whilst well below the 90% encouragement can be taken from noting that 92% of antibiotics were reviewed by a senior clinician (ST3 or above) within 72 hours after initiation, lack of documentation brought this down 58% overall.

The aim of the second part is to reduce the reliance on broad spectrum antimicrobials and decrease inappropriate antimicrobial usage. Reduction targets were: 2% reduction in total antimicrobial consumption compared to 2017/18 data; 2% reduction in carbapenem consumption by 2% on 2017/18 data; 3% increase of Awareness Why Anticipating and Responding is Essential (AWaRe) 'Access' group usage (essentially AWaRe is aimed at usage of antibiotics to minimise antimicrobial resistance). Total antibiotic usage has increased and AWaRe group usage reduced but a good reduction in Carbapenem usage has been achieved.

The proposed CQUIN for 2019/20 is centred around antimicrobial resistance and has 2 stems:

- Improving the management of lower Urinary Tract Infection in older people;
- Improving appropriate antibiotic surgical prophylaxis in elective colorectal surgery.

Each of these is designed to test compliance against national guidance and again the overall compliance target is 90%. Local guidelines have been updated in preparation and the AMS lead has begun a series of pilot ward antibiotic audits led by trainee doctors which have seen improvements in key areas in 8 of 11 wards as seen in the table below.

Ward	% with indication		% with stop or review date		% in keeping with guideline/exception		Overall	
	April	May	April	May	April	May	April	May
AMUB	88.2	82.4	94.1	88.2	70.6	70.6	84.3	80.4
AMUA	50.0	61.5	100	92.3	30.0	30.8	60.0	61.5 ↑
Oxford	75.0	88.9	87.5	77.8	87.5	44.4	83.3	70.4
KingsC2	90.9	88.9	45.5	100	36.4	61.1	57.6	83.3 ↑
RS	100	100	22.2	22.2	44.4	44.4	55.6	55.6
CM2	50.0	90.9	75.0	54.5	37.5	36.4	54.2	60.6 ↑
CJ	68.4	88.5	36.8	65.4	42.1	73.1	49.1	75.6 ↑
CL	75.0	80.0	37.5	90.0	31.3	50.0	47.9	73.3 ↑
CK	66.7	87.5	20.0	25.0	40.0	75.0	42.2	62.5 ↑
CM1	42.9	78.9	33.3	57.9	33.3	57.9	36.5	64.9 ↑
Bart	12.5	80.0	37.5	50.0	37.5	80.0	29.2	70.0 ↑

There is clearly a lot of work to be done to effect the necessary improvements to achieve an overall sustained performance of 90% against all key performance indicators. Introduction of electronic prescribing during the financial year will positively influence achievement but to ensure a successful Antimicrobial Stewardship Program this programme must be supported by the senior hospital

management. The AMS team members must be afforded sufficient resource to implement and evaluate the programme.

6. Influenza

The latest figures for Australia show nearly 94,000 confirmed cases of flu so far this year, last year the total number was around 12,000. Weekly figures for the beginning of June are on a par with the numbers of cases normally seen in July and August, the height of the Australian flu season. A 147 people have died from the flu in the first five months of the year, compared with 23 at the same point in 2018.

During the last flu season our uptake of vaccination by frontline workers was extremely good, exceeding the CQUIN target of 75%. Although flu activity in Australia is not necessarily a predictor of the UK's flu season, planning for vaccinations each year is usually based on what happens in the Southern hemisphere. What we are seeing to date in Australia highlights the importance of anyone who is eligible taking up the offer of flu vaccine when the campaign launches later this year. There are 3 strains of flu currently circulating in Australia, influenza A (H1N1), influenza A (H3) and influenza B.

Prior to the start of the season we have the opportunity to introduce point of care testing in the EDs to rapidly identify patients presenting with influenza in the EDs, enabling immediate isolation and augmenting management. The current turnaround time for identification of influenza is 24-48 hours, this could be shortened to 20 minutes by a point of care test. This is strongly recommended by our microbiologist with a specialist interest in virology.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**BOARD ASSURANCE FOR MANAGEMENT AND OVERSIGHT OF INVESTIGATION AND DISCIPLINARY PROCEDURES RELATING TO DOCTORS**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DECISION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

Baroness Dido Harding wrote to all NHS trusts in May 2019 highlighting the tragic suicide of a doctor following an investigation and disciplinary procedure. There were serious failings throughout and the doctor had been treated very poorly and the impact on his mental health had not been realised. A 'task and finish' Advisory Group established by NHS Improvement (NHSI) had considered to what extent the failings identified were either unique to the case or more widespread across the NHS. The analysis highlighted several key themes including:

- poor framing of concerns and allegations;
- inconsistency in the fair and effective application of local policies and procedures;
- lack of adherence to best practice guidance;
- variation in the quality of investigations;
- shortcomings in the management of conflicts of interest;
- insufficient consideration and support of the health and wellbeing of individuals;
- and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

Within the letter Baroness Harding asked 5 questions:

1. Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
2. Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response?
3. If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
4. What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and on-going direct support will be provided to them?
5. For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

This brief report details answers to the 5 questions for the Board to consider and also the additional actions relating to the management and oversight of local investigation and disciplinary procedures.

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IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Risks: Failure to follow good people practices in the investigation and subsequent disciplinary action involving doctors potentially puts at risk the doctor's mental health. Actions: Trust practice and policy in this area will be reviewed in the light of Board suggestions.
LINKS TO STRATEGIC OBJECTIVES:	**A great place to work:** Making the Trust a Great Place to Work for our current and future staff.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 8 - Inability to attract, recruit and retain high calibre staff (substantive) to the Trust. SRR 24 - If leadership and management is not effective staff may not be engaged to deliver a high quality, caring service. SRR 29 - If the Trust does not have a positive culture our ability to recruit and retain staff with the right skills is compromised.
RESOURCE IMPLICATIONS:	Dependent upon agreed actions.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is requested to receive this report and to discuss and agree whether or not they require additional assurance and/or additional Board level oversight.

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1. Response to the five questions for Board Assurance

1.1 Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

Yes, all cases and decisions to proceed to formal Maintaining High Professional Standards (MHPS) investigation are discussed at a monthly MHPS meeting involving the Medical Director, Deputy Medical Director, Head of Employee Relations and Deputy Head of Employee Relations/Medical Personnel Lead. Following the internal catch-up there is a telephone conference with NHS Resolution to discuss current and new MHPS cases.

1.2 Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response?

Alternative options other than the initiation of a formal intervention and investigation process are always considered.

1.3 If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

Each formal investigation is undertaken by a trained MHPS case investigator, supported by a member of the Employee Relations team. The case investigator's report is presented to a trained MHPS case manager who is able to call upon a different member of the Employee Relations team for advice and support. Before the case investigator and case manager take on the case they are asked to confirm that they are able to conduct their investigation and review in a timely manner.

1.4 What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and on-going direct support will be provided to them?

Occupational health advice and support is provided where appropriate and there is the option of counselling services. The individual concerned has the option of discussing the case with their British Medical Association (BMA) representative, legal representative or workplace colleague. We are considering an additional option of providing them with an independent Trust employee from the list of trained case investigators/case managers who will not be under the direction of management and will be able to explain to the employee how the MHPS process works.

1.5 For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

Yes, we will do so and discuss further at our monthly MHPS meeting.

2. Additional actions relating to the management and oversight of local investigation and disciplinary procedures

2.1 Adhering to best practice

Our disciplinary and grievance procedures comply with the Advisory, Conciliation and Arbitration Service (ACAS) code of practice. Our MHPS policy implements the national framework "Maintaining High Professional Standards in the Modern NHS" and we act in accordance with the Directions on Disciplinary Procedures 2005 and the Restriction of Practice and Exclusion from Work Directions 2003.

In appointing case investigators, case managers, Non-Executive Directors, HR support and where necessary formal hearing panel officers we ensure in discussion at the monthly MHPS meeting that there are no conflicts of interests and that these individuals undertake their roles independently, objectively and with no bias. Where employees have in the past objected to individuals taking on certain roles we have changed them. One of our case managers is not employed by the Trust and where necessary we can use their expertise and external advice.

2.2 Applying a rigorous decision-making methodology

Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, decisions are not made in isolation, they are discussed at the monthly MHPS meeting. A disciplinary hearing officer will always have a member of the Employee Relations Team supporting them and advising on their decision.

Decisions are well informed and thought through. A hearing officer will always have a member of the Employee Relations Team at the hearing to support them and offer advice and support. For particularly complex cases we have a panel comprising of two individuals, a chair and another hearing officer with support from Employee Relations.

2.3 Ensuring people are fully trained and competent to carry out their role

We are in the process of checking our pool of case investigators and case managers, scrutinising how many of them have undertaken this role since their training. If their involvement is not recent or never at all we will offer update training or remove them from the list. We will look to develop and expand our existing pool of managers and staff who are appropriately trained.

2.4 Assigning sufficient resources

Each case investigator and case manager is assigned a member of the Employee Relations team to assist them through the process, take notes of meetings, provide advice and assist in the decision-making process.

2.5 Decisions relating to the implementation of suspensions/exclusions

Suspension is a General Medical Council (GMC) function. Any decision to exclude an individual, or restrict their practice, should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. There may be circumstances where immediate safety or security issues prevail, which dictate immediate decision making, but this is always reviewed. The Trust Medical Director has delegated authority from the Chief Executive to make decisions relating to individual exclusion or restriction and to manage exclusion processes. The Medical Director discusses the need for exclusion or restriction with a senior member of the Employee Relations Team, the Deputy Medical Directors or with the relevant Care Group Clinical Director. Exclusion is recognised as a last resort and alternative options other than exclusion are always considered. These are set out in the Trust MHPS Policy and this meets National guidelines. There are regular reviews and senior level scrutiny built into the Policy.

2.6 Safeguarding people's health and wellbeing

Concern for the health and welfare of people involved in investigation and disciplinary procedures is continually assessed. Occupational Health support is always available through management referral or self-referral.

A communication plan is established with people who are the subject of an investigation or disciplinary procedure. An appropriate communication plan is built into all terms of reference, a potential weakness is when the MHPS process becomes prolonged for whatever reason.

To date we have not encountered a situation where a person who is the subject of an investigation or disciplinary procedure has suffered any form of serious harm. We recognise that were this to occur it would be the subject of an immediate independent investigation commissioned and received by the Board.

2.7 Board-level oversight

The Medical Director provides both verbal and written updates to the Board on MHPS cases in the closed part II section of the Board.

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REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: DEEP DIVE RISK CRR 28**

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 June 2019 Quality Committee meeting. The report seeks to answer the following questions in relation to the quality and safety performance:

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

MEETING HELD ON 25 JUNE 2019

1. Care Group Quality, Risk and Governance Reports

The Care Groups presented their key points and the Committee asks the Board to note the following:

Women and Children's

1.1 There has been improvement in Venous Thromboembolism (VTE) assessment compliance within gynaecology now reporting green at 97.7%. Overall compliance is 91.83%. Obstetrics is red at 88.59%. The Care Group continues with focussed work with the teams to ensure compliance improves, highlighting this is an essential part of the initial patient assessments that is required to be appropriately documented;

1.2 Following the Healthcare Safety Investigation Branch (HSIB) inspection and publication of the final report, the Head of Midwifery, Chief Executive and Medical Director met with HSIB representatives;

1.3 HSIB identified a number of cases in relation to babies being cooled. The Trust has a level 3 unit and there is a lower threshold for neonatologists for cooling babies, research also advises the cooling of babies as soon as possible. The Trust will be carrying out a deep dive looking at and identifying any themes, as well as reviewing and learning from processes followed in other trusts. The outcome of this deep dive will be reported to the Committee in October.

Cancer, Clinical Haematology and Haemophilia

2.1 Positive compliance against VTE assessment at 99.95%;
2.2 A reduced achievement of 74% against policy and audits for 2019/20 to date;
2.3 Full compliance of 100% regarding neutropenic sepsis prescription, in relation to improving the needle time for patients requiring antibiotics within an hour;
2.4 Harm free care positive at 100%;
2.5 The development of a cancer app for patients for chemotherapy and also for breast;
2.6 The Care Group had a highly successful haemophilia peer review and received excellent feedback. The review acknowledged the haemophilia unit's physiotherapy research commenting that this was world class.

Urgent and Emergency Care

3.1 Friends and Family Test (FFT) compliance improved from 79% to 84%;
3.2 Hand hygiene audits remained poor at 58%. There were no themes identified. The Care Group is focussed on raising staff awareness along with support to improve compliance around staff training, and any non-compliance is addressed with individual staff;
3.3 Compliance with the Bristol safety checklist is poor at 43%. Corrective action is in place to address this, which includes staff training, setting standards that are required to be met, completion of daily spot checks and managing individual staff for non-compliance.

General and Specialist Medicine

4.1 There were 14 wards that had gained 100% recommended, in relation to the FFT responses;
4.2 Compliance regarding Duty of Candour (DoC) letter, was significantly variable, 91% at the William Harvey Hospital, 58% at the Queen Elizabeth the Queen Mother Hospital and 47% at the Kent & Canterbury Hospital. This is being monitored weekly by the Clinical Governance Team;
4.3 The Care Group has challenges around carrying out Structured Judgement Reviews (SJRs) and sufficient time to be able to focus on these, which is being addressed through a Trust-wide business case already approved by the Strategic Investment Group;
4.4 The Care Group has introduced a carer passport. This was a direct action following a complaint from a patient's relative around the lack of access outside of visiting hours.

5 Principal Mitigated Quality Risks

The Committee received the report and ask the Board to note the following:

5.1 Three new risks have been added to the Corporate Risk Register as noted below:
- 5.1.1 CRR 69: Detriment to patients with a disability as we are non-compliant with the statutory Accessible Information standards;
- 5.1.2 CRR 70: Patients may not receive optimal care based on a clearly articulated clinical plan due to the requirement to maintain patient flow on a site;
- 5.1.3 CRR 71: Patients may be harmed if there is non-compliance with indicators within the medication safety thermometer, the Medicines Policy and national best practice. This risk is presented in Appendix 1, however, is currently under review to ensure that all relevant controls and mitigating actions are described. The risk name has been shortened to Patients may be harmed through poor medicines management.

5.2 The deep dive into risk CRR28: Lack of timely recognition of serious illness in patients presenting to the Emergency Departments (EDs) was discussed and is appended (Appendix 1) for the Board to discuss and note.

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6 Infection Control

The Committee received and discussed the report, and asks the Board to note:

6.1 The significantly high flu activity currently circulating in Australia. This is not necessarily a predictor of the UK's flu season but provides a warning of the potential risk for the UK. The flu vaccination campaign will be launched later in the year highlighting the importance that those eligible take up the offer of a vaccination. The Trust will continue to ensure good uptake and encourage frontline workers to be vaccinated ;

6.2 There has been no methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias up to 25 June;

6.3 There has been seven methicillin-sensitive Staphylococcus aureus (MSSA) bacteramias, an average rate comparative to other trusts in the South of England;

6.4 The Trust took immediate action following advice from Public Health England (PHE) in relation to the confirmed cases of Listeriosis, withdrawing all sandwiches and reverting to onsite production of sandwiches. A review of the Trust's food handling processes was also undertaken, verifying that all appropriate processes were and are being followed.

7 Integrated Performance Report – Quality, Safety, Experience, Effectiveness

The Committee received and discussed the report, and asks the Board to note:

7.1 Positive performance in relation to Harm Free Care (new harms) remains green, FFT inpatient satisfaction rate remains green at 96%, falls continue to remain below the national average for acute hospitals;

7.2 Performance for complaints has reduced to amber reporting 84.9% from green the previous three consecutive months;

7.3 Areas of concern include VTE assessment that remains red at 93.7%, confirmed grade 2 and above pressure ulcers (PUs) is 59. In month there have been 2 confirmed category 3 PUs and no category 4 PUs. Targeted actions are in place to address these issues. Although C. difficile is red rated this is because of the change in the counting system introduced this year, C. difficile counts are below trajectory;

7.4 Two never events were reported but one has since been down-graded to a near miss (which is actually positive);

7.5 There were 18 reported Serious Incidents (SIs);

7.6 The Trust's overall fill rate of 101.9% is misleading because the calculation is based on a lower bed base than actual, challenges remain within some areas particularly those with high vacancies. Action is being taken to address the staffing establishment with support around focussing on recruiting to substantive funded posts, movement of staff across the wards and flexing of ward staffing profiles according to patient need.

8 Care Quality Commission (CQC) Update:

The Committee received the CQC Update and asks the Board to note:

8.1 Good progress is being made on the improvement plans;

8.2 Assurance was provided regarding the review process developed and implemented regarding evidence, to ensure that each piece of evidence is examined for assurance purposes, and actions only closed when sufficient assurance is provided.

The Committee also received and discussed the following reports.

- Patient Safety Committee (PSC), which included the complete resolution of the 18 month stoma reversal waiting list (a previous outlier on the National Bowel Cancer Audit).
- Patient Experience Committee (PEC).

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- NICE/Clinical Audit and Effectiveness Committee.
- Progress update regarding the Getting it Right First Time (GIRFT) plan and actions.
- Update on the ophthalmology backlog.
- Quality Committee Work Plan.
- Care Group Quality and Risk Packs for:
    - Surgery – Head, Neck and Breast.
    - Surgery and Anaesthetics.
    - Clinical Support Services.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to **APPROVE** the Quality Committee Chair Report.

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Deep Dive – CRR 28: Lack of timely recognition of serious illness in patients presenting to the Emergency Department (ED)

1. The risk was initially identified in July 2016 following the April Board of Directors. The then Deputy Chair raised at the Board concern about the ability of the Emergency Department to deliver their trajectory and was not assured that the risks were adequately covered to make that happen. This was agreed by the Chief Executive and the risk was articulated on the Corporate Risk Register.

2. The causes identified could be a delay in assessment and evaluation of patients due to overcrowding in the Emergency Departments (EDs) and lack of flow through the Emergency Care Pathway; increased and unplanned local demand for emergency services that the Trust is unable to meet with the resources and infrastructure available; over time the demography, comorbidity and acuity of ED attendees has changed, together with the rise in number of attendees, resulting in an increased requirement for conversion to admission; inability to recruit into consultant and middle grade posts; lack of availability of GP at the front door; failure of the NHS 111 to provide appropriate advice; surge resilience plans do not meet unprecedented demand; lack of robust escalation plans and failure to respond appropriately to the Operational Pressure Escalation Framework.

3. The controls that were in place at the time of identification were an Urgent Care Recovery Plan and support from the Emergency Care Improvement Programme.

4. In November 2016 an Accident and Emergency Delivery Board was identified as a further control and an Acute Medical Model was developed. In January 2017 the Single Health Resilience Early Warning Database (SHREWD) was revised. An Emergency Care Improvement Plan was put in place and demand and capacity reviewed and monitored in all areas outlined in the Operating Framework. Daily intensive review/bed matching for emergency admissions, not in place at the time of review, was also implemented.

5. In August 2017 weekly site based meetings were put in place designed to improve ownership of the emergency care pathway and reduce overcrowding in the emergency department. In September 2017 SAFER bundles were in place at each of the acute hospital sites, support from 20:20 was in place from October - December 2017.

6. The opening hours of the Surgical Emergency Assessment Unit were increased to further mitigate the risk and a primary care service was in place at Queen Elizabeth the Queen Mother Hospital (QEQMH) and William Harvey Hospital (WHH) for a minimum of six hours per day.

7. In January 2018 Carnal Farrar were commissioned to provide a programme management office service to manage the delivery of the Accident & Emergency (A&E) Improvement Plan, Interim Hospital Directors were in place at WHH and QEQMH to support a greater site focus and an A&E Improvement Director was in place to support the delivery of the A&E Improvement Plan.

8. In March 2018 20:20 were employed to focus on length of stay and supporting bed occupancy. There was an increased acute medical bed capacity through moving the cardiology ward to the Arundel suite as part of creating a cardiology inpatient area including Coronary Care Unit (CCU) and general cardiology beds. The vacated space became an acute medical area and the Bristol safety checklist was introduced in the Emergency Departments.

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9. In May 2018 an internal Programme Management Office (PMO) service were put in place to manage the delivery of the A&E Improvement Plan and in June 2018 a review was undertaken of the emergency care pathway and a revised Improvement Plan was implemented.

10. In November 2018 intensive work had been undertaken on relationship management, lateral integrations and partnership working resulting in a Health Economy Plan and the primary care service at QEQMH and WHH was extended to a minimum of 12 hours per day. The medical assessment areas at QEQMH and WHH were opened in November 2018.

11. In addition, work was undertaken on the computer systems used within the departments so that early warning scores could be viewed electronically. The observation charts have been changed to mirror VitalPAC. eCasCard has been introduced along with TV screens to replace whiteboards which updates the nurse in charge on all patients within the department every 15 minutes.

12. A Rapid Assessment and Treatment area was implemented and ambulatory care units are seeing medical patients attending the ED.

13. There are now middle grade doctors in the departments 24 hours a day and a consultant during daylight hours. Paediatric nurse establishment has been increased from one per department to eight with a further business case to increase this number to twelve. The funded establishment for both nursing and medical staff has increased year on year, however, there are still vacancies in both emergency departments. There is now a band 7 emergency department sister on shift to offer senior nursing support. Two practice development nurses have been funded for each ED.

14. Intensive work has been undertaken on the identification of sepsis and collaboration with South East Coast Ambulance Services NHS Foundation Trust (SECAmb) to priority call sepsis patients. Training has been undertaken within the departments around the deteriorating patient.

15. A standard has been developed for observations, all patients in majors are assessed as a minimum one hourly and senior doctor board rounds take place two hourly with other members of the multidisciplinary team to highlight any patient deterioration.

16. Escalation protocols were developed and agreed with Care Groups.

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REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**CARE QUALITY COMMISSION (CQC) UPDATE**
BOARD SPONSOR:	**INTERIM CHIEF NURSE & DIRECTOR OF QUALITY AND MEDICAL DIRECTOR**
PAPER AUTHOR:	**QUALITY IMPROVEMENT PROGRAMME LEAD**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

October 2018 Paediatric inspection

The weekly reports continue to be provided to the Interim Chief Nurse for assurance until the data within them is embedded in the Care Groups' governance processes.

An issue has been identified through these reports in relation to poor compliance with sepsis screening and the lead consultant for patient safety is arranging a meeting to discuss strategy, barriers and improvements. Areas of poor compliance have also been identified through the Paediatric Early Warning Scoring (PEWS) audits, and actions are in place to address this.

The Paediatric Taskforce continues to meet weekly and maintains an oversight of the improvement plan. The status of the plan received and discussed by the Paediatric Taskforce on 17 June 2019 is shown below. The group agreed that a number of actions could be transferred to the Paediatric Transformation Programme to reduce duplication and so these have been removed from the plan.

There are two actions not yet started; these are actions dependent on previous actions being complete before timeframes can be confirmed and actions commenced.

Current status of the plan as at 3 June is:

	March 2019	April 2019	May 2019	June 2019	Number of actions June 2019
Total on track	45%	19%	22%	18%	22
Total complete	50%	45%	53%	56%	67
Total with risks to completion	0%	2%	0%	0%	0
Overdue	5%	11%	16%	24%	29
Total not started	0%	23%	9%	2%	2
Total actions	100%	100%	100%	100%	120

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	Clinical Support Services	Surgery & anaesthetics	Urgent & Emergency Care	Women & Children	Corporate
Total on track	0	1	13	7	1
Total complete	3	1	34	25	4
Total with risks to completion	0	0	0	0	0
Overdue	1	3	11	13	1
Not started	0	1	0	1	0
	4	**6**	**58**	**46**	**6**

CQC Improvement plan

The Improvement Plan Delivery Group (IPDG) has now been superseded by the Getting to Good Group, which has not met since its inaugural meeting on 17 May 2019. This update has therefore not been received at the Getting to Good Group which is next due to meet on 27 June 2019.

Monthly meetings are arranged between the Quality Improvement Team and the Care Group Clinical Directors to discuss progress against the plan. Some Care Groups have cancelled these meetings or not been available to meet monthly. The Medical Director and Chief Nurse will now be attending these meetings when possible. The status of monthly meetings for the last quarter is shown here:

	Cancer Services	Clinical Support Services	General & Specialist medicine	Surgery & Anaesthetics	Surgery, H& N, B& D	Urgent & Emergency Care	Women& Children
April							
May							
June							

Key
Meeting cancelled/unable to arrange due to availability
Meeting arranged for later this month
Meeting took place

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The current status of the plan (as at 12 June 2019) is:

High level status

	March 2019	April 2019	May 2019	June 2019	Number of actions
Total on track	47%	40%	2%	1%	1
Total complete	43%	44%	31%	33%	28
Total with risks to completion	1%	7%	0%	0%	0
Overdue	9%	9%	67%	66%	57
	100%	**100%**	**100%**	**100 %**	**86**

	Cancer	Clinical Support Services	Surgery & anaesthetics	Surgery - head, neck, breast & dermatology	Urgent & Emergency Care	Women & Children	General & Specialist Medicine	Corporate
Total on track	0	0	0	0	0	1	0	0
Total complete	15	19	24	20	29	23	19	20
Total with risks to completion	0	0	0	0	0	0	0	0
Overdue	17	15	13	13	19	12	11	18
	32	**34**	**37**	**33**	**48**	**36**	**30**	**38**

There are delays to completing some actions due to the absence of specific measures and outcomes associated with the actions. This makes it challenging to define exactly what is required and whether the action has been achieved. The plan is therefore being reviewed and mapped against the original CQC recommendations to identify what specific improvements are still required. The Chief Nurse and Medical Director will also be reviewing the plan with the Quality Improvement Programme Leads to agree measures for those actions that are unclear.

Discussions are underway with the information team to produce a dashboard of metrics and data against each of the CQC's Key Lines of Enquiry (KLOEs). This will incorporate metrics from audits, performance etc. that relate to the areas of improvement for both paediatrics and the main plan, as well as areas that link to the KLOEs that have not been identified by the CQC as requiring improvement.

The Quality Improvement Team have developed an evidence review process to ensure that each piece of evidence is examined for assurance purposes, and actions only closed when sufficient assurance is provided.

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CQC engagement

An End of Life (EoL) engagement visit by the CQC took place on 22 May 2019. The EoL team has delivered a presentation to two inspectors from the CQC and one NHS Improvement (NHSI) colleague, and drop in sessions for staff also took place.

No further core service visits have been confirmed by the CQC to date.

Routine Quality Reviews (RQRs)

RQRs are now business as usual, so that each of our core services receives a RQR on rolling basis (approximately every 8 months), irrespective of CQC activity. Should significant concerns be identified during a visit, more frequent RQRs would be undertaken. Dates completed and planned are:

22 January – critical care at William Harvey Hospital (WHH), Queen Elizabeth the Queen Mother Hospital (QEQMH) and Kent & Canterbury Hospital (K&CH) - complete
5 February – outpatients at K&CH - complete
22 February – end of life care at WHH - complete
26 February – paediatric Emergency Department (ED) and wards at QEQMH and WHH - complete
24 April – medical (including older people's care) - complete
24 May – surgical – complete
31 July – urgent and emergency care – planned (change to original date)
21 August – maternity and gynaecology – planned (change to original date)
26 September – surgery head, neck and breast - planned

Reports are shared with the service after the visit, and an improvement plan developed. Themes will be identified from the reports and used to identify Trust-wide areas for improvement.

CQC self-assessments

Care Groups have been asked to self-assess all their clinical areas against the CQC's five domains and key lines of enquiry (KLOEs). Services will focus on a domain each month as follows:

March – Caring
April – Responsive
May – Effective
June – Safe
July – Well led

A number of assessments have not yet been received. These are followed up in the monthly Care Group meetings and reminder emails are sent by the Quality Improvement (QI) team. For many services more support is required to better understand how to undertake the self-assessments and what "good" looks like.

A gap analysis at corporate level for each of the KLOEs has commenced and an initial review of the policies and processes for medical devices and equipment has taken place. At the same time the leads have been asked to review and update the CQC's Provider Information Request pages relating to medical devices and equipment. Leads are currently finishing this review. KLOE Lead meetings will continue to be arranged for all other KLOEs.

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CQC Insight report

The CQC published the latest insight report on 21 May 2019.

- Caring, Effective, Responsive, Safe, Well led performance is stable.
- Of the Core Services, Urgent and Emergency care, Critical Care, Maternity and Gynaecology, Medical Care, Outpatients and Diagnostic Imaging, Surgery performance is stable.

This has been shared with the Care Groups for them to review the data for their services and identify any anomolies.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Actions are not being completed within the timescales shared with the CQC; this is likely to result in some of the same issues being identified when the CQC next inspect which could result in further enforcement action being taken and impact upon Trust ratings and reputation. Actions in place to address are: meetings with each Care Group triumvirate to discuss their plan, attendance for these meetings is now being reported to the Getting to Good Group, also monthly.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR2 – Failure to maintain the quality and standards of patient care.
RESOURCE IMPLICATIONS:	Potential costs associated with harm arising from sub optimal patient experience.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Quality Committee
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

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

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East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**ANNUAL OBJECTIVES:** • **GREAT PLACE TO WORK** • **RIGHT TIME RIGHT SKILLS RIGHT PLACE**
BOARD SPONSOR:	**ACTING DIRECTOR OF HUMAN RESOURCES**
PAPER AUTHOR:	**ACTING DIRECTOR OF HUMAN RESOURCES**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: PROGRESS UPDATE** **APPENDIX 2: OBJECTIVE MEASURES**

BACKGROUND AND EXECUTIVE SUMMARY

The Trust has recently published its three year Organisational Strategy, which was developed in conjunction with the Board of Directors for the financial years 2019 – 2021. A golden thread runs through each of the strategic priorities and aligns to the personal objectives of individual members of staff from members of the Trust Executive Team through to the most junior member of each team.

The six priorities are Getting to good, Higher standards for patients, A great place to work, Delivering our future, Right skills right time right place and Healthy Finances.

Human Resources has responsibility for *A great place to work* and *Right skills, right time, right place*. Accordingly there is a programme of work to deliver 10 strategic objectives against these two specific strategic priorities during the course of the current financial year, although it is recognised that the HR function will have a bearing upon the successful delivery of other strategic priorities as part of the wider strategy.

A programme of work for 2019/20 has commenced and each of the ten individual objectives is aligned to individual areas of delivery within Human Resources.

The work is currently on track to deliver each of the objectives by the end of the financial year, but there are some inherent risks which largely centre upon capacity, available resources and willingness/ability of managers and staff to engage in new processes.

There has been a ready acknowledgement through the Strategic Workforce Committee (SWC) that people are our most important asset and we need to ensure that we pay attention to the needs of our staff in order to provide an effective service to outpatients. Whilst this is acknowledged in several forums, it is not necessarily expressed in this way and must be high on our agenda. The patient experience is often determined by their contact with individual members of staff therefore it is incumbent upon us to make sure the conditions are right for our staff to thrive.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	SR8 : Inability to attract and retain staff.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding**

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	care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	Links to SRR8 – ability to recruit and retain staff.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Strategic Workforce Committee
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is invited to note the progress towards meeting the strategic objectives and acknowledge the risks associated with their potential achievement.

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Appendix 1

Progress Update

1. Introduction

1.1 The Trust has recently published its three year Organisational Strategy, which was developed in conjunction with the Board of Directors for the financial years 2019 – 2021.

1.2 The Organisational strategy seeks to encapsulate much of the history of the Trust from achieving University status in 2007, subsequent formation as a Foundation Trust in 2009 and the continuing journey towards achieving excellence as a key long term objective. The document outlines the vision for the future, is aspirational in tone and lays out our high expectation that we will deliver our vision of Great Healthcare from Great People.

2. Method

2.1 We have built upon the set of 'we care' values developed in 2014 – 2016 and have since launched six transformation priorities which we are using to ensure a particular focus on getting to Good and then Outstanding with regard to the Care Quality Commission (CQC) rating awarded to the Trust. These priorities are the foundations for driving our performance and form the building blocks for sustainable services across East Kent.

2.2 The six priorities are Getting to good, Higher standards for patients, A great place to work, Delivering our future, Right skills right time right place and Healthy Finances.

2.3 A golden thread runs through each of the strategic priorities and aligns to the personal objectives of individual members of staff from members of the Trust Executive Group through to the most junior member of each team.

2.4 Of these six priorities, two are particularly focussed upon our staff and making sure that we are correctly positioned to support the delivery of services through our most important asset – our people.

These are *a great place to work* and *right skills, right time, right place*. The actions and activity which flow from these priorities support our drive to implement a significant programme of culture change that will not only improve the lives of our staff but will also reach to the heart of our patient experience and our journey to good and then outstanding.

3. A Great Place to Work

3.1 Making the Trust a great place to work as a strategic priority is targeting our current and future workforce and is summarised as follows:

- Attracting and developing and retaining a great workforce to deliver great healthcare, from great people. We want to ensure that everyone understands the way they make a difference and contribute to better patient care and can continue to develop a positive and caring culture.

3.2 This is supported by six main areas for focussed activity:

- caring for the team;
- developing the team;
- valuing the team;
- engaging and responding to the team;
- being a research active organisation; and
- engaging in research partnerships.

4. Right Skills Right Time Right Place

4.1 Right skills, right time, right place is similarly positioned with the purpose of developing teams, with the right skills to provide care at the right time, in the right place and achieve the best outcomes for patients. Again this overarching objective is summarised thus:

- To deliver great healthcare from great people we need to have teams with the right skills, delivering care to patients at the right time, in the right place. This includes providing more services 7 days a week, transforming teams and how they work and delivering new models of care.

4.2 This is again supported by seven individual areas for more focussed activity:

- making the best use of our staff;
- Sustainability and Transformation Partnership (STP) workforce plans;
- building an innovative and flexible workforce;
- working with the Kent and Medway Medical School;
- effective recruitment processes;
- seven day working; and
- a healthy workforce.

5. Timescales

5.1 The strategy has been written for delivery over a three year period, therefore the time frame for delivery of each objective has been considered in order to ensure a realistic and achievable programme of work.

5.2 Personal objectives set during the recent appraisal round have been determined with the strategic priorities and objectives as the overarching driver. This means that there is a common understanding of all that we are seeking to achieve from a HR perspective and each individual is able to recognise their own contribution to the achievement of our common workplan.

5.3 With reference to the specific objectives due to be delivered for the current financial year, 2019 – 2020 the programme of work is already underway (See Appendix 1).

6. Risks

6.1 There are some inherent risks to each of our programmes due to the number of variables that can affect individual delivery. However, the programme should be

viewed as incremental and longer term success will rely upon successful introduction and wider implementation of a number of programmes during this current year, from which we expect to realise longer term benefits in future financial years. For example successful recruitment in this year has the potential to make a positive financial impact as well as boosting individual morale and sense of wellbeing as people are less stretched to deliver patient care.

6.2 With regard to delivering a great place to work, the intrinsic risk is that we are relying upon individuals to embrace the changes that we seek to introduce and work collaboratively to develop systems and processes that will add value and support people in the here and now. There is a need to re-establish and build trust among staff and relationships that to date have been fragile must be encouraged and allowed to develop greater strength and resilience. In addition to this we must be cognisant of the need to empower staff and their teams, which we anticipate will be supported by the introduction of the Quality Improvement programme commonly referred to as Patient First at present.

6.2 The programme of work is large and the capacity of the HR team to deliver is limited. However, there is a strong appetite to take on the challenge and work with and through the Care Group leadership teams to deliver tangible outcomes, For example, development of new rostering policies, flexible working systems and leadership frameworks will only be as effective as the individuals who are required to use them in practice.

6.3 Much of the activity that is expected to influence cultural change relies heavily upon individuals being available to participate in programmes delivered by HR Business Partners and actively promote their benefits to colleagues and team members. Time is a huge factor to consider when there are so many individual programmes of activity underway throughout the Trust, some of which may be regarded as more directly associated with the provision of patient care.

6.3 The programme of work is being undertaken by a team that is already heavily engaged in delivering activity in support of other strategic programmes alongside a heavy transactional programme. Finding the capacity and balance within the team presents a risk , but this is recognised and is factored into the timescales for this year going forward.

6.4 The impact of the environmental surroundings must also be a consideration when reviewing the associated risks to delivery of this objective. The working environment plays a significant role is making staff feel valued and supported, properly equipped to perform their roles and adds to their sense of professionalism and wellbeing. The current state of our estate therefore poses a risk in this regard.

6.5 A mixture of success measures for each objective have been identified (See Appendix 2) . Some are quantitive in nature and can be determined by hard measures such as recruitment targets, new policies and procedures and implementation of new systems. The more challenging measures are the qualitative measures that rely upon individual perception and personal perspective upon their employment experience. These will be reflected in the staff survey and friends and family test, which although we would like to see a rapid, positive impact, in reality it is more likely to be achieved across the full three years of the strategy as the impact of the changes is truly felt.

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Great Place to Work	Progress	Right Skills Right Time Right Place	Progress
Respect for each other and our contributions to delivering service excellence, promoted at all levels and builds pride	Respect campaign has been relaunched by HR Business Partner (HRBP) lead. Programme planned across all care groups. Supported by the Chief Executive Officer (CEO) and Director of HR (DHR)	**A robust recruitment pipeline is in place We attract staff who haven't traditionally considered the NHS**	Recruitment levels have more than doubled in the last 12 months. Time to hire has reduced significantly and continues to fall. New media are being exploited to develop new talent and returners to work e.g. mums net, snapchat etc.
Behaviours are consistent with our values, or challenged Organisational Developement (OD) framework for consistent leadership standards in place	Programme of Basic behaviours and expectations against Trust values being rolled out. The initial programme will be concluded this financial year but will be subsumed as business as usual (BAU).	**Local Terms and Conditions enable individuals to have flexible working, with financial efficiencies and reduced reliance on temporary staff**	Flexible working policy revised and opportunities to employ more staff on twilight shifts/alternative shift patterns actively being progressed in departments such as ED/critical care.
All staff have a meaningful appraisal which adds value and supports them and their career development	HRBPs and Head of Learning and Development providing appraisal training. Quality checks undertaken by HRBPs for individual Care Groups.	**A positive approach to mental health, including mindfulness, promotes personal resilience for staff**	Healthy workplace programmes in development – some risk with regard to delivery around available resource to support mindfulness programmes. Demand driven and clear appetite for more availability.
Staff recognition/reward programme Infrastructure/capacity to deliver 'quick wins	Trust lead for retention working up revised benefits programmes. New offers being developed and launched this year via Trust intranet. Programme to support and recognise long service and achievement currently being revised.	**Staff have ready access to support to create a healthy, supportive and caring environment**	Staff support services currently available via Occupational health - access to counselling and individual health support. Capacity to deliver at scale in a timely way is challenged by available resource.
Staff support in first year is embedded	Review of Trust welcome undertaken. Determined optimum levels for Trust welcome programme - 70 new starters at a time. New services now invited to attend Trust welcome to	**Joint appointments with Kent and Medway Medical School (KMMS)**	Two joint appointments already agreed. More being explored with KMMS and our own consultants.

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	support and integrate new colleagues.		

A great place to work 2019-20

Objective	Measure	Related plan or strategy	Governance arrangements	What will this mean for patients/staff?
Respect for each other and our contributions to delivering service excellence in place	Staff survey reduction in number of grievances	People Strategy	Strategic workforce Committee Staff Committee, Local Negotiating Committee (LNC)	Improved communications between staff will facilitate better care
Behaviours that are inconsistent with our values, are challenged	Increase in use of freedom to speak up guardians, workplace buddies and use of Vandebilt programme	People strategy,	Strategic Workforce Committee (SWC), Staff Committee, LNC,	Improved behaviours will result improve retention and support the retention of experienced staff to provide high quality care for patients
Organisational Development (OD) framework for consistent leadership standards in place	The OD framework used as the basis for assessment and measurement of performance underpinning personal development plans	Integrated Education Board (IEB) strategy People Strategy including OD and leadership strategy	Integrated Education Board Clinical Executive Management Group (CEMG) Staff Committee Strategic Workforce Committee	Well led staff will provide higher standards of care for patients arising from with objectives, expectations and standards of provision.

A great place to work 2019-20

Meaningful appraisals support staff, their careers and skills acquisition	Personal development plans aligned to skills development opportunities at all levels	People strategy IEB strategy OD / leadership strategy	Integrated Education Board CEMG Staff Committee Strategic Workforce Committee	Patients will benefit from staff who are engaged in a process of continuous professional development with enhanced skills to enable better provision of care.
Staff supported in first year of employment is embedded	Staff retention within first year improved	People strategy IEB strategy OD / leadership strategy	Strategic workforce committee, staff committee, LNC	Increased retention leads to higher experienced staff to patient ratios therefore better care.
Staff recognition/ reward programme	New elements added to the reward and recognition programme. Increase in staff use of benefits platform	People strategy	Strategic workforce committee, staff committee, LNC, CEMG	Better staff engagement and motivation, improved attitudes and behaviours evident to patients.
Infrastructure/capacity to deliver ‘quick wins’	Improvement in staff survey results	People Strategy	Strategic Workforce committee, Workforce Committee, CEMG, LNC	Some quick wins relate to people, other to physical estate and provision of equipment. Improvements in all areas will enhance the patient experience.

Right skills, right time, right place 2019-20

Objective	Measure	Related plan or strategy	Governance arrangements	What will this mean for patients/staff?
A robust recruitment pipeline is in place	Reduction in vacancy numbers, reduction in time to hire	Recruitment & Retention strategy	SWC,CEMG, Transformation Improvement Group	Reduced number of vacancies, reduction in agency / bank workers, more consistent patient care
We attract staff who haven't traditionally considered a role in the NHS	Increased apprenticeships, wide range of sources of recruitment	Recruitment & Retention strategy People Strategy	SWC,CEMG, Transformation Improvement Group	Staff employed in non traditional roles and diverse training support providing specialist care
Local Terms and Conditions enable individuals to have flexible working, with financial efficiencies and reduced reliance on temporary staff	Increase in variety of flexible working contracts / informal arrangements reduction in temporary workforce	Recruitment & Retention strategy People Strategy	SWC,CEMG, Transformation Improvement Group Staff Committee, LNC	Reduced number of vacancies, reduction in agency / bank workers, more consistent patient care

Right skills, right time, right place 2019-20

Objective	Measure	Related plan or strategy	Governance arrangements	What will this mean for patients/staff?
A positive approach to mental health, including mindfulness, promotes personal resilience for staff	Increased take up of resilience workshops / mindfulness training or similar, reduction in absence due to mental ill health, staff survey , Friends and family	Occupational Health (OH) strategy People Strategy	SWC, CEMG, Healthy Workplace Staff Committee, LNC	Staff have more positive and resilient approach towards patients and co workers.
Kent & Medway Medical School research strategy	Trust R&I Director consulted on drafting KMMS research strategy	Research & Innovation Strategy (updated document)	QC	Increased opportunities for staff to be employed on joint clinical-academic departments between EKHUFT, KMMS and local Universities
Staff have ready access to support to create a healthy, supportive and caring environment	Reduced absence due to mental ill health, staff survey, friends and Family Test.	OH strategy People Strategy	SWC,CEMG, Healthy Workplace Staff Committee, LNC	

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East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE (SWC)**
BOARD SPONSOR:	**CHAIR OF THE SWC**
PAPER AUTHOR:	**GROUP COMPANY SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: ANNUAL OBJECTIVES – RIGHT SKILLS, RIGHT PLACE, RIGHT TIME AND GREAT PLACE TO WORK (PLEASE REFER TO APPENDIX 2 OF PAPER 19-063: STRATEGIC OBJECTIVES 2019/20)**

BACKGROUND AND EXECUTIVE SUMMARY

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

This report presented reflects Committee activity for the June 2019 meeting.

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

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

MEETING HELD ON 17 JUNE 2019

The Committee is focussed on ensuring the Trust has a robust workforce plan that fits with the NHS People Plan and the Strategic Workforce Plan will be a main agenda item for the August 2019 meeting. This will outline the plans, risks, benefits and where the Trust plan may deviate from the NHS Plan.

1. April 2019 Integrated Performance Report – HR Performance Metrics

It was noted that the April 2019 data was discussed at the June 2019 Board meeting but the following key headlines were shared in relation to May 2019 data:

1.1 All metrics were generally improving aside from sickness absence and it was noted that a deep dive will be presented to the Committee in August 2019;
1.2 It was also highlighted that in some instances recruitment is not like for like and consultant appointments may leave a gap in activity that may still require agency although the need will be less;
1.3 The Committee heard that the Information Team is working on providing trends and a forward look to aid identification of risk to support development of strategic plans;
1.4 The Committee sought assurance that the reduction in agency was not impacting on patient safety or workforce welfare. Re-assurance was provided that this was at the forefront of decision making.

2. Urgent and Emergency Care (UEC) Group Presentation

2.1 Recruitment in all areas is significantly improved; moving to the Care Group structure was highlighted as being a key driver in the change as well as the addition of support roles;

2.2 Appraisals and job planning were identified as areas of concern; plans were in place for completion of appraisals and the process for job planning was underway; assurance was sought on the quality of appraisals and it was confirmed that there was training to support this;
2.3 Sickness also remained a challenge.

3. Generalist and Specialist (GSM) Care Group Presentation

3.1 Nurse recruitment remains a challenge, particularly at William Harvey Hospital. It was noted that GSM was 6 weeks in to development and implementation of a workforce plan with a view to delivering more innovative solutions;
3.2 The Care Group highlighted the impact the delayed transfers of care have on their workforce planning as they are caring for patients who may be better supported in the community. An innovative programme called “I Can” is being rolled out which enables patients to identify what they can do without help and what they need help with. This allows staff to provide more individual care;
3.3 The Committee noted the general improvement in all the metrics except sickness. This is being addressed by a number of actions.

4. Workforce Race Equality Standard (WRES) / Disability Equality Standard (WDES)

4.1 The Committee noted an early draft of these documents and will be receiving final reports with action plans at its August 2019 meeting;
4.2 A specific action in relation to providing further breakdowns within the Black, Asian and Minority Ethnic (BAME) has been requested to allow for further analysis in relation to cultural aspects;
4.3 The Committee will be focussing on these action plans over the next year with a view to seeing a step change for 2020.

5. Staff Turnover and Exit Interview Report

The Committee received the report and highlights the following to the Board:

5.1 Premature turnover has risen slightly and the Committee heard that this is likely to be due to the increase in the level of joiners and the on-boarding process;
5.2 Significant improvements in nurse turnover (from 204 leavers in 2017/18 to 151 in 2018/19) have been made this year. The Committee endorsed a number of key actions to continue the improvement in that area;
5.3 The Committee heard that the Trust had attended and presented at a forum that NHS Improvement hosted on retention and this confirmed that the Trust is focussed on the right areas. The Committee has requested a review of the areas of high turnover to ensure a tailored intervention.

6. Board Assurance Framework 2018/19: Quarter 4

The Committee received the year-end position against the “People” annual priority for 2018/19 which had been included in the Annual Report and Accounts and as such approved by the Board previously.

7. Annual Objectives

The Board approved the annual objectives for 2019/20 at its meeting in April 2019. The Committee discussed the documents, which are attached as Appendix 1 and:

7.1 Received an update on progress with the objectives along with the suggested metrics for monitoring success;
7.2 Confirmed they would monitor these on a quarterly basis and provide feedback to the Board on progress throughout the year.

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The Committee is recommending the monitoring of Great Place to Work and Right Skills, Right Time, Right Place for approval by the Board. The Board is asked to note that in order to deliver these objectives our people need to be the highest priority (outside patient safety and experience).

8. Leadership Framework

The Committee was able to look at the Leadership Framework toolkit which was under development, it has been co-designed through the Leadership Forum and based on best practice. This Framework will be flexible enough to encompass the national picture and the work the Trust is undertaking in relation to a Quality / Cultural Improvement Programme; there would be an implementation plan. The Committee requested that it was made clear that this is to be a values based leadership programme.

9. Consultant Job Planning

The Board is asked to note that engagement remains the key issue in terms of progressing this work, some development of leaders is required to enable them to support this work. The Committee suggested a review of the process to make it as easy as possible and one of the Non-Executive Directors will be providing some guidance and support to the Deputy Medical Director. It was also agreed that this would be taken to the Clinical Executive Management Group.

10. Other Reports

The Committee received and discussed the following reports:

- Gender Pay Gap;
- Equality Diversity and Inclusion Steering Group;
- Joint Chairs Staff Committee;
- Joint Chairs of the Local Negotiating Committee (LNC) of the British Medical Association.

RECOMMENDATIONS AND ACTION REQUIRED:

The Committee asks the Board of Directors to **APPROVE** the following items:

- Annual Objective Monitoring for
  - Great Place to Work; and
  - Right Skills, Right Time, Right Place.

The Committee asks the Board to **NOTE** the report.

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East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR FPC**
PAPER AUTHOR:	**BOARD SUPPORT SECRETARY**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: MONTH 2 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 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.

2 July 2019 Meeting

The Committee reviewed the following matters:

Month 2 Finance Report:

1 The Committee received the month 2 finance report, provided as Appendix 1, the key points to note are below:
  1.1 Month 2 ended with a consolidated deficit of £3.2m in line with the planned position, year-to-date deficit of £7.9m that is £0.1m ahead of plan;
  1.2 The final year-end forecast remains in line with the planned position of a consolidated £37.5m deficit excluding technical adjustments;
  1.3 The EKHUFT's subsidiaries position remains on plan in month;
  1.4 The East Kent Clinical Commissioning Groups (CCGs) contract is an aligned incentive contract, meaning income (excluding high cost drugs) is fixed at £420m for the year;
  1.5 The Cost Improvement Programme (CIP) target for the year is £30m, and the level of CIP delivery increases significantly throughout the year. If EKHUFT continued the current financial run-rate by maintaining the average Year to Date (YTD) Income & Expenditure (I&E) position for the remainder of the financial year, adjusted to reflect the fixed £420m aligned incentive contract, it would generate a year-end deficit of £52m as compared to the £37.5m plan. This

demonstrates the required financial run-rate improvement required to deliver the £30m CIP target. The Trust is currently ahead of its CIP plan to date but a number of challenges remain, particularly the schemes around reducing agency spend. The Trust has not yet reached its target for CIP schemes to be fully green and these are currently at 70% (£21m), and continues to work hard on moving amber at 20% (£6m) and red at 10% (£3m) schemes to green. A key priority is having robust plans and controls in place to deliver the CIP target for 2019/20;

1.6 The focus on delivering the financial position and achieving the CIP target is being maintained by a combination of monthly Executive Performance Review (EPR) meetings and Confirm and Challenge meetings led by the Chief Operating Officer (COO) and Director of Finance and Performance;

1.7 Agency costs remain an area of concern and the main CIP scheme in relation to reducing agency spend. Continued focus is required around monitoring pay costs;

1.8 The Trust's cash balance at the end of M2 is £18.8m, £6.2m above plan;

1.9 The Committee will receive a forecast report following closure of the quarter one period.

Integrated Performance Report (IPR): for Emergency Access, Referral to Treatment (RTT), Cancer and Diagnostics

2 The FPC received highlight reports on the National Constitutional Standards for May 2019 – more details are provided in the Integrated Performance Report (IPR) which is a main item on the Board agenda. The Committee was provided with actions in place to improve performance:

2.1 Accident & Emergency (A&E) 4 hour access standard at 81.22% against the NHS Improvement (NHSI) trajectory of 81.9%, excluding Kent Community Health NHS Foundation Trust (KCHFT) Minor Injury Unit (MIU). This represents an improvement in performance compared to the previous month of 4.1% (from 77.13%). Overperformance in emergency activity due to 7.5% higher than planned levels that has led to an increase in admissions in the new observation bays. No trends have been identified for this level of increase, which has put additional pressure on the Trust's bed stock. The Trust continues to focus on taking forward the Emergency Department (ED) improvement plan;

2.2 There were no 12 Hour Trolley Waits in May;

2.3 Patient flow continues to be the main area of concern due to the high number of >7 and >21 day patients, many of whom are reportable delayed transfers of care (DTOC). The actions in place to mitigate the risk of patient delay are around proactively reviewing all delayed patients by Multi-disciplinary Team (MDT) with escalation at Director level;

2.4 There has been a deterioration in ambulance handover performance. The Trust continues to focus on taking forward the improvement plan that is in place to address this and achieve sustained improvement;

2.5 18 Week Referral to Treatment (RTT) at 80.65% against the trajectory of 79%. 52 week wait patients reported 4 in the month and these patients are being actively managed. The waiting list has increased from 45,867 to 46,331, the size of backlog has reduced and improved from 9,564 to 8,964. Performance is monitored via review of the primary care referrals and daily oversight of the 52 week wait patients;

2.6 62 day Cancer Standard at 80.18% against the improvement trajectory of 85.71%. Actions are in place to reduce >62 day breaches and overall the number of long waiting patients is decreasing and review at Director level will continue. There were 6 patients waiting 104 days or more for treatment or

potential diagnosis;

2.7 Achievement of the 6 week diagnostic standard with a compliance of 99.45%. At the end of the month 84 patients had been waiting over 6 weeks for their diagnostic procedure;

2.8 A review has been undertaken regarding new and follow-up appointments around addressing the number of Did Not Attends (DNAs) to improve the DNA rate. This included ensuring utilisation of text messages regarding appointment notifications. The current DNA rate for new is 7% and for follow-up is 9%, this remains a priority of the Trust to reduce DNAs, and patient appointments are fully booked out.

Aligned Incentive Contract

3 The FPC received and discussed a report regarding an Aligned Incentive Contract with the CCGs, in relation to a fixed contract value for activity of £420m and a variable contract value of £20m for high cost drugs and homecare. This will provide system wide benefits, supporting EKHUFT and the CCG to work together as a system as well as forward planning, and reduce financial risks as well as ensuring action plans are monitored and are being progressed. It was suggested that a joint FPC meeting be held with the CCG in the Autumn:

3.1 The Committee approved:

3.1.1 In principle to commit to an Aligned Incentive Contract for the next 3 to 5 years in alignment with the Joint System Recovery Plan;

3.1.2 To work towards a Joint Programme Management Office (PMO) to deliver improvements across the system.

2018/19 National Costs Collection Submission Report

4 The FPC received, discussed and noted a report regarding the submission of the 2018/19 National Costs Collection by the deadline of 8 July. The Committee received assurance that robust internal processes are in place, strengthened by continuous review and improvements in systems and data quality. Care Group Operational Directors had been engaged in the sign-off process. The final submission would be signed off by the Director of Finance and Performance.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to achieve financial plans as agreed with NHS Improvement (NHSI) under the Financial Special Measures Regime.
LINKS TO STRATEGIC OBJECTIVES:	**Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR5: Failure to achieve financial plans as agreed with NHS Improvement (NHSI) under the Financial Special Measures Regime.
RESOURCE IMPLICATIONS:	None
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	N/A

19/065

NHS
East Kent Hospitals University NHS Foundation Trust

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to **APPROVE** the Finance and Performance Committee Chair Report.

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2019/20

May 2019

Director of Finance and Performance Management
Philip Cave

We care

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Month 02 (May) 2019/20

Executive Summary

The Trust generated a consolidated deficit in month of £3.2m which is in line with the planned position. The year-to-date deficit of £7.9m is £0.1m ahead of plan. The final year-end forecast remains in line with the planned position of a consolidated £37.5m deficit excluding technical adjustments.

The main drivers of the in-month position were:
- EKHUFT Clinical income overperformance of £0.2m driven by £0.8m of overperformance in emergency activity due to 7.5% higher than planned levels YTD which has led to an increase in admissions driven by the new Observation Bays at QEQM and WHH. This overperformance is partially offset by £0.5m of underperformance in outpatient activity due to lower than planned referral rates.
- EKHUFT Pay underspend of £0.5m due to £0.7m of overspends in mainly medical agency staffing due to continued operational pressures, being entirely offset by £1.2m underspend in bank & substantive pay categories.
- EKHUFT Non-pay overspend against plan of £0.7m. The main drivers for the overspend are supplies and services - non clinical and drugs which are adverse to plan by a total of £1.6m in month and £1.9m YTD. The overspend on non-clinical supplies relates to the subjective impact of a change control notice with 2gether which transferred over the management of EME non pay and Modular Theatre rental budgets to them along with funding for 19-20 pay inflation.
- The subsidiaries position was on plan in month, but further work is required to ensure that key drivers of the position are understood and described as part of the Finance Performance report.

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income (inc PSF)	52,719	52,941	222	102,953	102,654	(299)
EKHUFT Pay	(34,136)	(33,682)	454	(67,954)	(67,355)	599
EKHUFT Non-Pay	(21,823)	(22,480)	(657)	(43,351)	(43,392)	(41)
EKHUFT Financial Position (inc PSF)	**(3,240)**	**(3,221)**	**20**	**(8,352)**	**(8,092)**	**260**
Subsidiaries Financial Position	16	22	5	277	122	(155)
Consolidated I&E Position (inc PSF)	**(3,224)**	**(3,199)**	**25**	**(8,075)**	**(7,970)**	**105**
Impairments/ Donated Assets Adjustment	32	46	14	64	93	29
PSF Funding	0	0	0	0	0	0
Consolidated I&E Position (excl PSF)	**(3,192)**	**(3,153)**	**39**	**(8,011)**	**(7,877)**	**134**

The East Kent CCGs contract is an aligned incentive contract which means that income (excluding high cost drugs) is fixed at £420m for the year.

Overall clinical income was £0.2m favourable to plan, although the East Kent CCG contract was in line with the plan excluding high cost drugs which was above plan by £0.4m, this was offset by an underperformance against plan with the NHSE specialised services contract of £0.3m driven by lower than anticipated NICU and ITU activity.

There are issues with the allocation of clinical income between reporting categories due to changes from the national allocation software and ensuring the new observation bay activity is coded correctly and allocated to the correct specialty / care group. Following a detailed review central adjustments have been applied to non-elective activity between care groups to ensure a more reasonable position is reported.

While the financial Month 2 position is positive, the level of CIP delivery increases significantly throughout the year. If EKHUFT continued the current financial run-rate by maintaining the average YTD I&E position for the remainder of the financial year, adjusted to reflect the fixed £420m aligned incentive contract, it would generate a year-end deficit of £52m as compared to our £37.5m plan. This demonstrates the required financial run-rate improvement required to deliver the £30m CIP target so having robust plans and controls in place to deliver this remains a key priority.

This focus on delivering the financial position is being maintained by a combination of monthly Executive Performance Review meetings and Confirm and Challenge meetings led by the COO and FD.

Income and Expenditure G

EKHUFT income was slightly ahead of plan in May by £0.2m, due to a combination of high cost drugs being above plan by £0.4m offset by the NHSE specialised services activity being below plan by £0.3m due to lower than anticipated NICU and ITU activity. With the majority of Trust income included in an aligned incentive contract with East Kent CCGs increased focus is required on delivering activity which remains on a cost and volume payment basis.

There remains an on-going focus on ensuring we deliver the required elective and outpatient activity to hit our access targets so weekly meetings are held with the COO and FD to monitor performance. Further improvement in monthly elective and outpatient activity will be required to deliver our challenging plan for 2019/20. Elective capacity is currently being supported by outsourcing to the independent sector and there are plans developed by each care group to ensure we minimise this.

Pay performance is favourable to plan in May by £0.5m. This was driven by an agency overspend of £0.7m due to above plan usage of agency staff for medical and nursing cover offset by underspends on substantive and bank staffing costs of £1.2m. Total expenditure on pay in May was £33.7m, a £0.1m reduction from April. Excluding the effect of lump sum payments for non-consolidated pay award in April and clinical excellence awards in May, there is an underlying increase in spend of £0.6m which relates mainly to bank holiday enhancements and temporary staff usage.

Non Pay expenditure is adverse to plan in May by £0.7m. This is predominantly due to an overspend on non-clinical supplies relating to a change control notice with 2gether which transferred over the management of EME non pay and Modular Theatre rental budgets to them along with funding for 19-20 pay inflation.

Cash G

The Trust's cash balance at the end of May was £18.8m which is £6.2m above plan. The main drivers for this position were higher than planned payments received from Health Education England of £4.5m combined with £1m lower than planned payments to 2SS.

The Trust did not borrow any cash in May therefore total Trust borrowings remained at £96.5m. The planned 19/20 loan is £37.2m in line with the plan pre technical deficit.

Capital Programme G

Total expenditure at the end of May 2019 is £0.2m (16.5%) above plan. This is mainly due to legacy spend from 2018/19 schemes in A&E and equipment replacement. It is expected that spend will fall back in line with the YTD plan for Month 3.

Cost Improvement Programme G

The target for the year is £30m. The Trust has achieved £2.8m of savings YTD against a plan of £2.1m. Within this £0.5m of savings were delivered non-recurrently.
The forecast CIP achievement for the year is £30m, but as the target increases throughout the year the Trust is maintaining confirm and challenge meetings to ensure robust delivery plans are in place.
As at the time of reporting, c.70% of schemes forecast were delivered or 'green' rated. Care Groups, supported by the PMO, continue working up schemes for 2019/20 focusing on delivery of planned target and moving Red and Amber schemes to Green.

Income and Expenditure Summary

Month 02 (May) 2019/20

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	8,268	8,443	175	15,899	15,926	27	97,761
Non-Electives	15,687	16,519	832	30,653	31,161	508	180,314
Accident and Emergency	2,910	2,997	87	5,616	5,872	256	33,838
Outpatients	7,298	6,785	(513)	13,823	13,150	(673)	82,026
High Cost Drugs	4,489	4,887	398	8,837	9,253	416	53,027
Private Patients	45	22	(24)	89	63	(26)	528
Other NHS Clinical Income	10,192	9,359	(833)	20,379	19,609	(770)	122,658
Other Clinical Income	148	232	84	297	274	(23)	1,781
Total Clinical Income	**49,038**	**49,243**	**205**	**95,593**	**95,308**	**(285)**	**571,932**
Non Clinical Income	3,681	3,698	17	7,360	7,346	(14)	44,856
Total Income	**52,719**	**52,941**	**222**	**102,953**	**102,654**	**(299)**	**616,788**
Expenditure							
Substantive Staff	(30,452)	(29,318)	1,134	(60,562)	(59,049)	1,513	(353,473)
Bank	(1,477)	(1,416)	61	(2,907)	(2,682)	225	(24,941)
Agency	(2,207)	(2,948)	(741)	(4,485)	(5,624)	(1,139)	(18,585)
Total Pay	**(34,136)**	**(33,682)**	**454**	**(67,954)**	**(67,355)**	**599**	**(396,999)**
Non Pay	(19,877)	(20,928)	(1,050)	(39,458)	(39,632)	(173)	(233,850)
Total Expenditure	**(54,013)**	**(54,609)**	**(596)**	**(107,412)**	**(106,987)**	**426**	**(630,849)**
Non-Operating Expenses	(1,946)	(1,553)	394	(3,893)	(3,760)	133	(24,554)
Income and Expenditure Surplus/(Deficit)	**(3,240)**	**(3,221)**	**20**	**(8,352)**	**(8,092)**	**260**	**(38,615)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	49,745	50,110	365	96,963	96,887	(76)	580,458
Non Clinical Income	3,669	4,401	732	7,336	8,261	925	44,710
Total Income	**53,414**	**54,511**	**1,097**	**104,299**	**105,148**	**849**	**625,168**
Expenditure						-	
Pay	(36,677)	(36,190)	487	(72,877)	(72,531)	346	(426,208)
Non Pay	(18,070)	(19,977)	(1,907)	(35,728)	(36,901)	(1,173)	(212,244)
Total Expenditure	**(54,747)**	**(56,167)**	**(1,420)**	**(108,605)**	**(109,432)**	**(827)**	**(638,452)**
Non-Operating Expenses	(1,891)	(1,543)	348	(3,769)	(3,686)	83	(24,247)
Income and Expenditure Surplus/(Deficit)	**(3,224)**	**(3,199)**	**25**	**(8,075)**	**(7,970)**	**105**	**(37,531)**

Clinical Income

East Kent CCGs contract is an aligned incentive contract which means that income (excluding High cost drugs) is fixed at £420m for the year. Public Health Screening contracts are also fixed values for the year with all other contracts operating on a PbR basis.

Elective income overall is performing to plan, whilst Non Elective income is higher than plan due in large part to the opening of the observation bays at QEQM and WHH. The trust planned for £3m additional income for the year from these bays and actual income generated is forecast to be in excess of this based on the first two months. It is important to note that under a PbR contract this activity would have been subject to a local tariff and that this activity is currently being costed at an artificially high tariff. In addition, under a PbR contract, over performance would have been capped at 20% and therefore payable income overperformance would have been nearer £100k ytd.

Other NHS clinical income is under performing due to lower than plan activity in both NICU and ITU. This type of activity is typically difficult to forecast due to unpredictable variations month to month.

Non Clinical Income and Expenditure

Non clinical income is marginally favourable to plan in May and marginally adverse to plan ytd.

Total expenditure is adverse to plan by £0.6m in May and favourable by £0.4m ytd. In month, non pay is the main driver for the overspend at £1.1m with pay under spending by £0.5m. Substantive staff are underspent by £1.1m and this is partially offset by an overspend on agency and directly engaged staff of £0.7m. There was an increase in pay spend of £0.6m when compared to April, mainly in substantive staff which incurred £0.3m of bank holiday enhancements.

The main drivers for the non pay overspend in month are supplies and services - non clinical and drugs which in total are adverse to plan by £1.6m in month and £1.9m ytd. These overspends are offset by a favourable performance on the purchase of healthcare from external organisations of £0.4m.

Actual expenditure on non pay increased by £2.2m when compared to April, with increased spend on drugs of £1.0m, clinical supplies £0.4m, non clinical supplies £0.4m and other operating expenses £0.4m.

Key Highlights
Month 02 (May) 2019/20

CLINICAL INCOME

Pressure on A&E departments continues as activity is 7.5% higher than planned levels YTD and 6% in May. This has led to an increase in admissions. However, the actual increase in short stay non elective patients is also being driven by the new Observation Bays at QEQM and WHH.

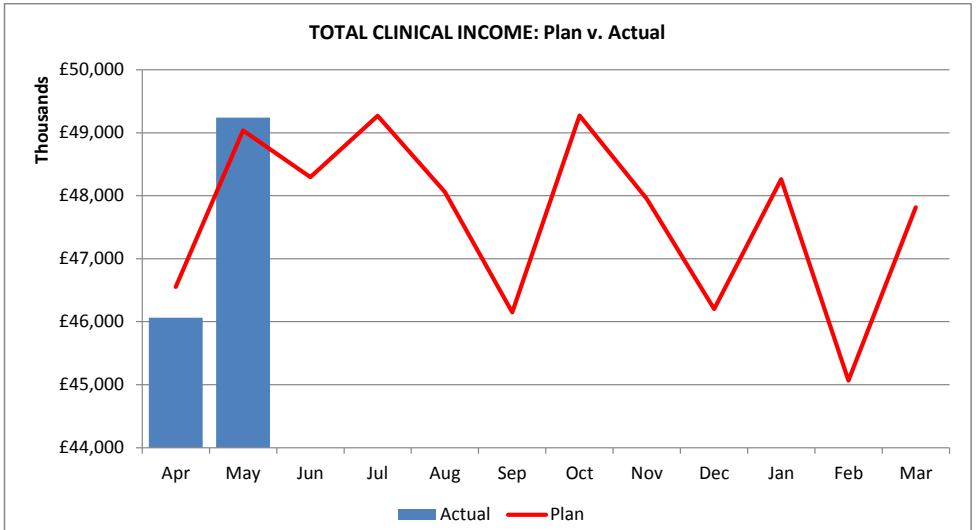
Long stay patients non elective patients are showing a richer case mix than planned and there is concern at the increasing number of super stranded patients due to pressures on community and social services. The Trust is in negotiations with commissioners to find suitable solutions at pace to solve this issue.

PbR income in month is under performing by £391k with to specialised services provided by Cardiology and Neonatology under plan. This type of activity is typically difficult to forecast due to unpredictable variations month to month.

ACTIVITY

A&E demand is ahead of plan by 7% this month.
Non-elective activity is 991 over plan in month. However the mix between short and long stay patients has favoured shorter stays during the month, this is likely a result of the introduction of the Observation Bay at QEQM and WHH.
Outpatient activity is slightly below plan in month, new appointments are on plan (+72) but we are showing 2% under plan (-473) for follow up appointments.

Total Elective activity is 3% ahead of plan in month, and on plan YTD.



COMMISSIONER ANALYSIS

East Kent CCGs contract is an aligned incentive contract which means that income (excluding High cost drugs) is fixed at £420m for the year. Drugs Expenditure is planned at £20m however this will be monitored and paid on a variable basis depending on actual spend. Any over or underperformance against drugs will have an offsetting effect against expenditure so is net nil position to the bottom line.

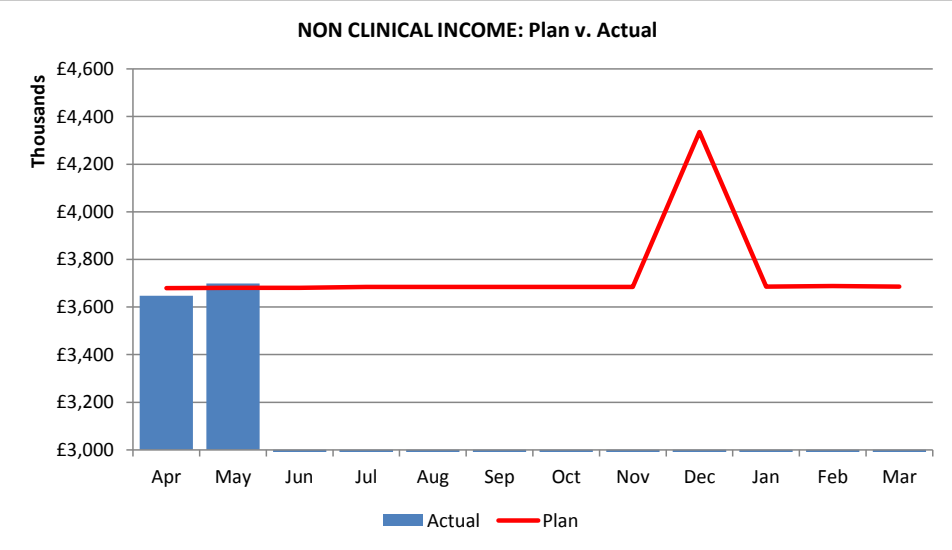
Public Health Screening contracts are also fixed values for the year with all other contracts operating on a PbR basis.

NHSE contract value for the year is £84.8m within which is an expectation of commissioner QIPP of £2.8m. The Trust will support commissioners in the delivery of this QIPP, however the risk of non delivery sits with the commissioner.

Key Highlights
Month 02 (May) 2019/20

NON CLINICAL INCOME

Non clinical income is marginally favourable to plan in May and marginally adverse to plan ytd. In month, profits on the sale of assets of £0.1m are offset by an adverse variance on non patient care income (theatre services provided to Spencer Wing currently under investigation) of £0.1m. These themes are reflected in the ytd position with profits on the sale of assets totalling £0.3m being offset by an underperformance against plan for non patient care services, car parking and property rental income totalling £0.3m.

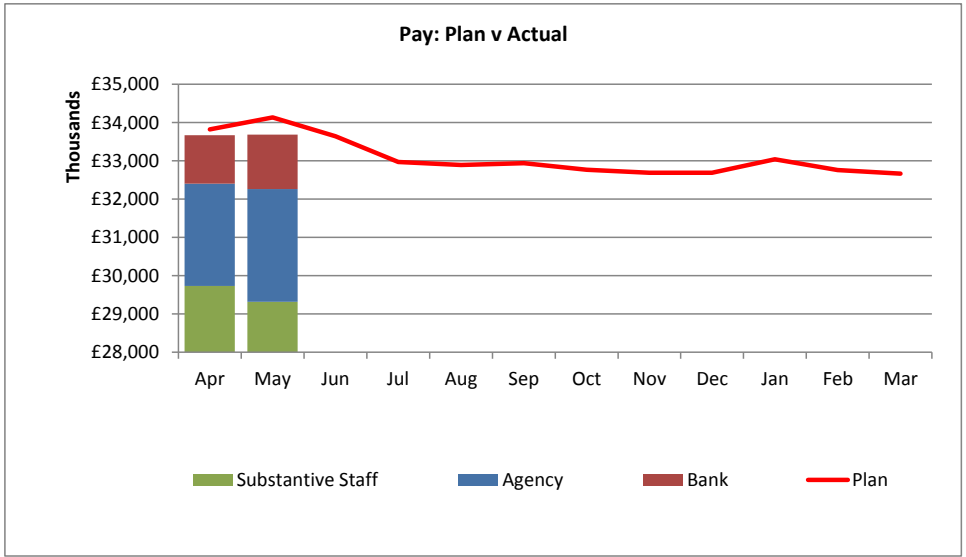


PAY

Pay performance is favourable to plan in May by £0.5m (0.88%) and by £0.6m ytd. Pay CIPs are adverse to plan by £0.4m in month and by £0.9m ytd.

In month, underspends on substantive staff and medical locum sessions including waiting list payments and bank staff totalling £1.2m offset an overspend on agency and directly engaged staff, mainly medical staff, totalling £0.7m.

Total expenditure on pay in May was £33.7m, showing only a marginal movement in expenditure when compared to April. Excluding the effect of lump sum payments for non consolidated pay award in April and clinical excellence awards in May, the underlying increase in spend of £0.6m relates mainly to bank holiday enhancements and temporary staff usage.



Key Highlights
Month 02 (May) 2019/20

NON-PAY
Non pay expenditure is adverse to plan in May by £1.1m and by £0.2m yd. (0.44%). Non pay CIP schemes are favourable to plan in month by £0.1m and adverse to plan ytd by £0.3m.

The main drivers for the overspend in month are supplies and services - non clinical and drugs which are adverse to plan by a total of £1.6m in month and £1.9m ytd. The overspend on non clinical supplies relates to the subjective impact of a change control notice with 2gether which transferred over the management of EME non pay and Modular Theatre rental budgets to them along with funding for 19-20 pay inflation. The drug overspend is split equally between rechargeable and other drugs. These overspends are offset by a favourable performance on the purchase of healthcare from external organisations of £0.4m.

Actual expenditure on non pay increased by £2.2m when compared to April, with increased spend on drugs of £1.0m, split equally between rechargeables and other drugs, clinical supplies £0.4m, non clinical supplies £0.4m and other operating expenses £0.4m.

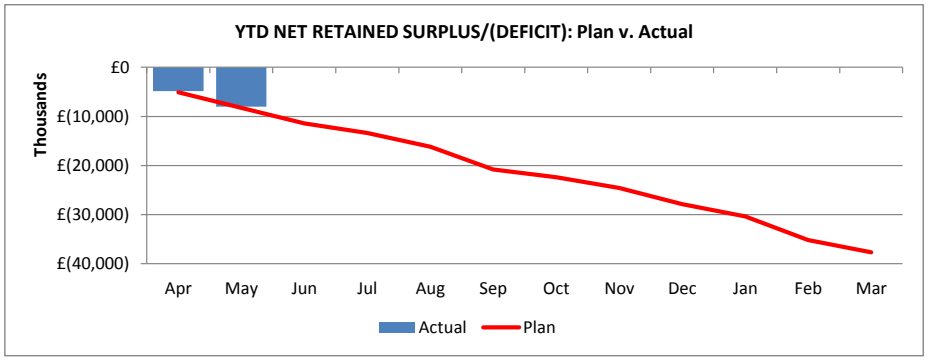
DEBT
Total invoiced debtors have reduced in month by £3.9m to £18.2m. The largest debtors at 31st May were 2gether Support Solutions £3.9m and NHS England £1.9m.

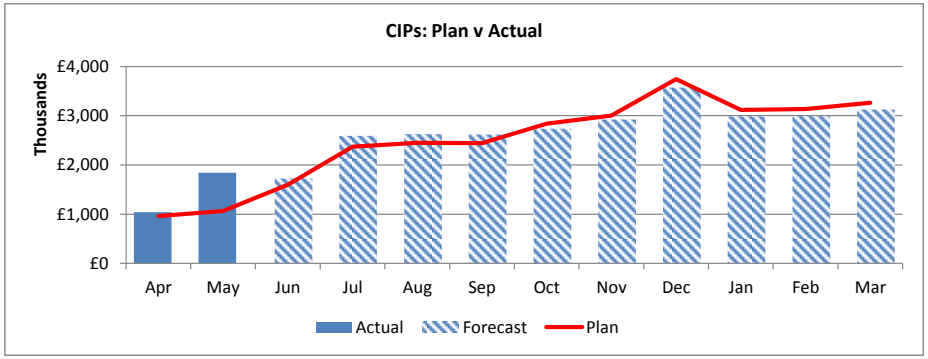
CAPITAL
Total YTD expenditure for Mth 2 2018/19 is £1.5m.

EBITDA
The Trust is reporting a year to date deficit EBITDA of £4.3m

CASH
The closing cash balance for the Trust as at 31st May was £18.8m.
The value of aged debt was £15.9m, a reduction of £755k in month.

FINANCING
£413k of interest has been incurred year-to-date in respect of the drawings against working capital facilities.

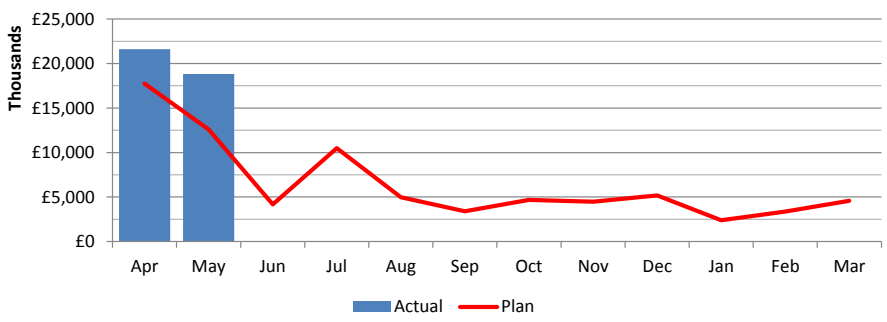




CIPS
The target for the year is £30m. The Trust is maintaining confirm and challenge meetings. As at the time of reporting, c.67% of schemes forecast were 'green' rated. Care Groups, supported by the PMO, continue working up schemes for 2019/20 focusing on delivery of planned target and moving Red and Amber schemes to Green.

Cash Flow

Month 02 (May) 2019/20



Unconsolidated Cash balance was £18.8m at the end of May 2019, £6.2m above plan.

Total receipts in May 2019 were £4.2m above plan

- Receipts from East Kent CCGs were consistent with plan
- VAT reclaim £0.2m above plan
- Receipts from Health Education England £4.5m above plan
- Other receipts £0.5m below plan

Total Payments in May 2019 were £1.8m above plan

- Monthly payroll (inc Tax/NI and Pensions) was £1.0m above plan
- Creditor payments inc Capital were £1.8m above plan
- Payments to 2gether Support Solutions were £1.0m below plan

Provider Sustainability Funding

As a result of the Trust not agreeing to a control total, the Trust is not eligible for any PSF funding in 2019/20.

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
2018/19 Received	42,122	ISUCL	2021/22	3.5%	4,447
April 2019 (Received)	8,147	ISUCL	2022/23	3.5%	859
June 2019 (Agreed)	2,972	ISUCL	2022/23	3.5%	TBC
July 2019 (Requested)	1,769	ISUCL	2022/23	3.5%	TBC
Aug' 2019 (Plan)	2,737	ISUCL	2022/23	3.5%	TBC
Sept' 2019 (Plan)	4,502	ISUCL	2022/23	3.5%	TBC
Oct' 2019 (Plan)	1,597	ISUCL	2022/23	3.5%	TBC
Nov'2019 (Plan)	2,157	ISUCL	2022/23	3.5%	TBC
Dec' 2019 (Plan)	2,983	ISUCL	2022/23	3.5%	TBC
Jan' 2020 (Plan)	2,634	ISUCL	2022/23	3.5%	TBC
Feb' 2020 (Plan)	4,644	ISUCL	2022/23	3.5%	TBC
Mar' 2020 (Plan)	2,858	ISUCL	2022/23	3.5%	TBC

Planned 19/20 Loan is £37.2m in line with the plan pre technical deficit.

Borrowings of £8.1m in April 19 have been received and a further £3.0m has been agreed for June. Borrowings of £1.8m have been requested for July.

Creditor Management

- At the end of May 2019 the Trust was recording 42 creditor days (Calculated as invoiced creditors at 31st May/ Forecast non pay expenditure x 365)
- The Trust has continued to pay supplier to due date throughout May 19.

- 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

Risks and Opportunities
Month 02 (May) 2019/20

Risk/Opp	Area	Description	Narrative	Full Year (Risk)/Opp £000	Probability	Impact £,000
Risk	CIP Delivery	Red and Amber Schemes to be fully developed	Schemes which do not yet have a fully finalised plans have a higher risk of non delivery	(2,800)	50%	(1,400)
			Total Risk			(1,400)
			Total Opportunity			
			NET (RISK)/OPPORTUNITY			(1,400)

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

Clinical Income

Month 02 (May) 2019/20

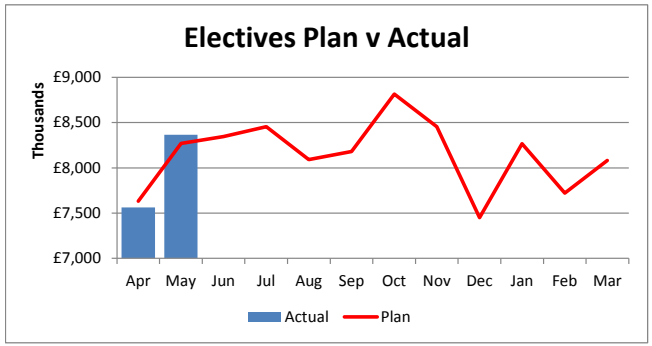
	This Month				Year to Date				Annual
£000	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	8,268	8,365	97	1.2%	15,899	15,926	27	0.2%	97,761
Non-Electives	15,687	15,819	132	0.8%	30,653	31,161	508	1.7%	180,314
Accident and Emergency	2,910	2,985	75	2.6%	5,616	5,872	256	4.6%	33,838
Outpatients	7,298	6,659	(639)	(8.8%)	13,823	13,150	(673)	(4.9%)	82,026
High Cost Drugs	4,489	4,792	303	6.7%	8,837	9,253	416	4.7%	53,027
Private Patients	26	21	(5)	(20.9%)	51	62	11	22.1%	318
Other NHS Clinical	10,212	10,139	(73)	(0.7%)	20,418	19,610	(808)	(4.0%)	122,867
Other Clinical	148	153	5	3.5%	296	274	(22)	(7.5%)	1,781
Prior Month Adjustment		309	309	0.0%				0.0%	
Total	**49,038**	**49,242**	**204**	0.4%	**95,593**	**95,308**	**(285)**	(0.3%)	**571,932**
			Favourable					Adverse	

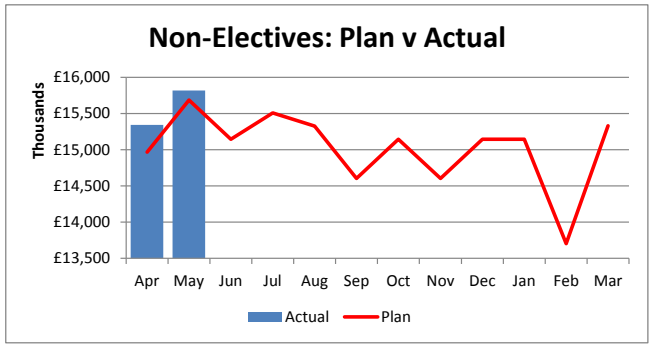
Income is over plan in May however under plan YTD.

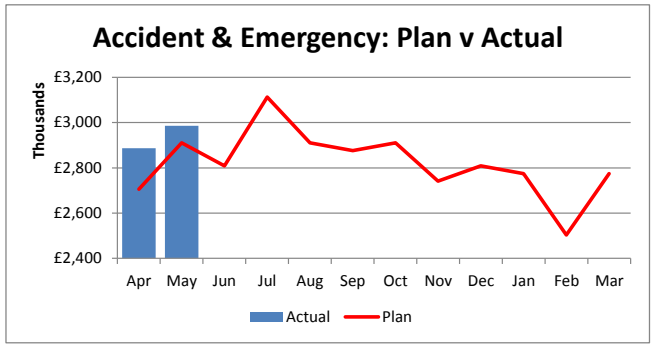
Within May the primary over performance is within A&E (£75k), short stay non elective (£338k), day cases (£274k) and first outpatient procedures (£110k), with patients being treated and discharged quicker across the Trust when compared to the plan.

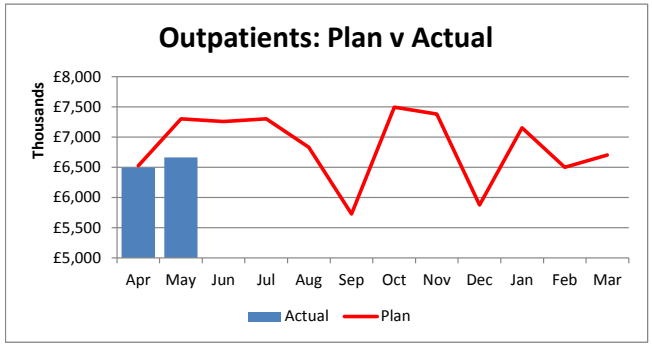
Elective activity overall has over performed in month, meaning YTD it is roughly on plan this is because Day cases and regular day attenders are over performing, with long stay inpatients underperforming.

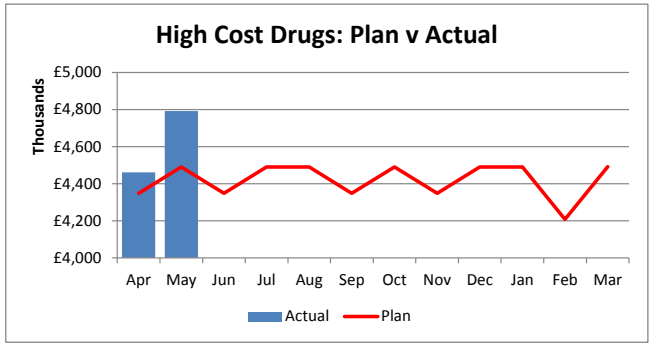
Rechargeable income for drugs, devices and haemophilia blood products is above plan YTD, however £200k of this is due to our contracted benefit share of the reduced costs of the Trust prescribing biosimilar products. This improves the Trusts bottom line. The remaining £216k over performance does not impact the bottom line as the costs are pass-through and therefore are offset by a similar increase in drugs expenditure.

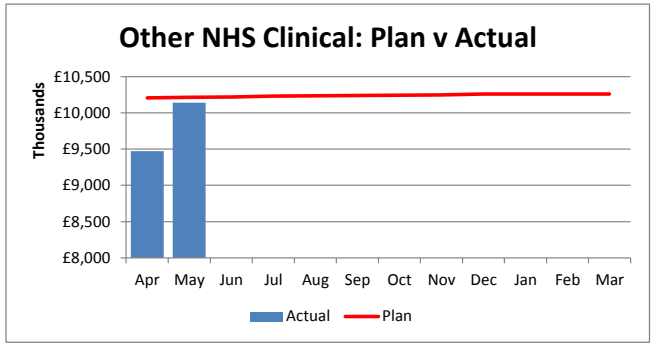












Clinical Activity
Month 02 (May) 2019/20

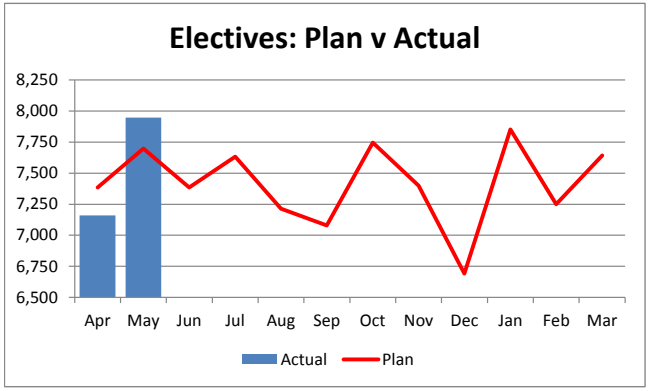
	This Month				Year to Date				Annual
Activity Units	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	7,698	7,948	250	3.2%	15,084	15,107	23	0.2%	88,976
Non-Electives	6,794	7,788	994	14.6%	13,233	15,102	1,869	14.1%	79,574
Accident & Emergency	18,766	19,882	1,116	5.9%	36,248	38,955	2,707	7.5%	221,719
Outpatients	64,859	63,413	(1,446)	(2.2%)	122,483	125,569	3,086	2.5%	772,072
Other NHS Clinical	490,202	510,213	20,011	4.1%	964,288	996,380	32,092	3.3%	5,802,718
Total	**98,117**	**99,031**	**914**	0.9%	**187,048**	**194,733**	**7,685**	4.1%	**1,162,341**
			Favourable				Favourable		

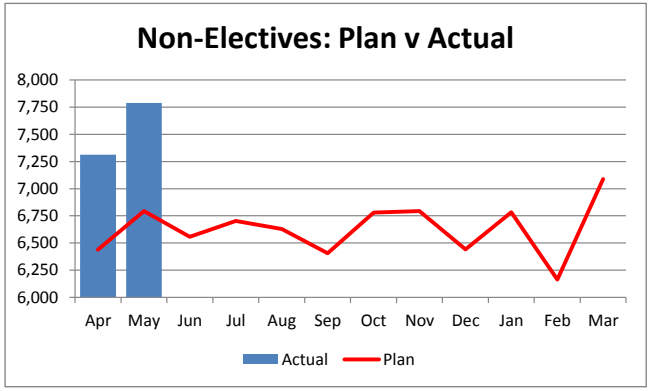
Total Elective activity is on plan YTD, with Day Cases being 1% under, inpatients being 15% under, this however is countered by Regular Day Attenders being 30% over plan in month. The specialties with notable variances from plan are Urology by 135, Ophthalmology by -198, general medicine by -170 and Rheumatology by 236.

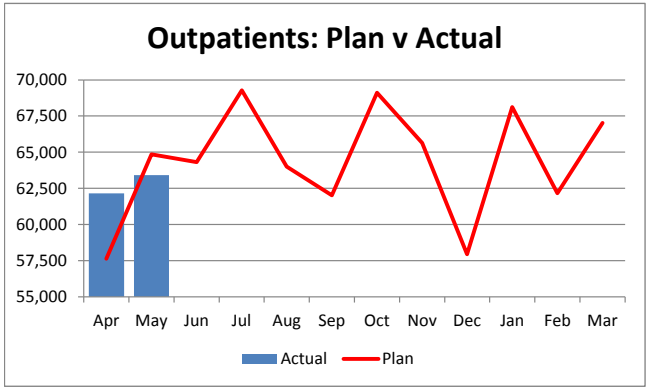
Outpatient activity is over performing YTD by 6% in new and 3% in follow up attendances.

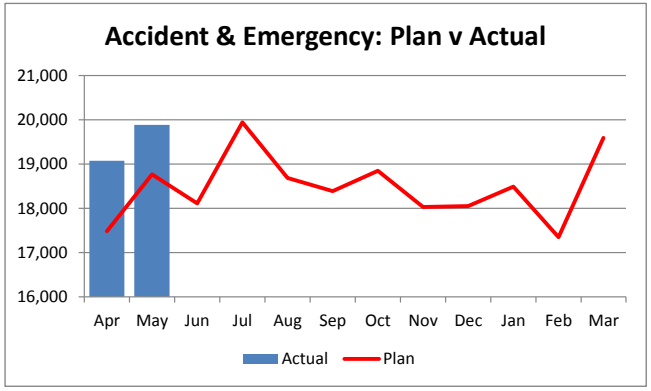
For new appointments the notable variances are Cardiology by -310, Colorectal Surgery by+ 254, T&O by +490, ENT by -169 and Ophthalmology by +240.

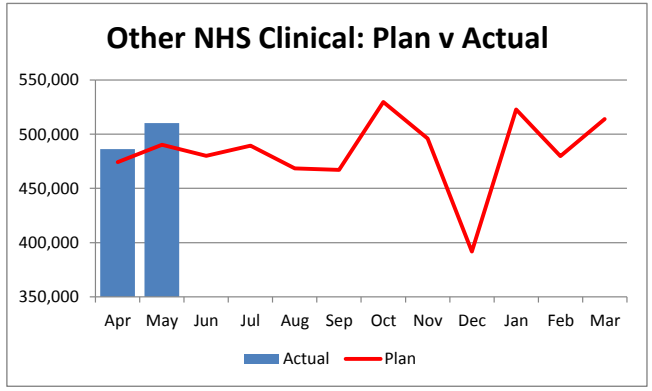
For Follow up appointments the notable variances are Urology by +383, Cardiology by -290, Community Paeds by -264, Dermatology by +136, Gynaecology by +336, Orthoptics by +798 and Ophthalmology by -597.







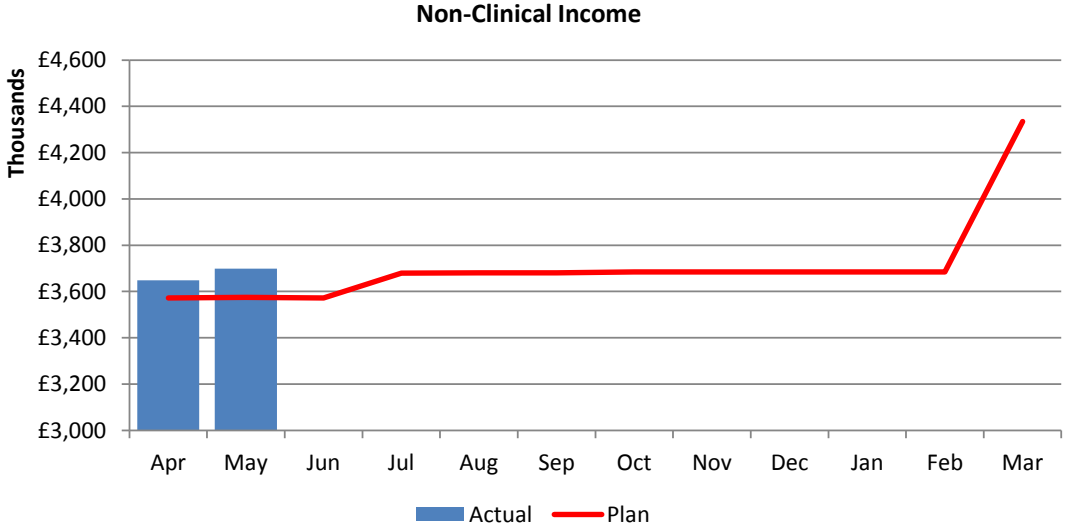




Non Clinical Income

Month 02 (May) 2019/20

Non-Clinical Income	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,348	1,274	(74)	2,696	2,498	(198)	16,180
Research and development	241	267	26	482	525	43	2,924
Education and Training	1,286	1,271	(15)	2,570	2,615	45	15,430
Car Parking income	429	421	(8)	858	816	(42)	5,156
Staff accommodation rental	195	182	(13)	390	393	3	2,342
Property rental (not lease income)	18	()	(18)	36	2	(34)	213
Cash donations / grants for the purchase of capital assets	38	38	(1)	76	75	(1)	450
Charitable and other contributions to expenditure	12	13	1	24	25	1	143
Other	114	233	119	228	397	169	2,018
Total	**3,681**	**3,698**	**17**	**7,360**	**7,346**	**(14)**	**44,856**
			0.47%			-0.19%	
			Favourable			Adverse	



Non clinical income is marginally favourable to plan in May and marginally adverse to plan ytd. Non clinical income CIPs are also marginally adverse to plan in May and ytd.

In month, profits on the sale of assets released in May of £0.1m are offset by an adverse variance on non patient care income (theatre services provided to Spencer Wing currently under investigation) of £0.1m. These themes are reflected in the ytd position with profits on the sale of assets totalling £0.3m being offset by an underperformance against plan for non patient care services (mainly Spencer Wing as above), car parking and property renal income totalling £0.3m.

Pay
Month 02 (May) 2019/20

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	1,147	1,075	72	(9,492)	(8,992)	500	(18,877)	(17,704)	1,173	(112,507)
Nurses and Midwives	2,450	2,120	331	(8,554)	(8,264)	290	(17,011)	(16,729)	282	(101,388)
Scientific, Therapeutic and Technical	1,467	1,384	84	(4,774)	(4,595)	178	(9,494)	(9,382)	112	(56,585)
Admin and Clerical	1,465	1,339	126	(2,895)	(2,896)	(1)	(5,758)	(5,911)	(153)	(34,320)
Other Pay	1,526	1,421	105	(4,105)	(4,179)	(74)	(8,165)	(8,446)	(281)	(48,673)
Permanent Staff Total	**8,056**	**7,339**	**717**	**(29,820)**	**(28,926)**	**893**	**(59,304)**	**(58,171)**	**1,133**	**(353,473)**
Waiting List Payments										
Medical and Dental	0	0	0	(362)	(206)	156	(721)	(418)	303	(4,296)
Waiting List Payments Total	**0**	**0**	**0**	**(362)**	**(206)**	**156**	**(721)**	**(418)**	**303**	**(4,296)**
Medical Locums/Short Sessions										
Medical and Dental	0	23	(23)	(270)	(185)	85	(537)	(460)	77	(3,201)
Medical Locums/Short Sessions Total	**0**	**23**	**(23)**	**(270)**	**(185)**	**85**	**(537)**	**(460)**	**77**	**(3,201)**
Substantive	**8,056**	**7,362**	**694**	**(30,452)**	**(29,318)**	**1,134**	**(60,562)**	**(59,049)**	**1,513**	**(360,970)**
Bank										
Medical and Dental	0	14	(14)	(377)	(265)	112	(742)	(440)	301	(4,450)
Nurses and Midwives	0	107	(107)	(386)	(457)	(71)	(760)	(864)	(104)	(4,562)
Scientific, Therapeutic and Technical	0	6	(6)	(24)	(32)	(9)	(47)	(62)	(15)	(280)
Admin and Clerical	0	52	(52)	(207)	(146)	62	(408)	(285)	123	(2,448)
Other Pay	0	181	(181)	(483)	(516)	(33)	(951)	(1,031)	(80)	(5,704)
Bank Total	**0**	**361**	**(361)**	**(1,477)**	**(1,416)**	**61**	**(2,907)**	**(2,682)**	**225**	**(17,444)**
Agency										
Medical and Dental	36	142	(106)	(1,225)	(1,809)	(584)	(2,490)	(3,541)	(1,051)	(10,318)
Nurses and Midwives	0	163	(163)	(671)	(813)	(143)	(1,363)	(1,535)	(172)	(5,647)
Scientific, Therapeutic and Technical	0	18	(18)	(153)	(107)	46	(312)	(234)	78	(1,292)
Admin and Clerical	0	3	(3)		(15)	(15)		(30)	(30)	
Other Pay	0	8	(8)	(47)	(18)	28	(95)	(18)	76	(392)
Agency Total	**36**	**334**	**(298)**	**(2,096)**	**(2,763)**	**(667)**	**(4,259)**	**(5,359)**	**(1,100)**	**(17,649)**
Direct Engagement - Agency										
Medical and Dental	0	14	(14)	(111)	(186)	(75)	(226)	(264)	(38)	(936)
Direct Engagement - Agency Total	**0**	**14**	**(14)**	**(111)**	**(186)**	**(75)**	**(226)**	**(264)**	**(38)**	**(936)**
Agency	**36**	**348**	**(312)**	**(2,207)**	**(2,948)**	**(741)**	**(4,485)**	**(5,624)**	**(1,139)**	**(18,585)**
Total	**8,092**	**8,071**	**21**	**(34,136)**	**(33,682)**	**454**	**(67,954)**	**(67,355)**	**599**	**(396,999)**
						1.33%			0.88%	
						Favourable			Favourable	

Pay performance is favourable to plan in May by £0.5m and by £0.6m ytd (0.88%). Pay CIPs are adverse to plan by £0.4m in month and by £0.9m ytd.

Total expenditure on pay in May was £33.7m, showing only a marginal movement from expenditure in April. However the pay bill in April included £0.9m of cost relating to the non consolidated pay award lump sum paid to substantive staff at top of scale. In May, lump sum clinical excellence award costs were paid or accrued totalling £0.3m, suggesting an underlying increase in spend of £0.6m. Excluding the effect of the movement in lump sum payments, increases in spend can be seen in most pay headings, particularly substantive staff which increased by £0.4m, mainly relating to bank holiday enhancement costs of £0.3m. Expenditure on overtime costs and locum medical sessions fell by a total of £0.2m when compared to April.

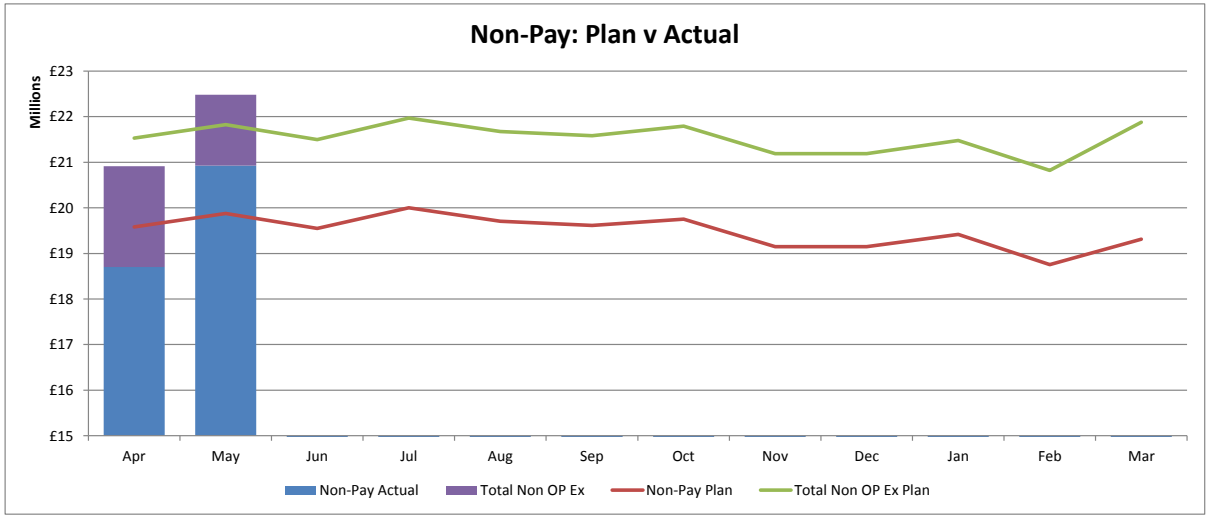
Expenditure on substantive staff is favourable to plan in May by £1.1m and by £1.5m ytd including payments relating to locum medical sessions and waiting list activity. All clinical staff groups are favourable to plan, partially offset by overspends on admin and clerical and other staffing groups including HCAs.

Expenditure on bank staff is favourable to plan by less than £0.1m in May and by £0.2m ytd, predominantly relating to medical and dental staff. Actual expenditure on bank staff increased by £0.1m when compared to expenditure in April.

Expenditure on agency staff including directly engaged agency staff is adverse to plan in May by £0.7m and by £1.1m ytd. The main driver for the overspend is medical staff, again mainly relating to staff in General and Specialist Medicine, Urgent and Emergency Care and Surgery and Anaesthetic care groups. Agency CIP schemes are behind plan by £0.1m in May and by £0.4m ytd. Actual expenditure on agency staff increased by £0.3m when compared to spend in April.

Non-Pay
Month 02 (May) 2019/20

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(5,518)	(6,084)	(566)	(10,856)	(11,143)	(287)	(65,019)
Clinical Supplies and Services - Clinical	(2,506)	(2,604)	(98)	(4,887)	(4,812)	75	(28,530)
Supplies and Services - Non-Clinical	(6,949)	(7,978)	(1,029)	(13,925)	(15,535)	(1,610)	(82,903)
Purchase of Healthcare	(793)	(344)	449	(1,562)	(788)	774	(9,473)
Education & Training	(282)	(165)	117	(564)	(298)	266	(3,383)
Consultancy	(73)	(97)	(24)	(151)	(121)	30	(883)
Premises	(908)	(659)	249	(1,817)	(1,473)	344	(10,336)
Clinical Negligence	(1,814)	(1,814)		(3,628)	(3,628)		(20,899)
Transport	(240)	(215)	25	(480)	(383)	97	(2,879)
Establishment	(298)	(371)	(73)	(596)	(609)	(13)	(3,576)
Other	(496)	(597)	(101)	(992)	(843)	149	(5,969)
Total Non-Pay Expenditure	**(19,877)**	**(20,928)**	**(1,050)**	**(39,458)**	**(39,632)**	**(173)**	**(233,850)**
Depreciation & Amortisation-Owned Assets	(1,281)	(1,332)	(51)	(2,562)	(2,665)	(103)	(16,071)
Impairment Losses							(500)
Profit/Loss on Asset Disposals							
PDC Dividend	(291)	(291)		(581)	(581)		(3,487)
Interest Receivable	214	230	16	428	458	30	2,568
Interest Payable	(589)	(160)	429	(1,177)	(972)	206	(7,064)
Other Non-Operating Expenses							
Total Non-Operating Expenditure	**(1,946)**	**(1,553)**	**394**	**(3,893)**	**(3,760)**	**133**	**(24,554)**
Total Expenditure	**(21,823)**	**(22,480)**	**(657)**	**(43,351)**	**(43,392)**	**(41)**	**(258,404)**



Non pay expenditure is adverse to plan in May by £1.1m and by £0.2m ytd. (0.44%). Non pay CIP schemes are favourable to plan in month by £0.1m and adverse to plan ytd by £0.3m.

Drug expenditure is adverse to plan by £0.6m in May and by £0.3m ytd. Pass-through drugs are adverse to plan in month by £0.2m and by £0.1m ytd, offset by a favourable position on clinical income. All other drugs are adverse to plan by £0.4m in May and by £0.2m ytd with most clinical care groups showing an overspend. Drug CIPs are favourable to plan in month and ytd by less than £0.1m.

Supplies and Services - Clinical are adverse to plan in month by £0.1m and favourable to plan ytd by £0.1m. CIP schemes are adverse to plan by £0.1m in month and by £0.3m ytd, predominantly in General and Specialist Medicine. In month, an adverse position on referred diagnostics to Viapath of £0.2m is under investigation, and estimated costs relating to the MRI breakdown at WHH of £0.1m are offset by a favourable position on medical equipment and disposables £0.3m.

Supplies and Services - Non-Clinical are adverse to plan in April by £1.0m and by £1.6m ytd. This is mainly driven by the subjective impact of an approved change control notice with 2gether which transferred over the management of EME non pay and Modular Theatre rental budgets to them and funding for 19-20 pay inflation. These changes create a subjective movement between categories as they are enacted. CIP schemes are marginally favourable to plan in month and are adverse £0.1m ytd.

Purchase of healthcare from external organisations is favourable to plan £0.4m in month and £0.8m ytd, which continues to reflect slippage on planned activity change. CIP schemes are ahead of plan by £0.2m in may and by £0.3m ytd.

Education and training is favourable to plan by £0.1m and £0.3m ytd, mainly in post graduate medical education.

Expenditure on premises costs are favourable to plan in May by £0.2m and by £0.3m ytd, mainly relating to modular theatre rental - see above offset to non clinical supplies re CCN with 2gether.

The favourable variance for other expenditure of £0.1m ytd relates predominantly to slippage on planned investments.

Actual expenditure on non pay increased by £2.2m when compared to April, with increased spend on drugs of £1.0m, split equally between rechargeables and other drugs, clinical supplies £0.4m, non clinical supplies £0.4m and other operating expenses £0.4m.

Non-Operating Expenditure is £0.1m better than plan. The Trust has incurred £1.0m interest charges in respect of the £96.5m (no movement from April's value as no borrowing incurred in month) cumulative facility utilised to date.

Cost Improvement Summary

Month 02 (May) 2019/20

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	129	685	556	252	936	684	7,913	(49)
Workforce *	335	234	(101)	659	599	(60)	2,720	(2,722)
Procurement	41	173	132	82	179	97	1,892	(108)
Medicines Value	140	285	145	279	309	30	2,027	262
Theatres	193	278	85	307	467	160	4,175	1,363
Care Group Schemes **	229	188	(41)	450	389	(61)	9,033	1,255
Sub-total	**1,067**	**1,842**	**775**	**2,030**	**2,880**	**850**	**28,759**	**-**
Central	-	-	-	-	-	-	1,241	-
Grand Total	**1,067**	**1,842**	**775**	**2,030**	**2,880**	**850**	**30,000**	**-**

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

Delivered £000

Month	Target	Actual
April	963	1,039
May	1,067	1,842
June	1,602	
July	2,371	
August	2,452	
September	2,446	
October	2,836	
November	3,000	
December	3,746	
January	3,118	
February	3,135	
March	3,264	
	30,000	**2,880**
		9.6%

CIPs

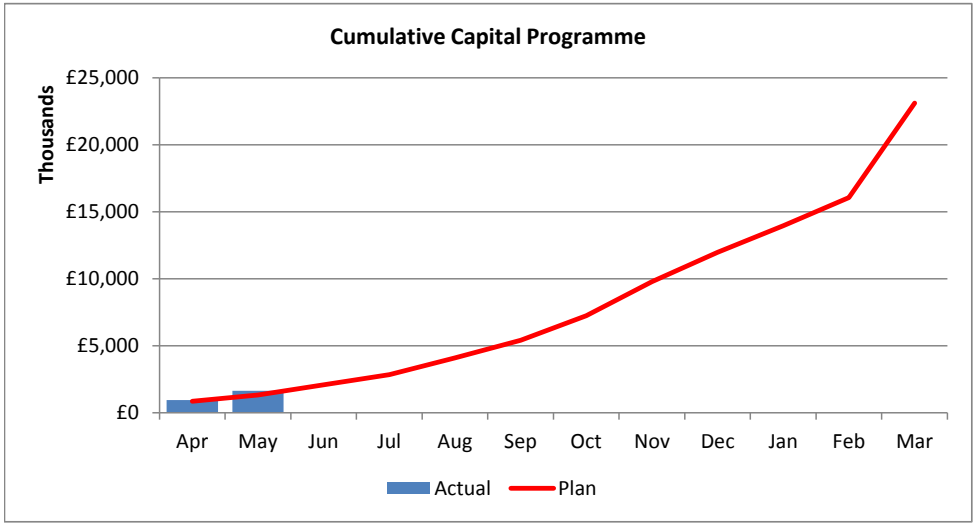
The CIPs Plan of £30.0m is net of the cost of delivery. CIPs achieved in M02 amounting to £1.8m were above forecast and Plan. Agency, Procurement Medicines Value and Theatres over performed in month. CIPs in May amounted to £1.6m recurrent and £0.2m on a non-recurrent basis. The YTD position is recurrent £2.4m and non-recurrent £0.5m

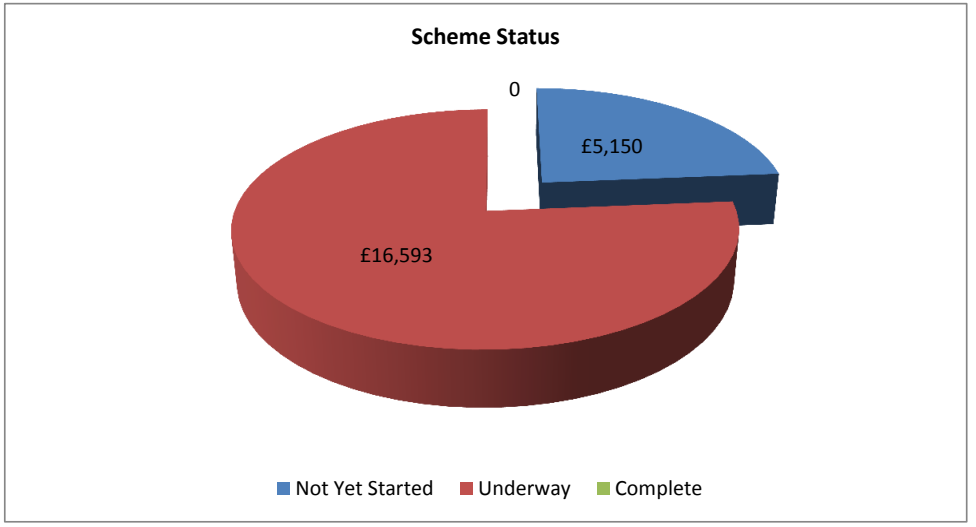
Capital Expenditure

Month 02 (May) 2019/20

Capital Programme	Annual	To Date		
£000	Plan	Plan	Actual	Variance
Dementia Village	1,829		604	(604)
Clinical Strategy Plans			7	(7)
CT/CT SPECT Replacement	1,790			
Observation Areas	4,983		448	(448)
Energy Efficiency	4,602	634	92	542
Medical Devices Group	2,500	50	235	(185)
PEIC/H & S/CQC	2,200	171		171
IDG	1,800	310	157	153
T3	1,243	274	3	271
Other Building Schemes	1,465		3	(3)
Other Equipment Schemes	120			
Other IT Schemes			(19)	19
All Other	1,040	(37)	105	(142)
Total	23,572	1,402	1,634	(232)

- Total expenditure at the end of May 2019 (Month 2) is 16.5% above plan. This is mainly due to legacy spend from 2018/19 schemes in A&E and equipment replacement. It is expected that spend will fall back in line with the YTD plan for Month 3.
- As planned, the 2019/20 capital plan has been through a reprioritisation process, with various additional schemes expected to start in June funded by a re-phasing of the CT SPECT scheme.





Statement of Financial Position

Month 02 (May) 2019/20

£000	Opening	To Date	Movement	
Non-Current Assets	**340,662**	**339,216**	**(1,446)**	▼
Current Assets				
Inventories	3,658	3,727	69	▲
Trade and Other Receivables	29,500	32,053	2,553	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	18,700	18,844	143	▲
Total Current Assets	**51,858**	**54,624**	**2,766**	▲
Current Liabilities				
Payables	(37,252)	(27,253)	9,998	▼
Accruals and Deferred Income	(33,933)	(46,248)	(12,316)	▲
Provisions	(799)	(836)	(37)	▲
Net Current Assets	**(20,126)**	**(19,714)**	**412**	▲
Non Current Liabilities				
Provisions	(3,094)	(3,057)	37	▼
Long Term Debt	(181,626)	(188,721)	(7,094)	▲
Total Assets Employed	**135,816**	**127,724**	**(8,092)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	200,706	200,706	-	
Retained Earnings	(117,989)	(126,081)	(8,092)	▼
Revaluation Reserve	53,098	53,098	-	
Total Taxpayers' Equity	**135,816**	**127,724**	**(8,092)**	▼

Non-Current asset values reflect in-year additions (including donated assets) less depreciation charges of £1.3m (£1.3m April). Non-Current assets also includes the loan and equity that finances 2gether Support Solutions c.£99.3m

Trust closing cash balances for May was £18.8m (£21.2m April) £6.2m above revised plan. See cash report for further details.

Trade and other receivables have increased from the 2019/20 opening position by £2.6m (£5.2m increase in April). Invoiced debtors have decreased from the opening position by £6.6m to £18.2m (£22.1m April) at the end of May.

Payables have decreased by £10.0m (£2.0m increase in April). Creditors have increased by £14.1m from the opening position to £38.0m. 55% (45% April) relates to current invoices with 5% (7% April) or £1.7m (£2.3m April) over 90 days.

The long term debt entry reflects drawings against working capital facilities. Total drawing to date £96.5m (£96.5m April) see cash report for details. The balance relates to the long term finance lease debtor with 2gether.

The movement in Retained earnings reflects the year-to-date unadjusted deficit.

Working Capital
Month 02 (May) 2019/20

Creditors

Invoiced creditors have increased by £6.4m from the opening position to £30.2m. 55% relates to current invoices with 5% or £1.7m over 90 days.

Over 90 days NHS creditors have decreased by £136k in Month.

- Maidstone & Tunbridge Wells NHS Trust (RWF) - £220k
- Kent Community Health NHS Foundation Trust (RYY) - £(66)k

YTD the Trust has paid 64% of NHS and 77.1% of non NHS invoices by value to 30 days compared to last year where the Trust paid 70% and 41.6% respectively.

Debtors

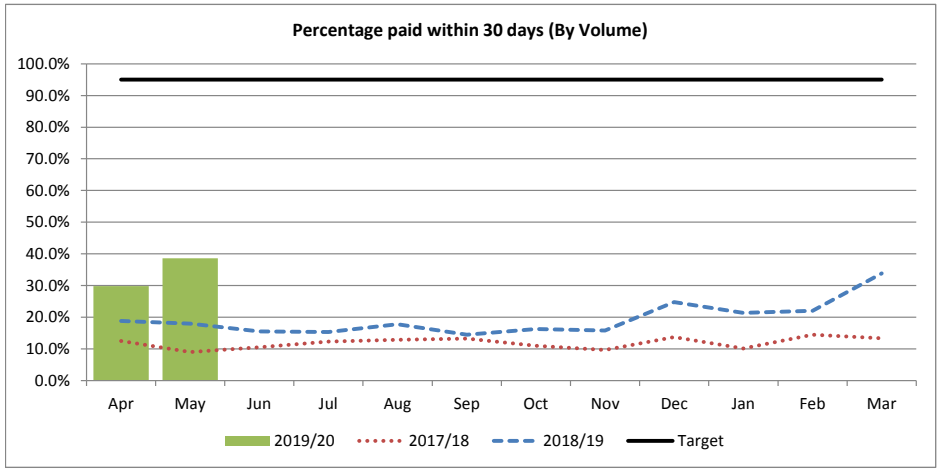
Total invoiced debtors have decreased from the opening position of £24.8m by £6.6m to £18.2m.
At 31st May there were 6 debtors owing over £1m.

- East Kent CCGs owing: Thanet CCG £1.5m, South Kent Coast CCG £0.1m, Canterbury & Coastal CCG £0.4m
- East Kent Medical Services outstanding balance: £1.7m (Healthex £0.6m)
- NHS England £2.9m; 1819 overperformance
- 2gether Support Solutions £3.9m; £1.1m IHSS Decontamination Contract
- West Kent CCG £1.5m; £0.9m 1819 overperformance invoices

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

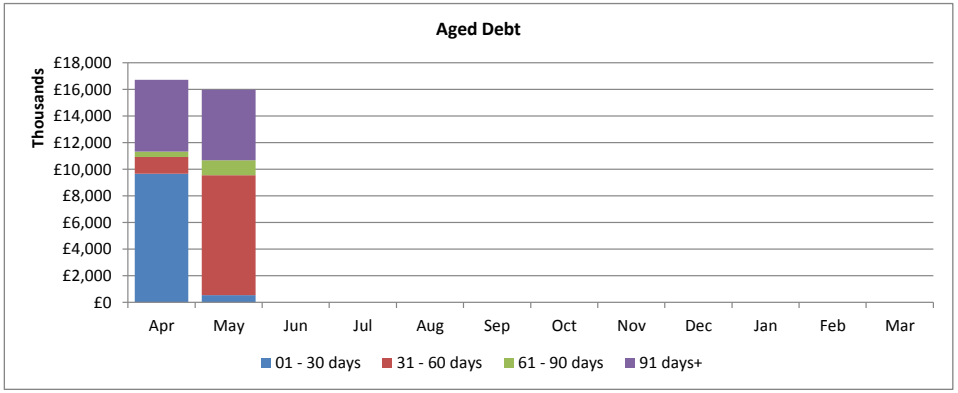
Better Payment Practice Code

	Year to Date		This Month	
	Non NHS Creditor Invoices	NHS Creditor Invoices	Non NHS Creditor Invoices	NHS Creditor Invoices
By Value £000				
0 - 30 days	(51,481)	(4,867)	(25,736)	(2,555)
30+ days	(15,316)	(2,739)	(8,298)	(2,270)
By Volume				
0 - 30 days	3,820	152	2,429	93
30+ days	7,053	464	3,785	261
% by Value £	77.1%	64.0%	75.6%	53.0%
% by Volume	35.1%	24.7%	39.1%	26.3%
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	5,378	9,666	1,254	411	5,401	16,732
May	2,203	539	9,024	1,120	5,294	15,977
Jun	0	0	0	0	0	0
Jul	0	0	0	0	0	0
Aug	0	0	0	0	0	0
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
		3%	56%	7%	33%	



Care Group Performance
Month 02 (May) 2019/20

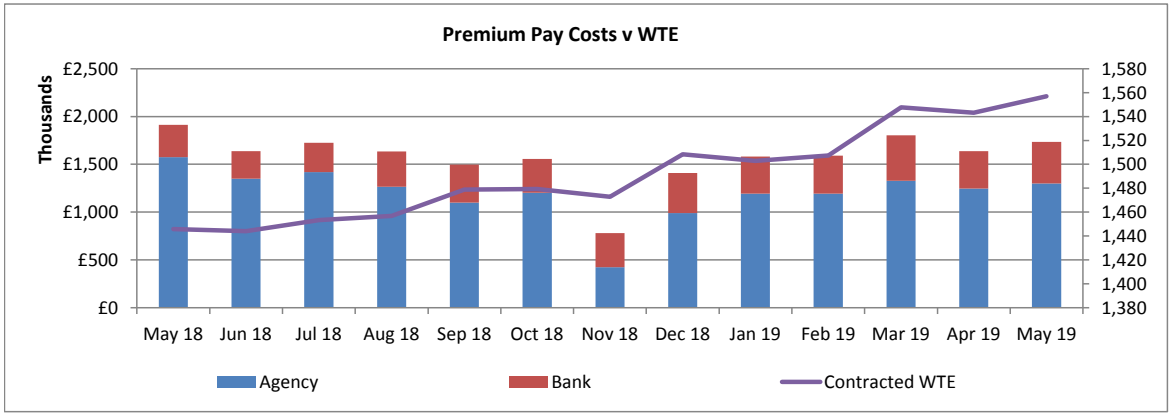
Year to Date Actual £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
General and Specialist Medicine	3,555	16,334	0	4,006	1,527	6	3,852	150	(15,377)	(4,691)	9,362
Urgent and Emergency Care	3	1,125	5,872	0	3	0	161	10	(6,595)	(809)	(230)
Surgery and Anaesthetics	7,984	6,848	0	2,572	56	29	3,204	219	(15,450)	(4,441)	1,022
Surgery - Head and neck, Breast Surgery and Dermatology	2,404	379	0	3,303	1,250	9	256	24	(2,746)	(1,995)	2,885
Clinical Support	159	15	0	569	2,584	18	6,454	881	(10,789)	(7,569)	(7,678)
Cancer Services	747	23	0	1,411	3,759	0	1,574	160	(1,420)	(4,469)	1,784
Women's and Children's Services	1,076	5,483	0	1,481	28		5,135	166	(8,616)	(981)	3,772
Clinical Total	**15,926**	**30,208**	**5,872**	**13,343**	**9,208**	**62**	**20,636**	**1,610**	**(60,993)**	**(24,955)**	**10,917**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	1,454	(1,080)	(9,323)	(8,949)
Corporate	0	0	0	0	0	0	0	3,038	(4,496)	(5,049)	(6,507)
Care Group Total	**15,926**	**30,208**	**5,872**	**13,343**	**9,208**	**62**	**20,636**	**6,101**	**(66,569)**	**(39,326)**	**(4,539)**
Central	0	953	0	(193)	45	0	(752)	1,245	(786)	(305)	207
							EBITDA				**(4,332)**
							Capital Charges and Interest			(3,760)	(3,760)
							Income and Expenditure Surplus/(Deficit)				(8,092)

Year to Date Variance to Plan £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
General and Specialist Medicine	(258)	()	0	9	(60)	(9)	(20)	(27)	(437)	(510)	(1,312)
Urgent and Emergency Care	(3)		340	0	(11)	0	(69)		(149)	9	118
Surgery and Anaesthetics	47		0	154	5	15	(118)	(182)	(963)	449	(594)
Surgery - Head and neck, Breast Surgery and Dermatology	(353)		0	188	150	(1)	61	(6)	73	(205)	(92)
Clinical Support	99		0	(26)	(37)	5	108	(48)	(53)	84	132
Cancer Services	32	()	0	67	172	()	4	10	(2)	(239)	44
Women's and Children's Services	65		0	185	(22)	()	(167)	4	(233)	15	(153)
Clinical Total	**(372)**		**340**	**578**	**199**	**10**	**(202)**	**(249)**	**(1,764)**	**(397)**	**(1,858)**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	14	(73)	(436)	(496)
Corporate	0	0	0	0	0	0	0	(71)	(249)	78	(242)
Care Group Total	**(372)**		**340**	**578**	**199**	**10**	**(202)**	**(307)**	**(2,086)**	**(755)**	**(2,596)**
Central	399	508	(84)	(1,250)	217	2	(628)	293	2,685	582	2,723
							EBITDA				**127**
							Capital Charges and Interest			133	133
							Income and Expenditure Surplus/(Deficit)				260

General and Specialist Medicine

Month 02 (May) 2019/20

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,999	1,871	(128)	3,813	3,555	(258)
Non-Electives	8,242	8,242		16,334	16,334	()
Accident & Emergency	0	0	0	0	0	0
Outpatients	2,065	2,023	(43)	3,997	4,006	9
High Cost Drugs	806	777	(29)	1,587	1,527	(60)
Private Patients	7	4	(3)	15	6	(9)
Other NHS Clinical	1,949	1,969	19	3,846	3,831	(15)
Other Clinical	13	11	(2)	26	21	(5)
Prior Month Adjustment	0	167	167	0	0	0
Total Clinical Income	**15,082**	**15,064**	**(18)**	**29,619**	**29,280**	**(338)**
Non Clinical Income	53	39	(15)	177	150	(27)
Total Income	**15,136**	**15,103**	**(33)**	**29,796**	**29,431**	**(365)**
Expenditure						
Substantive Staff	(5,897)	(6,033)	(136)	(11,698)	(12,005)	(307)
Bank	(366)	(437)	(71)	(731)	(825)	(94)
Agency	(1,269)	(1,299)	(30)	(2,511)	(2,547)	(36)
Total Pay	**(7,532)**	**(7,768)**	**(236)**	**(14,940)**	**(15,377)**	**(437)**
Non Pay	(2,235)	(2,349)	(114)	(4,182)	(4,691)	(510)
Total Expenditure	**(9,767)**	**(10,117)**	**(350)**	**(19,122)**	**(20,068)**	**(947)**
Contribution	**5,369**	**4,985**	**(383)**	**10,674**	**9,362**	**(1,312)**



The Care Group is £0.4m adverse in May and £1.3m adverse ytd.

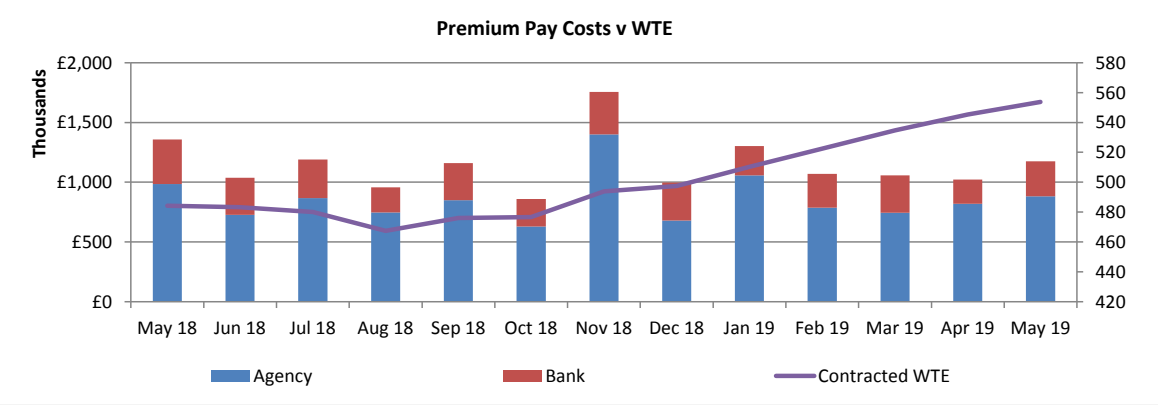
Income for Care Groups is reflective of PbR performance, with the aligned incentive adjustment being held centrally. The NEL favourable variance of £0.2m has been reduced to nil whilst Obs Ward activity changes are worked through and the plan realigned with UEC. Elective income reflects an under-performance of endoscopy; in addition to this Speciality activity coded as Gen Med is being re-aligned to the relevant speciality with the balance being Ambulatory Care and transferrable to UEC.

Pay overspent by £0.2m in May. Agency spend increased by £0.1m to £1.3m, attributable to junior doctors; an analysis of this workforce shows a spend in April/May above the trend of 18/19 despite a lower vacancy level. Discussions are on-going with UEC Care Group who currently manage these posts, a joint workshop is planned for June to review every post and agree controls.

Non-pay overspent by £0.1m in May and £0.5m ytd. The outlier recharge stands at £0.4m and is being reassessed for Mth 2. Drugs overspent by £150k this month across all areas; detailed Pharmacy information will be reviewed. The shortfall in CIP plans is phased in 12ths and causing a £0.3m adverse ytd position across pay and non-pay.

Urgent and Emergency Care
Month 02 (May) 2019/20

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	4	3	(2)	6	3	(3)
Non-Electives	617	617	()	1,125	1,125	
Accident & Emergency	2,864	2,985	121	5,532	5,872	340
Outpatients	0	0	0	0	0	0
High Cost Drugs	7	3	(4)	13	3	(11)
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	115	78	(37)	230	161	(69)
Prior Month Adjustment	0	339	339	0	0	0
Total Clinical Income	**3,607**	**4,026**	**419**	**6,906**	**7,163**	**257**
Non Clinical Income	5	8	3	10	10	
Total Income	**3,612**	**4,034**	**422**	**6,916**	**7,173**	**258**
Expenditure						
Substantive Staff	(2,151)	(2,184)	(33)	(4,330)	(4,398)	(69)
Bank	(265)	(293)	(28)	(560)	(496)	63
Agency	(859)	(881)	(21)	(1,557)	(1,700)	(143)
Total Pay	**(3,275)**	**(3,358)**	**(83)**	**(6,446)**	**(6,595)**	**(149)**
Non Pay	(411)	(402)	8	(817)	(809)	9
Total Expenditure	**(3,686)**	**(3,761)**	**(75)**	**(7,264)**	**(7,404)**	**(140)**
Contribution	**(74)**	**273**	**347**	**(348)**	**(230)**	**118**



A&E attendance income is significantly above plan, reflecting the continuation of higher than expected attendances over the past 12 months. May' s activity was 6 % higher than planned.

Due to issues with the non-elective plan, all variances (plus or minus), have been adjusted to zero. Work continues to review the plan prior to publication of the month 3 position. The favourable variance adjusted to zero in May was £0.94m - £1.97m year to date.

Other NHS Clinical Income is under performing due to lower CRU (Compensation Recovery Unit) receipts. Income fluctuates significantly in this area and did partially recover in May.

Negotiations are also taking place with colleagues in the GSM Care Group to ensure income and expenditure plans and budgets have been fairly allocated following the separation of the former Urgent and Long Term Conditions Division into the two care groups.

Pay was overspent in month and overall the average pay run rate this month has increased by £230k on the 18/19 average. Agency actuals in May were £30k higher than 18/19 average with improvements in nursing usage offset by higher medical costs. Bank actuals were comparable to average whereas locum costs were £55k lower.

Substantive actuals are £260k higher than the 18/19 average. This is predominantly due to the investments that have been made in Observation Bay and ED Paediatric Nursing staff, which started during 2018/19, and the national pay award. Vacancies have been recognised as non recurrent savings but savings targets are causing pressures on the budget. Further analysis on pay position is being undertaken.

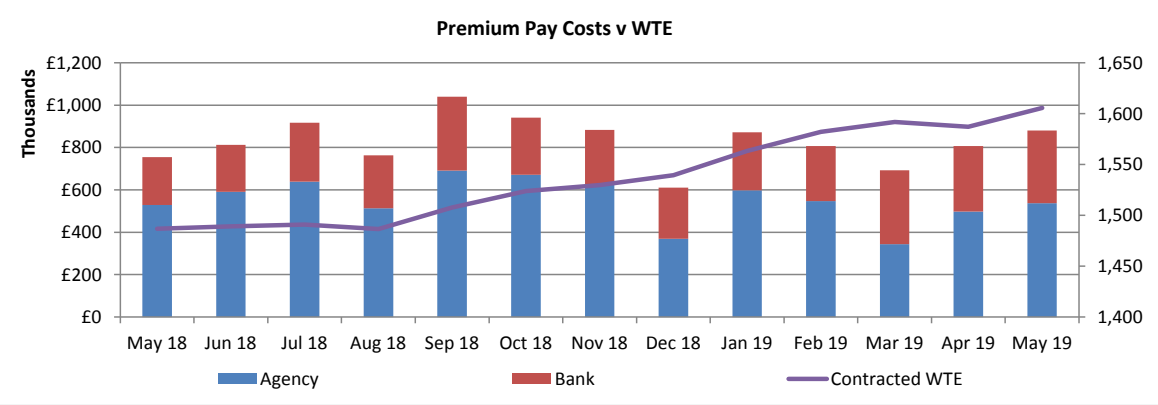
Non-pay was break-even in the month. Drugs are marginally overspent. This can be linked to the additional activity performed. Lower ad hoc discretionary costs and recruitment fees are offsetting overspends in non-clinical supplies relating to patient transport charges and security.

The annual CIP target for the care group is £2.2m. Performance was on plan in month, albeit a significant percentage of savings achieved were non recurrent and the month 2 target was relatively low. Achievement of the target is heavily reliant on sustained reductions in temporary staffing spend. Recruitment pipeline data indicates that savings will be insufficient to meet the target in full. The Care Group is planning a further international recruitment drive and is working on identifying non-recurrent measures that can be used to bridge the gap .

Surgery and Anaesthetics

Month 02 (May) 2019/20

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	3,925	4,070	145	7,937	7,984	47
Non-Electives	3,498	3,498	()	6,848	6,848	
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,259	1,260		2,419	2,572	154
High Cost Drugs	26	27	1	51	56	5
Private Patients	7	1	(7)	14	29	15
Other NHS Clinical	1,923	1,518	(405)	3,305	3,155	(149)
Other Clinical	9	49	40	18	49	31
Prior Month Adjustment	0	147	147	0	0	0
Total Clinical Income	**10,648**	**10,569**	**(78)**	**20,592**	**20,694**	**102**
Non Clinical Income	206	98	(108)	402	219	(182)
Total Income	**10,854**	**10,668**	**(187)**	**20,994**	**20,913**	**(80)**
Expenditure						
Substantive Staff	(6,572)	(6,856)	(284)	(13,045)	(13,764)	(719)
Bank	(267)	(343)	(76)	(515)	(652)	(137)
Agency	(464)	(537)	(73)	(927)	(1,035)	(107)
Total Pay	**(7,303)**	**(7,736)**	**(433)**	**(14,487)**	**(15,450)**	**(963)**
Non Pay	(2,389)	(2,193)	196	(4,890)	(4,441)	449
Total Expenditure	**(9,693)**	**(9,929)**	**(237)**	**(19,377)**	**(19,891)**	**(514)**
Contribution	**1,161**	**738**	**(423)**	**1,616**	**1,022**	**(594)**



The Care Group is £594k adverse to plan.

Elective income is now above plan (£47k), with small under performances in Orthopaedics & General Surgery offset with a large over performance in Urology.

Outpatient performance is favourable (£154k) in all specialties apart from a small under performance in Urology.

Other NHS Clinical Income is adverse (£149k) solely due to ITU, where the phasing of the activity plan (based on last year actuals) was considerably higher in May than for any other time this year . Fully expect this performance to improve back to favourable next month when the monthly plan drops by £550k.

Pay is adverse (£963k) with an unmet CIP target (£603k), partly offset with non pay CIPs. In addition there continued to be high medical agency costs for middle grade vacancies in Urology and Vascular, but appointments have been made with some start dates in June. Nursing agency costs continue to reduce , however bank costs have risen.

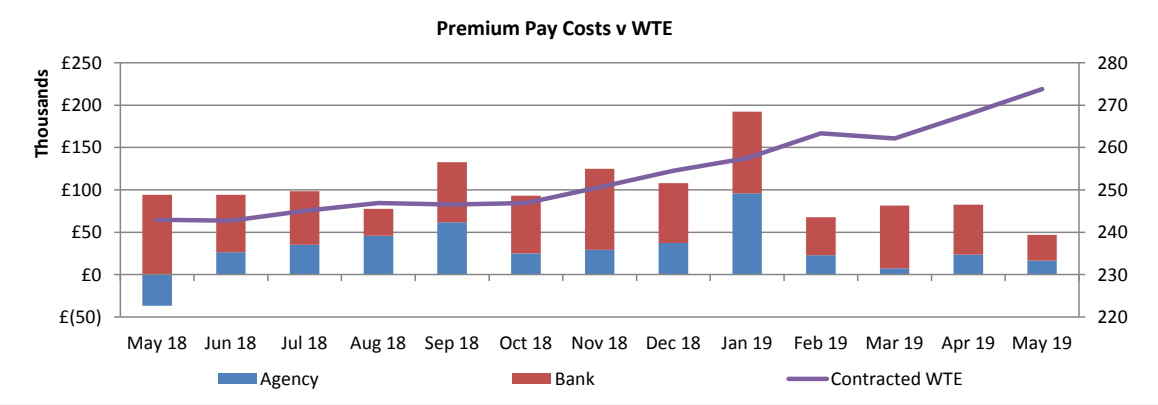
Non Pay is favourable (£449k) with CIPs over performance £(274k) and net recharge benefit for patient outliers (£306k).

CIPs target of £868k is underachieved by £282k.

Surgery - Head and neck, Breast Surgery and Dermatology

Month 02 (May) 2019/20

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,374	1,357	(17)	2,756	2,404	(353)
Non-Electives	178	178		379	379	
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,694	1,708	13	3,115	3,303	188
High Cost Drugs	559	834	275	1,100	1,250	150
Private Patients	5	2	(3)	11	9	(1)
Other NHS Clinical	102	118	16	194	255	61
Other Clinical	1	1		1	1	(1)
Prior Month Adjustment	0	47	47	0	0	0
Total Clinical Income	**3,915**	**4,245**	**331**	**7,556**	**7,601**	**45**
Non Clinical Income	15	11	(4)	30	24	(6)
Total Income	**3,929**	**4,256**	**327**	**7,586**	**7,625**	**40**
Expenditure						
Substantive Staff	(1,340)	(1,318)	22	(2,634)	(2,617)	17
Bank	(63)	(30)	33	(126)	(89)	37
Agency	(30)	(17)	13	(60)	(40)	20
Total Pay	**(1,433)**	**(1,364)**	**68**	**(2,820)**	**(2,746)**	**73**
Non Pay	(898)	(1,266)	(367)	(1,789)	(1,995)	(205)
Total Expenditure	**(2,331)**	**(2,630)**	**(299)**	**(4,609)**	**(4,741)**	**(132)**
Contribution	**1,598**	**1,626**	**27**	**2,977**	**2,885**	**(92)**



The Care Group is £92k adverse to plan YTD.

Below plan elective income (£353k) is across all specialties and mostly relates to April. The largest under performances are in Ophthalmology and ENT. The activity plan phasing was set very high in April despite the Easter bank holidays, and activity has been lost in ENT and MaxFax with theatre staffing shortages.

Outpatient performance is favourable (£188k), in all specialties apart from a small under performance in ENT.

High Cost Drugs over performance (£150k) is solely in relation to Ophthalmology AMD patients, and is offset with an overspend in expenditure.

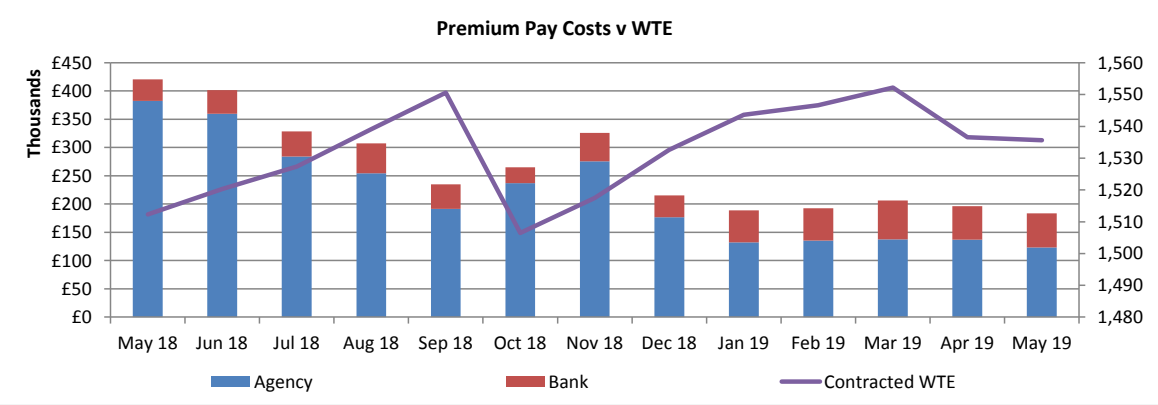
Pay is favourable (£73k).

Non Pay is adverse (£205k) primarily due to the overspend on high cost drugs (offset in income).

CIPs target of £125k has been over achieved by £61k.

Clinical Support
Month 02 (May) 2019/20

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	33	101	68	60	159	99
Non-Electives	7	7		15	15	
Accident & Emergency	0	0	0	0	0	0
Outpatients	321	291	(30)	595	569	(26)
High Cost Drugs	1,332	1,207	(125)	2,622	2,584	(37)
Private Patients	6	14	7	12	18	5
Other NHS Clinical	3,219	3,295	76	6,346	6,454	108
Other Clinical		0	()			
Prior Month Adjustment	0	(669)	(669)	0	0	0
Total Clinical Income	**4,919**	**4,246**	**(673)**	**9,650**	**9,799**	**149**
Non Clinical Income	464	438	(27)	929	881	(48)
Total Income	**5,383**	**4,684**	**(699)**	**10,579**	**10,680**	**101**
Expenditure						
Substantive Staff	(5,061)	(5,098)	(37)	(10,315)	(10,409)	(93)
Bank	(27)	(60)	(33)	(54)	(120)	(66)
Agency	(183)	(123)	60	(366)	(260)	106
Total Pay	**(5,271)**	**(5,281)**	**(11)**	**(10,735)**	**(10,789)**	**(53)**
Non Pay	(3,931)	(3,906)	25	(7,652)	(7,569)	84
Total Expenditure	**(9,201)**	**(9,187)**	**14**	**(18,388)**	**(18,357)**	**30**
Contribution	**(3,818)**	**(4,503)**	**(685)**	**(7,809)**	**(7,678)**	**132**



The Care Group is now meeting its overall financial plan. Income is in excess of the year to date plan and expenditure is within budget.

There is over performance against plan in Radiology particularly in Interventional Radiology electives, CT and MRI unbundled outpatient and direct access. Nuclear Medicine and Ultrasound are not meeting plan (-10%), these deficits are in relation to workforce capacity issues. Pathology is also above plan (5%). This is mainly due to direct access and the GUM contract. Therapies is not meeting plan at the moment, 2% overall, which is being driven by a reduction in physiotherapy referrals.

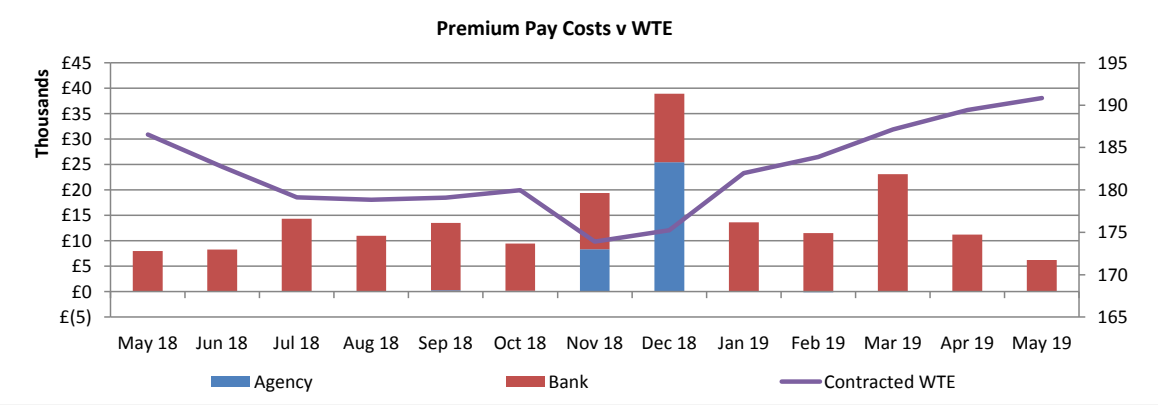
There are overspends relating to the PAMs Prof & Tech staff group caused by the improvement in staff recruitment and retention since the last financial year versus the relative outturn funding. This has resulted in a more expensive monthly pay bill. Overtime cost is running higher than the closing months of last financial year particularly in Radiology. The General Manager for Radiology is focussing on tightening controls to reduce this expense. Agency cost in the Care Group, particularly Radiology both Medical and PAM's staff has reduced significantly.

Non-pay is underspent overall in the Care Group mainly due to Pharmacy Homecare drugs underspend. Pathology, Radiology and Therapies are currently overspent, the main drivers being high diagnostics demand referred to specialist centres and allergy testing for Pathology. The main driver for the overspend in Radiology non-pay is the recent breakdown of the MRI scanner at the WHH for which £0.08m was recognised in Month 2. In Therapies there is a relatively small over spend on license fees which is more a phasing issue rather than a true overspend.

The CIP plan has been exceeded so far with 99% recurrent efficiencies.

Cancer Services
Month 02 (May) 2019/20

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	376	384	7	715	747	32
Non-Electives	11	11		23	23	()
Accident & Emergency	0	0	0	0	0	0
Outpatients	692	705	13	1,344	1,411	67
High Cost Drugs	1,817	1,909	92	3,587	3,759	172
Private Patients		0	()		0	()
Other NHS Clinical	819	820	1	1,569	1,572	2
Other Clinical		1	1		2	2
Prior Month Adjustment	0	92	92	0	0	0
Total Clinical Income	**3,716**	**3,923**	**206**	**7,238**	**7,513**	**275**
Non Clinical Income	75	95	20	150	160	10
Total Income	**3,791**	**4,018**	**226**	**7,388**	**7,673**	**285**
Expenditure						
Substantive Staff	(698)	(698)		(1,394)	(1,402)	(8)
Bank	(12)	(6)	6	(24)	(17)	6
Agency	()	0		()	0	
Total Pay	**(710)**	**(704)**	**6**	**(1,418)**	**(1,420)**	**(2)**
Non Pay	(2,128)	(2,309)	(181)	(4,230)	(4,469)	(239)
Total Expenditure	**(2,838)**	**(3,013)**	**(175)**	**(5,648)**	**(5,889)**	**(241)**
Contribution	**953**	**1,005**	**51**	**1,740**	**1,784**	**44**



CCHH has a balanced position at the end of month 2.

There is surplus income above plan in Clinical Oncology mainly in relation to pass-through High cost drugs recharge and also outpatient attendances, chemotherapy and Saturday clinics.

Haemophilia is above income plan whilst Clinical Haematology is below. These are not material variances, however the outpatient follow up attendances in Clinical Haematology are 10% behind as at month 2.

The Care Group continues to control its pay cost well with minimal overspend and no agency expense.

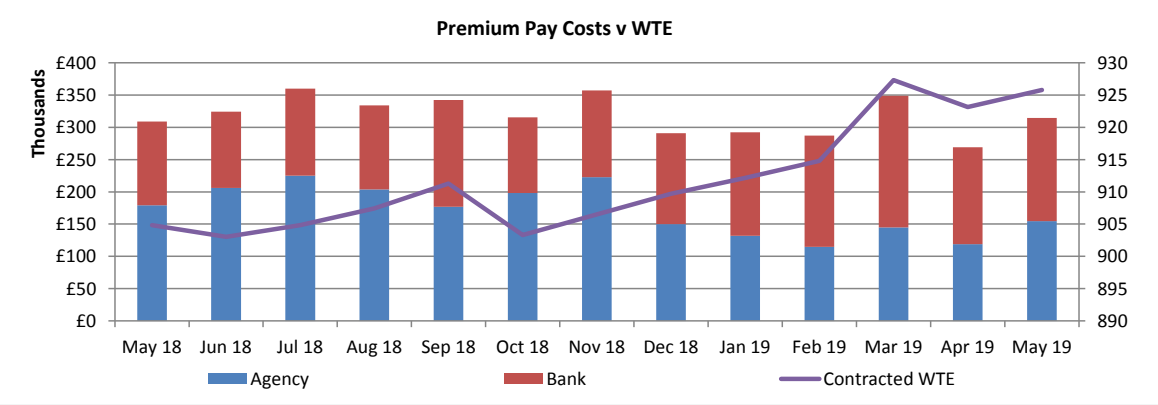
The Non-pay overspend is mostly pass-through high cost drugs and Haemophilia blood products. There is also an unmet non-pay CIP target, an overspend on the Infloflex system, Computer Hardware and a small overspend on breast prosthesis.

Overall the CIP plan is so far exceeded mainly due to income overperformance in relation to Outpatients and Saturday clinic attendances (Regular Day attenders). These are funded via Specialised commissioning.

Women's and Children's Services

Month 02 (May) 2019/20

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	525	579	54	1,011	1,076	65
Non-Electives	2,906	2,906	()	5,483	5,483	
Accident & Emergency	0	0	0	0	0	0
Outpatients	704	770	66	1,296	1,481	185
High Cost Drugs	25	16	(10)	50	28	(22)
Private Patients						()
Other NHS Clinical	2,633	2,597	(35)	5,290	5,114	(177)
Other Clinical	6	13	7	12	22	9
Prior Month Adjustment	0	(48)	(48)	0	0	0
Total Clinical Income	**6,800**	**6,833**	**34**	**13,143**	**13,204**	**61**
Non Clinical Income	80	86	6	162	166	4
Total Income	**6,880**	**6,920**	**40**	**13,305**	**13,370**	**65**
Expenditure						
Substantive Staff	(4,003)	(3,985)	18	(7,926)	(8,033)	(107)
Bank	(71)	(160)	(89)	(142)	(310)	(167)
Agency	(159)	(155)	4	(315)	(274)	41
Total Pay	**(4,234)**	**(4,300)**	**(66)**	**(8,384)**	**(8,616)**	**(233)**
Non Pay	(493)	(506)	(13)	(997)	(981)	15
Total Expenditure	**(4,727)**	**(4,806)**	**(79)**	**(9,380)**	**(9,598)**	**(217)**
Contribution	**2,152**	**2,114**	**(39)**	**3,925**	**3,772**	**(153)**



Elective income is on track and reflects a more realistic plan as well as successful work focused on improving theatre utilisation and productivity.

The non-elective plan is being re-evaluated. In the meantime all variances (plus or minus), have been adjusted to zero. The total adverse variance adjusted for is £480k in month and £860k year to date.

New outpatient activity is significantly above plan, again a reflection of a more realistic plan and work to ensure clinics are fully booked. Follow up underperformance is marginally below plan in both specialties. However, this is expected to recover over the course of the year.

Other NHS Clinical Income predominantly includes NICU/SCBU and Maternity Pathway activity. Maternity Pathway was £68k above plan in month and is £33k above plan year to date. Insulin pump/consumables overperformance is £66k. Insulin pumps/consumables are recharged so any income overperformance translates into an overspend. These areas of overperformance are offset by NICU/SCBU bed days underperformance which was £270k below plan in month and cumulatively-April's activity was over-estimated and this exacerbated May's reported adverse variance.

Overall pay was overspent and the run rate increased by £190k on the 18/19 average. Overall agency actuals are marginally lower than the average, reflecting improvements in Gynaecology middle/junior grade rota cover because of recruitment successes. Padua agency expenditure is higher than average and is not expected to improve until September. Medical locum costs and bank actuals were slightly higher so overall temporary staffing costs were relatively unchanged.

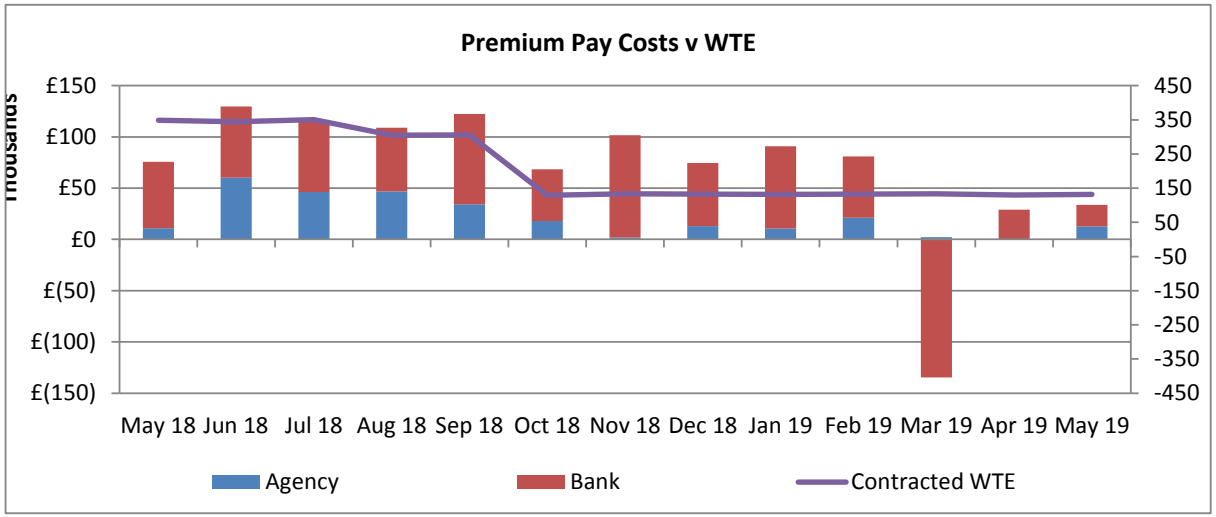
Substantive actuals were £190k higher than the 18/19 average and are overspent cumulatively. This is due to a number of factors. Firstly, the national pay award. Secondly, a higher run rate towards the end of 18/19 compared to the average for the year (the budget is set according to the average). Thirdly, a shortfall in recurrent pay savings is causing budgetary pressures. Further analysis on the pay position is being undertaken.

Non-pay is marginally overspent. A favourable £60k outlier adjustment offsets a £40k overspend caused by a CNST bonus booked as a non-recurrent CIP last year. Ordinarily this kind of non-recurrent saving would be adjusted for at budget setting but funding principles set this year mean this wasn't possible. A further £35k overspend is caused by the continued use of an external dictation service beyond the dates scheduled for a CIP scheme to begin.

The annual CIP target for the Care Group is £3.0m. Performance was on plan in month, albeit a significant percentage of savings achieved were non recurrent and the month 2 target was relatively low.

Strategic Development and Capital Planning
Month 02 (May) 2019/20

Statement of Comprehens	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Clinical Income	741	754	13	1,440	1,454	14
Total Income	**741**	**754**	**13**	**1,440**	**1,454**	**14**
Expenditure						
Substantive Staff	(439)	(510)	(71)	(938)	(1,017)	(80)
Bank	(32)	(21)	11	(64)	(50)	14
Agency	(5)	(13)	(8)	(5)	(13)	(8)
Total Pay	**(476)**	**(544)**	**(68)**	**(1,007)**	**(1,080)**	**(73)**
Non Pay	(4,700)	(5,073)	(373)	(8,887)	(9,323)	(436)
Total Expenditure	**(5,176)**	**(5,617)**	**(441)**	**(9,893)**	**(10,403)**	**(509)**
Contribution	**(4,435)**	**(4,864)**	**(428)**	**(8,453)**	**(8,949)**	**(496)**



The Strategic Development and Capital Planning position as at month 2 is £(428)k adverse in month and adverse £(496)k YTD.

Income is favourable by £13k in month and £14k YTD. Car Parking is favourable by £37k in month and £48k favourable YTD but this is currently being offset by the shortfall in site tenancy income, this is being reconciled and discussions taking place with 2gether for final resolution. The position YTD is mostly due to Accommodation income over-achievement - mainly at WHH.

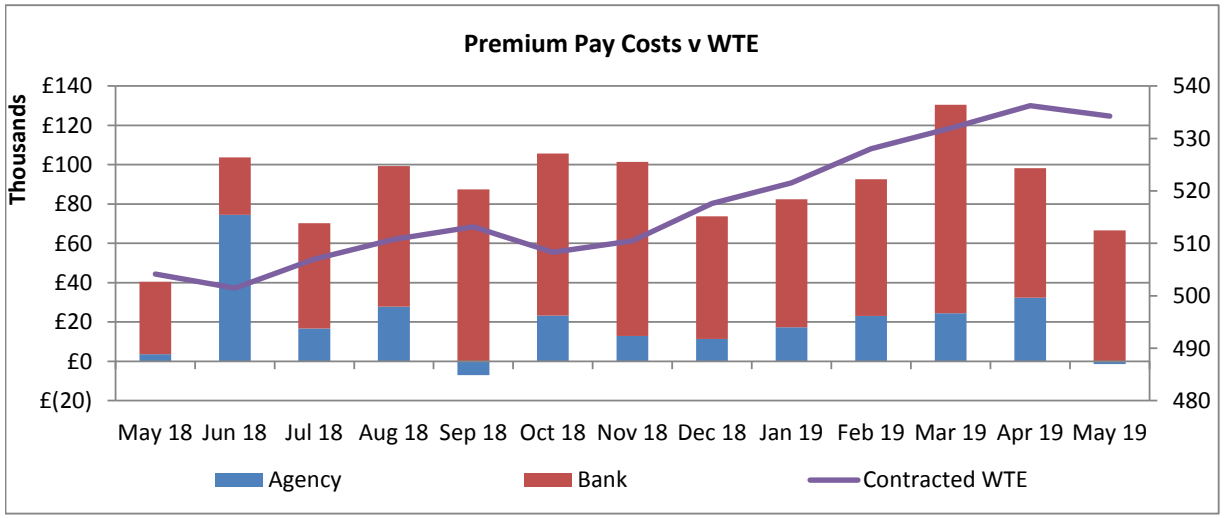
Pay is adverse £(68)k in month and adverse £(73)k YTD most of which is due to savings not being achieved.

Non Pay is adverse £(373)k in month and adverse £(436)k YTD.
The position in month can be broken down as follows:
£(117)k due to the 2gether OHF/EMS report due to an issue with the billing model being used, potentially over-charged for utilities and using incorrect margin percentage. This is to be raised with 2gether.
£(52)k postage mostly franking machines - this to be queried with the budget holder for validation.
£(19)k is due to IT non-pay
The rest is mainly attributable to savings.
The position YTD is mainly due to savings and 2gether billing issue (see above).
Performance against savings, forecast plan £118k and achieved £55k in month. Forecast plan £291k and achieved £55k YTD. Some of this is due to the profiling , where there were no plans the balance was profiled in 12ths. A meeting is scheduled for the 21st June in order to close the Gap.

Corporate

Month 02 (May) 2019/20

Statement of Comprehensi	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Non Clinical Income	1,519	1,541	22	3,109	3,038	(71)
Total Income	**1,519**	**1,541**	**22**	**3,109**	**3,038**	**(71)**
Expenditure						
Substantive Staff	(2,104)	(2,104)		(4,267)	(4,332)	(66)
Bank	6	(67)	(73)	19	(133)	(152)
Agency	16	1	(15)	0	(31)	(31)
Total Pay	**(2,082)**	**(2,169)**	**(88)**	**(4,247)**	**(4,496)**	**(249)**
Non Pay	(2,556)	(2,619)	(64)	(5,127)	(5,049)	78
Total Expenditure	**(4,637)**	**(4,789)**	**(151)**	**(9,374)**	**(9,545)**	**(171)**
Contribution	**(3,118)**	**(3,248)**	**(130)**	**(6,265)**	**(6,507)**	**(242)**



The position is adverse £(130)k in month and adverse £(242)k YTD. This is almost wholly attributable to non achievement of savings. Following the corporate performance review the leads were tasked to compile plans to rectify this. Meetings are currently taking place in order to take this forward.

Non Clinical income is showing a favourable position of £22k in month and an adverse position of £(71)k YTD.
The position YTD is due to Post Grad outturn adjustment on income. This is currently being reconciled and adjusted with the Directorate and it is anticipated that this will be complete by month 3 following a meeting with the Chief Executive, in order to improve subjective analysis.

Pay is also showing an adverse variance of £(88)k in month and adverse £(249)k YTD of which the split between substantive and temporary staffing is shown in the table. £(102)k in month and £(206)k YTD is attributable to savings. £(32)k YTD is attributable to an overspend at Hospital Management QEQM, the funding is for 13.30 WTE against 15.56 WTE paid, this is a mixture of overtime and over establishment following the recruitment of additional posts of which funding is to be drawn down. The costings have been completed, therefore, it is anticipated that the pay budget adjustment will be actioned for month 3.

Non Pay is adverse £(64)k in month and favourable £78k YTD. The adverse position in month is made up of overspends on HR work permits, Legal Services solicitor costs and HR CIPs under-achievement.
The favourable YTD position is mostly due to CQ&PS Management underspend on training and outturn funding.

Year on Year Analysis
Month 02 (May) 2019/20

	Year to Date	Prior Year to Date	Year on Year	
	Actual	Actual	Variance	Variance %
Income				
Electives	15,926	15,118	809	5.3%
Non-Electives	31,161	28,103	3,058	10.9%
Accident and Emergency	5,872	4,815	1,057	22.0%
Outpatients	13,150	12,727	423	3.3%
High Cost Drugs	9,253	8,700	552	6.3%
Private Patients	63	46	17	36.2%
Other NHS Clinical Income	19,609	17,963	1,646	9.2%
Other Clinical Income	274	288	(15)	(5.1%)
Total Clinical Income	**95,308**	**87,761**	7,547	8.6%
Non Clinical Income	7,346	7,240	106	1.5%
Total Income	**102,654**	**95,001**	7,653	8.1%
Expenditure				
Substantive Staff	(57,272)	(51,837)	(5,435)	(10.5%)
Overtime	(899)	(994)	94	9.5%
Waiting List Payments	(418)	(569)	151	26.6%
Medical Locums/Short Sessions	(460)	(468)	8	1.7%
Bank	(2,682)	(2,383)	(299)	(12.6%)
Agency	(5,359)	(6,610)	1,251	18.9%
Direct Engagement - Agency	(264)	(28)	(236)	(832.2%)
Total Pay	**(67,355)**	**(62,889)**	(4,466)	(7.1%)
Non-Pay				
Drugs	(11,143)	(10,263)	(880)	(8.6%)
Clinical Supplies and Services - Clinical	(4,812)	(11,161)	6,350	56.9%
Supplies and Services - Non-Clinical	(15,535)	(3,674)	(11,861)	(322.8%)
Purchase of Healthcare	(788)	(1,359)	571	42.0%
Education & Training	(298)	(323)	25	7.8%
Consultancy	(121)	(90)	(31)	(34.9%)
Premises	(1,473)	(3,684)	2,211	60.0%
Clinical Negligence	(3,628)	(3,705)	78	2.1%
Transport	(383)	(562)	179	31.8%
Establishment	(609)	(613)	4	0.7%
Other	(843)	(647)	(196)	(30.2%)
Total Non-Pay	**(39,632)**	**(36,082)**	(3,549)	(9.8%)
Total Expenditure	**(106,987)**	**(98,971)**	(8,015)	(8.1%)
EBITDA	**(4,332)**	**(3,970)**	(362)	(9.1%)
Non-Operating Expenses	(3,760)	(4,289)	529	12.3%
Income and Expenditure Surplus/(Deficit)	**(8,092)**	**(8,259)**	167	2.0%

Clinical Income

- Non Elective is showing a move from long stay patients to short stay patients against plan, however a richer case mix in long stay patients is offsetting the reduced activity from a financial point of view.
- A&E Activity is higher, but case mix is slightly lower than plan.
- Elective activity is also showing a move to more same day treatment with RADAY activity over performing and long stay activity under performing.

Non Clinical Income

- Contract uplifts 19-20
- Non recurrent benefits 19-20

Pay

- Pay inflation AfC
- AFC non consolidated pay award 19-20 paid in full in April and Clinical Excellence Awards for 19-20 accounted for in full in May
- Medical Pay Award 18-19 FYE and 19-20 estimate
- Increased substantive in post year on year including the impact of approved investments

Non Pay

- Drugs - mainly growth in rechargeables 19-20
- Clinical Supplies - Consumables 19-20 now form part of OHF as shown in Supplies and Services - Non-Clinical
- Supplies and Services - Non-Clinical impact of OHF contract including approved Change Control Notices
- Purchase of Healthcare - reduced outsourcing and insourcing usage in 19-20
- Premises - Utilities 19-20 now part of OHF as shown in Supplies and Services - Non-Clinical

Cash Flow

Month 02 (May) 2019/20

Year to Date		This Month			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual		Plan	Actual	Variance	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
18,603	**Opening Bank Balance**	17,750	21,628	3,877	18,700	21,628	18,844	6,598	10,318	4,996	3,390	4,675	4,477	5,198	4,898	8,014
12,646	Ashford CCG - Main	6,881	6,867	(14)	5,780	6,867	5,447	5,477	6,024	6,024	6,024	6,024	6,024	6,024	6,024	6,024
20,744	C4G - Main	11,144	11,125	(19)	9,619	11,125	11,488	11,096	10,739	10,739	10,739	10,739	10,739	10,739	10,739	10,739
23,276	South Kent Coast CCG - Main	12,337	12,358	21	10,918	12,358	10,914	11,353	11,353	11,353	11,353	11,353	11,353	11,353	11,353	11,353
16,708	Thanet CCG - Main	8,888	8,964	76	7,745	8,964	8,918	8,550	8,550	10,044	8,550	8,550	8,550	8,550	8,550	8,550
	Additional Income															
83	Dartford, Gravesham & Swanley CCG	38	45	7	38	45	42	39	39	39	39	39	39	39	39	39
357	Medway CCG	164	176	12	181	176	230	192	192	192	192	192	192	192	192	192
609	Swale CCG	306	304	(2)	305	304	63	286	286	286	286	286	286	286	286	286
920	West Kent CCG	449	454	5	466	454	486	482	482	482	482	482	482	482	482	482
16,814	NHS England	9,249	8,756	(493)	8,058	8,756	8,346	8,346	9,146	8,346	8,346	8,346	8,346	8,346	8,346	8,346
6,335	All Other NHS Organisations	974	4,947	3,972	1,388	4,947	1,037	5,633	987	947	5,673	947	966	5,612	966	967
0	Capital Receipts										2,144				2,007	
0	All Other Receipts	2,678		(2,678)												
	Revenue Loans															
	Loans Repaid															
116,759	**Total Receipts**	**53,108**	**57,282**	**4,175**	**59,477**	**57,282**	**51,245**	**57,325**	**53,469**	**55,595**	**60,781**	**51,777**	**55,056**	**59,494**	**56,231**	**52,312**
	Payments															
(57,853)	Monthly Payroll inc NI & Super	(28,309)	(29,292)	(983)	(28,561)	(29,292)	(29,170)	(28,557)	(28,799)	(28,399)	(29,095)	(29,579)	(29,579)	(29,927)	(30,168)	(30,168)
(46,516)	Creditor Payment Run	(27,909)	(29,452)	(1,543)	(17,064)	(29,452)	(31,653)	(23,727)	(28,383)	(23,268)	(25,913)	(19,628)	(22,541)	(27,385)	(20,735)	(20,517)
(12,102)	Capital Payments	(1,932)	(1,234)	698	(10,868)	(1,234)	(2,547)	(1,224)	(1,452)	(2,537)	(4,286)	(2,683)	(2,041)	(2,353)	(2,002)	(2,010)
	PDC Dividend Payment									(1,950)						(1,950)
(145)	Interest Payments	(88)	(88)		(56)	(88)	(122)	(95)	(158)	(1,046)	(202)	(85)	(174)	(130)	(209)	(1,108)
(116,616)	**Total Payments**	**(58,238)**	**(60,066)**	**(1,828)**	**(56,550)**	**(60,066)**	**(63,492)**	**(53,604)**	**(58,791)**	**(57,200)**	**(59,497)**	**(51,975)**	**(54,335)**	**(59,794)**	**(53,115)**	**(55,753)**
143	**Total Movement In Bank Balance**	**(5,130)**	**(2,784)**	**2,346**	**2,927**	**(2,784)**	**(12,246)**	**3,721**	**(5,322)**	**(1,606)**	**1,284**	**(197)**	**720**	**(300)**	**3,116**	**(3,441)**
18,844	**Closing Bank Balance**	**12,620**	**18,844**	**6,224**	**21,628**	**18,844**	**6,598**	**10,318**	**4,996**	**3,390**	**4,675**	**4,477**	**5,198**	**4,898**	**8,014**	**4,573**
	Plan				17,750	12,620	4,179	10,508	4,996	3,390	4,674	4,477	5,198	2,408	3,366	4,573
	Variance				3,877	6,224	2,419	(190)	()				()	2,490	4,649	

Clinical Income - by Commissioner

Month 02 (May) 2019/20

	This Month £000			Year to Date £000			Annual £000
Commissioner	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**
NHS Ashford CCG	6,560	6,539	(21)	12,701	12,670	(32)	75,719
NHS Canterbury & Coastal CCG	10,710	10,763	53	20,810	20,729	(81)	124,356
NHS South Kent Coast CCG	11,975	12,014	39	23,276	23,249	(27)	139,038
NHS Thanet CCG	8,672	8,641	(31)	16,841	16,737	(104)	100,683
East Kent Overseas	17	17		33	33		203
East Kent CCGs	37,934	37,973	40	73,662	73,418	(244)	440,000
NCA - England	783	717	(66)	1,525	1,462	(63)	9,116
NHS England - Armed Forces	16	4	(12)	30	26	(4)	182
NHS England - Specialised Services	7,402	7,111	(292)	14,494	14,418	(77)	85,791
NHS England - Health In Justice		2	1	1	3	2	3
NHS England - Secondary Dentistry	591	555	(36)	1,137	1,048	(89)	6,905
NHS England - Public Health	701	781	80	1,401	1,381	(20)	8,409
Kings	23	22	(1)	45	44	(2)	272
NCA - Wales		7	7		11	11	
NCA - Northern Ireland		2	2		4	4	
NCA - Scotland		4	4		4	4	
Other Trusts	138	215	77	275	389	115	1,648
NHS Dartford, Gravesham & Swanley CCG	43	43		81	78	(3)	473
NHS Medway CCG	206	206		401	419	18	2,307
NHS Swale CCG	327	401	74	637	757	121	3,722
NHS West Kent CCG	558	596	39	1,085	1,187	102	6,362
Other Organisations	78	38	(40)	347	231	(116)	3,922
Cancer Drugs Fund	240	199	(41)	471	354	(118)	2,820
Prior year Income		58	58		73	73	
Local Authority							2
Total	49,038	48,933	(106)	95,593	95,308	(286)	571,932

East Kent CCGs contract is an aligned incentive contract which means that income (excluding High cost drugs) is fixed at £420m for the year. Drugs Expenditure is planned at £20m however this will be monitored and paid on a variable basis depending on actual spend. Any over or underperformance against drugs will have an offsetting effect against expenditure so is net nil to the bottom line.

Public Health Screening contracts are also block values for the year with all other contracts operating on a PbR basis.

NHSE contract value for the year is £84.8m within which is an expectation of commissioner QIPP of £2.8m. The Trust will support commissioners in the delivery of this QIPP, however the risk of non delivery sits with the commissioner. NHSE Specialised Services contract is on plan YTD but behind plan for NICU activity in May.

East Kent Commissioner contracts are under performing against plan due to the pass through costs of Drugs and Devices, however this is countered by a corresponding reduction in expenditure to the Trust. The position in May has improved as the drugs gainshare of £200k for the switch to biosimilars has been recognised.

The under performance within Public Health being down to the performance of bowel scoping. This is a change in recording which should mean that activity currently charged to EL CCGs in the aligned incentive contract, will actually be charged on a PbR basis to PHE. Therefore there is some potential upside in the published position.

The Cancer Drugs Fund is showing an underperformance which is offset reduced expenditure.

KPIs

Month 02 (May) 2019/20

		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Clinical Income	**Plan**	47,218	49,745	49,002	50,019	48,806	46,814	50,066	48,697	46,823	49,014	45,731	48,523
Consolidated	**Actual**	46,777	50,110										
	Variance	-441	365										
	Quarterly rolling average spend	47,029	48,786										
Other Income	**Plan**	3,667	3,669	3,669	3,672	3,672	3,672	3,672	3,672	4,322	3,672	3,673	3,678
Consolidated	**Actual**	3,860	4,401										
	Variance	193	732										
	Quarterly rolling average spend	3,748	3,853										
Pay	**Plan**	-36,200	-36,677	-36,179	-35,352	-35,271	-35,397	-35,146	-35,072	-35,066	-35,582	-35,221	-35,045
Consolidated	**Actual**	-36,353	-36,190										
	Variance	-153	487										
	Quarterly rolling average spend	-35,578	-36,103										
Non Pay Operating Expenses	**Plan**	-17,658	-18,070	-17,740	-18,309	-18,007	-17,649	-18,172	-17,431	-17,041	-17,675	-16,754	-17,738
Consolidated	**Actual**	-16,912	-19,977										
	Variance	746	-1,907										
	Quarterly rolling average spend	-17,821	-18,756										
Non Operating	**Plan**	-1,878	-1,891	-1,892	-1,933	-1,937	-1,942	-2,017	-2,023	-2,021	-2,063	-2,073	-2,577
Consolidated	**Actual**	-2,143	-1,543										
	Variance	-265	348										
	Quarterly rolling average spend	-2,099	-1,775										
Agency	**Plan**	-2,163	-2,096	-1,871	-1,667	-1,535	-1,451	-1,193	-1,154	-1,098	-1,155	-1,155	-1,113
Unconsolidated	**Actual**	-2,675	-2,948										
	Variance	-512	-853										
	Quarterly rolling average spend	-2,745	-2,777										
CIPS	**Plan**	963	1,067	1,602	2,371	2,452	2,446	2,836	3,000	3,746	3,118	3,135	3,264
Unconsolidated	**Actual**	1,039	1,842										
	Variance	76	775										
Cash	**Plan**	17,750	12,620	4,179	10,508	4,996	3,390	4,674	4,477	5,198	2,408	3,366	4,573
Unconsolidated	**Actual**	21,628	18,844										
	Variance	3,877	6,224										

Cost Improvement Summary

Month 02 (May) 2019/20

Planned Summary	2018 - 2019			Target Variance	
Programme Care Groups £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Clinical Support	3,635	3,376	3,109	(259)	(526)
General & Specialist Medicine	6,138	5,531	4,980	(607)	(1,158)
Urgent & Emergency Care	2,170	1,823	1,578	(347)	(592)
Surgery & Anaesthetics	6,500	5,897	4,761	(603)	(1,739)
Surgery - Head and neck, Breast Surgery and Dermatology	1,000	1,186	844	186	(156)
Women's & Children's	3,000	3,209	3,101	209	101
Cancer	800	825	735	25	(65)
Corporate	1,800	489	147	(1,311)	(1,653)
SD&CP	1,752	1,167	941	(585)	(811)
Procurement	2,000	2,325	1,736	325	(264)
Medicines Value	1,765	2,027	1,825	262	60
Sub-total	**30,561**	**27,854**	**23,757**	**(2,706)**	**(6,804)**
Central	(561)	2,146	2,443	2,706	3,004
Grand Total	**30,000**	**30,000**	**26,200**	**-**	**(3,800)**

Planned Summary	2018 - 2019			Target Variance	
Programme Themes £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Patient Flow/LOS	1,000	1,000	250	-	(750)
Agency	7,962	7,913	7,422	(49)	(540)
Workforce *	5,442	2,720	3,262	(2,722)	(2,180)
Procurement	2,000	1,892	1,302	(108)	(698)
Medicines Value	1,765	2,027	1,825	262	60
Theatres	2,812	4,175	3,701	1,363	889
Division Schemes **	7,778	9,033	7,648	1,255	(130)
Sub-total	**28,759**	**28,759**	**25,410**	**-**	**(3,349)**
Central	1,241	1,241	790	-	(451)
Grand Total	**30,000**	**30,000**	**26,200**	**-**	**(3,800)**

Cost Improvement Phasing

Month 02 (May) 2019/20

Work stream Gross £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	100	100	100	100	100	100	100	100	100	100	1,000
Agency	123	129	612	738	874	969	695	829	714	728	727	824	7,962
Workforce	324	335	337	448	401	396	414	391	525	628	617	627	5,442
Procurement	41	41	41	208	208	208	208	208	208	209	210	210	2,000
Medicines Value	139	140	140	149	149	149	150	150	150	150	150	150	1,765
Theatres	115	193	193	318	318	240	240	240	240	240	240	240	2,812
Clinical Support Services	35	35	35	79	79	79	94	94	95	110	110	110	956
General & Specialist Medicine	71	71	26	103	93	5	244	313	314	321	321	321	2,203
Urgent & Emergency Care	1	1	1	1	1	2	2	2	2	2	2	22	40
Surgery & Anaesthetics	17	17	17	52	52	52	52	52	52	52	52	52	523
Surgery - Head and neck, Breast Sui	8	8	14	20	20	20	20	20	20	20	20	20	208
Women's & Children's	11	19	19	25	27	32	169	169	169	169	170	170	1,147
Cancer Services	(7)	(7)	(19)	26	26	90	92	92	92	94	94	95	670
Corporate - Other	9	9	9	9	9	9	34	34	59	59	59	59	359
SD&CP	75	75	76	96	96	96	148	198	203	203	203	202	1,672
Sub-total	**963**	**1,067**	**1,602**	**2,371**	**2,452**	**2,446**	**2,662**	**2,892**	**2,943**	**3,085**	**3,075**	**3,202**	**28,759**
Central	-	-	-	-	-	-	174	108	803	33	60	62	1,241
Grand Total	**963**	**1,067**	**1,602**	**2,371**	**2,452**	**2,446**	**2,836**	**3,000**	**3,746**	**3,118**	**3,135**	**3,264**	**30,000**

Workstream RAG adj £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	100	100	100	100	100	100	100	100	100	100	1,000
Agency	252	685	656	1,065	1,025	1,073	414	522	466	584	568	605	7,913
Workforce	365	234	(41)	24	128	50	485	518	354	295	163	145	2,720
Procurement	6	173	118	110	117	122	183	184	199	199	199	279	1,892
Medicines Value	24	285	161	156	164	164	165	166	186	186	186	186	2,027
Theatres	190	278	260	383	383	383	383	383	383	383	383	383	4,175
Clinical Support	38	27	91	158	158	165	181	181	181	196	196	195	1,767
General & Specialist Medicine	65	55	52	65	65	65	162	231	305	377	370	377	2,188
Urgent & Emergency Care	-	3	1	1	1	2	2	2	2	2	2	22	40
Surgery & Anaesthetics	3	16	56	148	148	148	160	160	160	163	163	163	1,489
Surgery - Head and neck, Breast Sui	(0)	2	9	14	14	14	14	14	14	11	11	11	126
Women's & Children's	11	15	25	30	32	39	175	175	175	175	176	176	1,207
Cancer Services	56	45	38	59	59	64	80	80	80	82	82	83	806
Corporate - Other	3	-	7	7	7	7	32	32	57	57	57	57	319
SD&CP	25	26	70	51	51	51	93	143	143	143	143	151	1,091
Sub-total	**1,039**	**1,842**	**1,603**	**2,371**	**2,453**	**2,446**	**2,628**	**2,890**	**2,804**	**2,953**	**2,798**	**2,934**	**28,759**
Central	-	-	-	-	-	-	174	108	803	33	60	62	1,241
Grand Total	**1,039**	**1,842**	**1,603**	**2,371**	**2,453**	**2,446**	**2,802**	**2,998**	**3,607**	**2,986**	**2,859**	**2,996**	**30,000**

Debtor Balances
Month 02 (May) 2019/20

Debtor	Top ten debtor balances outstanding as at 31/05/2019						Creditor balance as at 31/05/2019	Notes
	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total		
76480-2GETHER SUPPORT SOLUTIONS LTD	504,489	1,099,006	1,658,351	569,228	35,547	3,866,621	16,448,306	Creditor balance reduced to nil in early June.
62138-NHS ENGLAND SOUTH EAST COMMISSIONING HUB (14G)	0	(584,575)	2,448,254	0	0	1,863,678		£2.3m 1819 overperformance
51136-EAST KENT MEDICAL SERVICES	27,633	204,047	96,971	276,041	1,102,492	1,707,184	1,152,019	Intercompany
62033-NHS THANET CCG	5,286	(302,781)	1,807,991	3,344	21,532	1,535,373	80,522	£1.8m Q4 1819 overperformance
62048-NHS WEST KENT CCG	293	(107,133)	869,006	0	689,826	1,451,992		On-going discussions with West Kent to resolve outstanding disputed on invoices over 90 days old
62140-NHS ENGLAND Q88 SOUTH EAST (KENT, SURREY AND SUSS	195,215	17,482	818,894	(539)	0	1,031,053		1819 Q2-4 overperformance
50010-MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	29,477	48,193	151,220	31,681	462,237	722,808	1,098,914	Large amount of debts cleared in Month but balance owing to MTW outweighs their debt
59742-HEALTHEX	12,187	12,187	12,187	12,187	572,778	621,525		Intercompany
61865-NHS CANTERBURY AND COASTAL CCG	6,139	(31,887)	359,456	4,091	106,029	443,828	141,762	£0.4m Q3 1819 overperformance
69345-WESSEX SPECIALISED COMMISSIONING HUB 13N	155,046	76,021	150,000	0	0	381,067		
Other Govn.	1,017,023	(78,706)	423,922	154,924	1,715,414	3,232,577		
Other Non Govn.	250,467	187,263	228,037	69,278	587,944	1,322,989		
	2,203,255	539,116	9,024,290	1,120,234	5,293,798	18,180,694	18,921,524	

Actions Taken To Reduce Value and Age of Debtors

The Finance Consortium provide a full Credit Control function with escalation to Assistant Finance Director at the Foundation Trust.

Inter-company debt is being specifically targeted (both debtors and creditors) with regular meetings with subsidiaries to resolve historic issues.

Comprehensive reporting of debtor, creditor and cash positions and KPI's being developed for regular reporting at the Financial Improvement Oversight Group (FIOG)

Creditor Balances

Month 02 (May) 2019/20

Top Ten Aged Creditor

Supplier Name	Current	1-30	31-60	60-90	90 +	Total
Other Creditors	6,785	2,189	714	733	582	11,003
2gether Support Solutions Ltd	8,735					8,735
NHS Professionals Ltd	1,767	1,048		9	47	2,872
NES Holdings (UK) Ltd	367	478	348	415	241	1,850
East Kent Medical Services Ltd T/a The Spencer Wing		202	449	438	64	1,152
Maidstone & Tunbridge Wells NHS Trust (RWF)	349	453	46	15	237	1,099
Medway NHS Foundation Trust (RPA)	145	8	79	45	574	850
Ashford Borough Council	730	2				732
Thanet District Council	672	2				674
Canterbury City Council	659					659
Healthcare At Home Ltd	637					637
Total	**20,845**	**4,382**	**1,635**	**1,655**	**1,745**	**30,262**

Aged Creditor By Reason

Reason Description	Current	1-30	31-60	60-90	90 +	Total
Current	19,952					19,952
Waiting on a GRN		1,399	632	680	589	3,300
Cash Flow	893	1,581				2,474
Disputed		184	285	22	1,345	1,836
Order Raised after Invoice Received		202	279	416	90	988
Not Recorded		742	195	119	128	928
Waiting on Authorisation		115	195	412	225	496
Purchase Order Value Exceeded		131	42	5	29	207
Price Query		32	6	1	43	82
Procurement Issue					3	3
Other		4			2	6
Total	**20,845**	**4,382**	**1,635**	**1,655**	**1,745**	**30,262**

At the last payment run of the period we paid invoices totalling £3m.

Aged Creditors now stands at £38m of which £12.7m is now over due.

The main two reason for our over due invoices are:

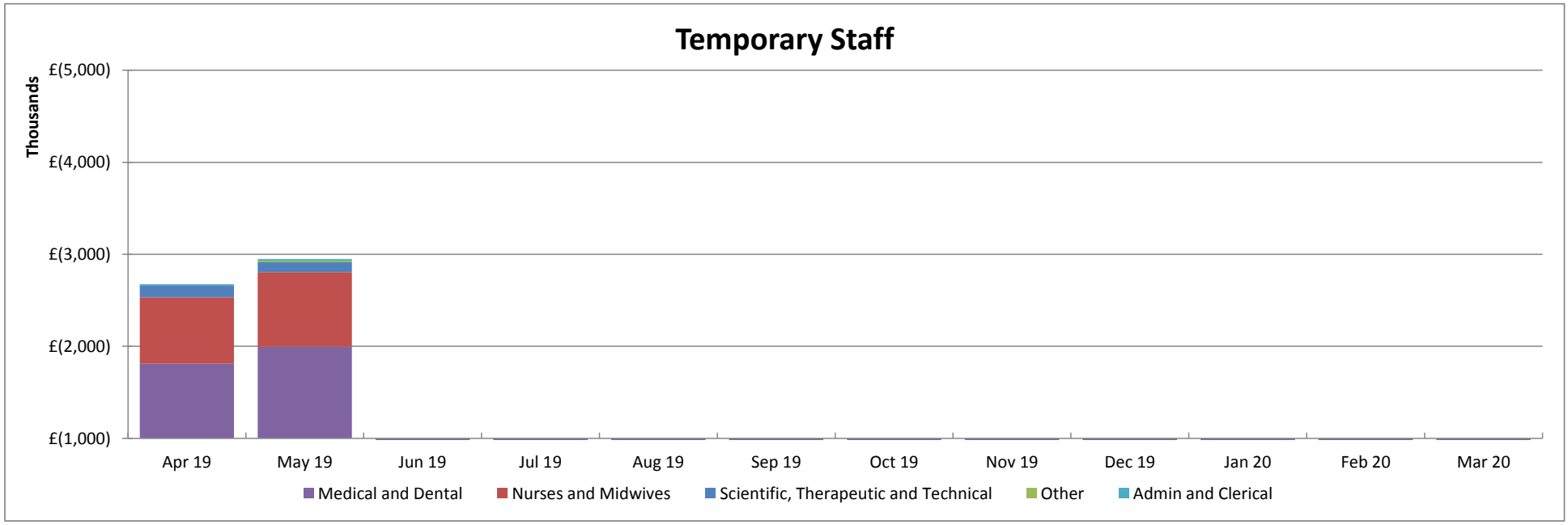
- Purchase Orders have no Goods Received Note - £1.9m
- Disputed Invoices - £1.6

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

Pay Analysis - Temporary Staff

Month 02 (May) 2019/20

In Month £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medical and Dental	**(1,811)**	**(1,995)**										
Agency	(1,733)	(1,809)										
Direct Engagement	(78)	(186)										
Scientific, Therapeutic and Technical	**(127)**	**(107)**										
Agency	(127)	(107)										
Nurses and Midwives	**(722)**	**(813)**										
Agency	(722)	(813)										
Admin and Clerical	**(15)**	**(15)**										
Agency	(15)	(15)										
Other	**()**	**(18)**										
Agency	()	(18)										
Total	**(2,675)**	**(2,933)**										



Pay Analysis - Temporary Staff

Month 02 (May) 2019/20

Temporary Staff Actual £m	M & D	N & M	PAMS	A&C Other	Total	Variance v 2019/20	Variance v 2018/19
General and Specialist Medicine	1.02	0.27	0.01		1.30	0.03	0.10
Urgent and Emergency Care	0.47	0.40		0.01	0.88	0.03	0.03
Surgery and Anaesthetics	0.44	0.08	0.02		0.54	0.02	(0.01)
Surgery - Head and Neck, Breast Surgery and Dermatol	0.01	0.01			0.02		(0.02)
Clinical Support Services	0.04		0.08		0.12	(0.01)	(0.12)
Women's and Children's Services	0.10	0.05			0.16	0.02	(0.02)
Strategic Development and Capital Planning				0.01	0.01	0.01	(0.01)
Corporate	(0.02)			0.02		(0.02)	(0.02)
Central	(0.08)				(0.07)	0.06	(0.02)
0							
Total	**1.98**	**0.81**	**0.11**	**0.04**	**2.94**	**0.14**	**(0.09)**
Variance v 2019/20 average	0.09	0.05	(0.01)	0.01	0.14		
Variance v 2018/19 average	0.22	(0.13)	(0.10)	(0.08)	(0.09)		

Temporary Staff Year to Date £m	M & D	N & M	PAMS	A&C Other	Total	Average per Month
General and Specialist Medicine	2.00	0.53	0.02		2.55	1.27
Urgent and Emergency Care	0.85	0.85		0.01	1.70	0.85
Surgery and Anaesthetics	0.86	0.14	0.03		1.04	0.52
Surgery - Head and Neck, Breast Surgery and Dermatol	0.03	0.01			0.04	0.02
Clinical Support Services	0.08		0.18		0.26	0.13
Women's and Children's Services	0.18	0.09			0.27	0.14
Strategic Development and Capital Planning				0.01	0.01	0.01
Corporate				0.03	0.03	0.02
Central	(0.19)	(0.08)			(0.28)	(0.14)
0						
Total	**3.81**	**1.54**	**0.23**	**0.05**	**5.63**	**2.82**
Average per month	1.90	0.77	0.12	0.02	2.81	

19/066.1

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**INTEGRATED PERFORMANCE REPORT (IPR)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: IPR – MAY 2019 DATA**

BACKGROUND AND EXECUTIVE SUMMARY

The Integrated Performance Report (IPR) is produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance. The IPR provides assurance to the Board that all areas of performance are monitored with sentinel indicators, allowing the Board to gain assurance regarding actual performance, Trust priorities and remedial actions.
Below are the highlights from the May 2019 report. The report has been discussed in detail by the Board's Quality Committee, Finance and Performance Committee and Strategic Workforce Committee. A summary of discussions at these meetings are included in Chair Reports to the Board of Directors.

Accident & Emergency (A&E) 4 Hour Compliance

- May performance for the organisation against the 4 hour target was 84.26%; against the NHS Improvement (NHSI) trajectory of 81.9%. This represents an improvement in performance compared to the previous month of 4.1% (from 77.13%).
- There were no 12 Hour Trolley Waits in May.
- The proportion of patients who left the department without being seen was 3.49%.
- The unplanned re-attendance position remains high at 9.98%. Time to treatment within 60 minutes remained below 50% at 45.9%.

Patient flow continues to be compromised by a high number of >7 and >21 day patients, many of whom are reportable delayed transfers of care (DTOC). Patient delays are proactively reviewed by the Multi-disciplinary Team (MDT) with escalation to Director level. Work continues with key partner organisations to increase community capacity and improve external flow with recovery plans in place.

18 Weeks Referral to Treatment (RTT) Standard

- The 18 week performance is above the agreed trajectory reporting at 80.57% against a trajectory of 79% for May 2019. A further reduction in 52 week wait patients was reported (now 4) and further reduction in backlog size.

Cancer 62 day GP RTT Standard

- 62 day performance reported at 80.09% against the improvement trajectory of 85.71% for May 2019. Validation continues until the beginning of July in line with the national time table.
- There were 6 patients waiting 104 days or more for treatment or potential diagnosis. Care Groups have carried out potential harm reviews against all 104 day patients and assurance can be provided that no harms have been reported.

The actions to reduce >62 day breaches is improving waiting times and progressing to timescale and the number of long waiting patients is decreasing overall. This will continue with Director level review.

6 Week Referral to Diagnostic Standard

The standard has been met for May with a compliance of 99.45%. At the end of the month there were 84 patients who had waited over 6 weeks for their diagnostic procedure.

Patient Experience and Patient Safety

- There has been a very slight increase with respect to patients **not** recommending the Trust to their friends and family from 1.5% to 1.8% (by 0.3% compared to the previous month). This is a declining trend that has continued for the last 4 months.
- Overall the inpatient satisfaction rate remains positive.
- The number of mixed sex accommodation breaches in May 2019 reduced to zero for the first time in 6 months.
- May reported 99% harm free care delivery for new harms in our control. The Trust remains below the national average for harms in acute hospitals.
- All harms (those patients are admitted with) has improved in month (99%) but remains below the national average of 93.76%. Work with our community colleagues continues to address this.
- Year to date we have no methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias.
- The Friends and Family Test (FFT) satisfaction rate remains green, however, the FFT rate fell slightly in inpatients, Emergency Department (ED) and maternity.
- The number of falls in May has decreased at 5.33 per 1000 bed days.
- Incident reporting is static, but May has seen a rise in STEIS reportable incidents (with moderate harm or worse). Although associated with low harm there are 2 reported never events (although one of these should be downgraded to a near miss following investigation).
- Complaints response times have decreased to 84.9% for May from 89.1% in April. The Trust continues to focus on improving complaints responsiveness with renewed focus on capturing and reporting learning.

Financial Performance

The Trust has reported a deficit in month of £3.2m which is in line with the planned position. The year to date deficit of £7.9m of £0.1m ahead of plan.

The main drivers of this position were:
- Clinical income over-performance in emergency activity.
- EKHUFT Pay underspend of £0.5m driven by overspends in agency staffing, offset by £1.2m bank underspend.
- EKHUFT Non-pay overspend against plan of £0.7m. The main drivers of overspend include non-clinical supplies, services and drugs.
- Subsidiaries position was on plan on month.

The Cost Improvement Programme (CIP) target for the year is £30m. The Trust has achieved £2.8m of savings Year to Date (YTD) against a plan of £2.1m. Within this £0.5m of savings were delivered non-recurrently.

19/066.1

NHS
East Kent
Hospitals University
NHS Foundation Trust

Human Resources

The vacancy rate for the average of the last 12 months decreased to 10.8%, which is an improvement on last month (12.8%) but higher than last year. However, the monthly rate increased slightly to 8.65% (up from 7.99%). More work is being undertaken with Care Groups to target hard to fill vacancies, particularly within nursing and Medical specialties.

The turnover rate in month decreased to 11.7% (last month 11.8%), and the 12 month average increased to 14.3% (14.2% last month). Exit data is reviewed to highlight any areas of concern and a detailed report is provided periodically to the Board's Strategic Workforce Committee and reported to Board through the Chair Report.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The report links to the corporate and strategic risk registers.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
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	Relevant sections of the IPR Performance have been considered by the following Board Committees: • Quality Committee. • Finance and Performance Committee. • Strategic Workforce Committee. Performance is discussed at an Executive and Care Group level at the following Groups: • Executive Management Team. • Executive Performance Review Meetings.
SUBSIDIARY IMPLICATIONS:	N/A

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the report.

NHS
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MAY 2019

INTEGRATED PERFORMANCE REPORT

East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

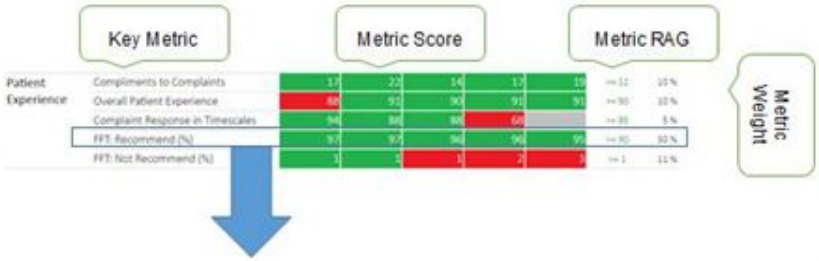
1 **Headlines**: Each domain has an aggregated score which is made up of a weighted score derived from their respective sub-domain. There is an overall executive Trust summary followed by more specific commentaries for each of the five domains which are based on the recent Carter review and the way that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

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Strategic Priorities

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Headlines

	Positives	Challenges	
Caring	The number of mixed sex breaches continued an improving trend in May achieving the Trust target of zero for the first time in six months. Friends and Family Test (FFT) inpatient satisfaction rate (including paediatrics) also remains green registering 96%. Overall patient experience, measured through the Trust Internal Patient Survey questions “did you get the care that matters to you?” also improved. The internal survey has shown variable performance over recent months and achievement is monitored closely to inform / refine further improvement actions.	While Friends and Family Test (FFT) inpatient satisfaction rate (including paediatrics) remains green, FFT performance fell slightly in inpatients, ED and maternity. Also of note performance against "not recommended" increased (unfavourably) from 1.5 in April to 1.8 in May. The Trust focus on improving complaints responsiveness continues with renewed focus on capturing and reporting learning.	J F M A May  Amanda Hallums

Effective	Beds The number of DTOC (Delayed Transfers of Care) have decreased from 97 to an average of 94 per day. The high number of DTOC continues to have a detrimental impact on patient flow across all emergency pathways. To mitigate the lack of external capacity there has been an increased focus on reducing internal delays with 19% of patients discharged before noon. Demand and Capacity The number of DNA for New and Follow Up patients have remained at 7% and 9% respectively. Productivity Length of stay across elective pathways has increased to 3.2% and non elective days have remained static at 6.5 days. Theatre utilisation is 80% with theatre start times reducing to 43%. The number of non-clinical cancellations has improved to 1.2%. Non clinical cancellation breaches has improved from 17 % to 8%.	Beds The number of reportable DTOC's remains high with an average of 97 per day. Patient flow has been severely compromised due to low discharge profile for all sites and is creating delays for emergency admissions being delayed in ED awaiting transfer to a ward. The reduction in external capacity for supportive discharge continues to cause serious concern with escalation at CEO level across the health economy. Demand and Capacity The DNA rate for new out patients has remained static at 7% with follow up patients also deteriorating to 9%. It remains a priority to continue to reduce DNA's by fully booking out patient appointments. Productivity To maximise theatre capacity and to increase productivity, including exploring the opportunity for all day theatre lists for specific specialities. To reduce the vacancy rate in theatres and reduce the high use of agency staff with substantive recruitment. To improve length of stay by reducing internal and external delays.	J F M A May	 Lee Martin

Responsive	4 hour Emergency Access Standard. May performance was 84.26% which is a 4% improvement on April, This improvement in performance has been achieved despite an 7% increase in attendances to ED. There have been no 12 Hour Trolley Waits. RTT Performance has improved to 80.57% against a trajectory of 79%. The Waiting list has increased from 45,867 to 46,331; however,the Backlog has improved from9564 to 8964. The number of patients waiting over 52 weeks for first treatment 4. This is a significant achievement since April 2018 when there were 222 patients waiting. DM01 The standard is compliant at 99.45% . Cancer May performance for 62 day treatments is currently 80.09%, validation continues until the beginning of July in line with the national timetable. 2ww performance has been achieved at 96.53% against a performance standard of 93% and there has been a notable increase in the number of referrals on the breast cancer pathway.	4 hour Emergency Access Standard Over 50% of A&E breaches are due to bed availability. This is due to poor patient flow across the emergency pathway and the high number of patients delayed in hospital over 7days (stranded) and 21 days (super stranded) who require a supportive discharge. RTT Increasing number of patient DNA's to out patient clinics. A detailed review of issues driving the increase is underway. CANCER To manage the increase in referrals and identify sufficient capacity to enable the first appointment within 7 days. To reduce any delays in a patients pathway once they have been referred on to a tertiary centre for on going assessment or treatment. DM01 Maintaining excellent performance consistently across all diagnostic modalities.	J F M A May	 Lee Martin
Safe	May has reported 99.0% harm free care delivery for new harms in our control and we have been at 99.0% or above for the last 5 months. We continue to remain below the national average for harms in acute hospitals. The number of falls in May has come down again. Year to date we have had no MRSA bacteraemias.	All harms (those patients are admitted with) has again improved in the month but remains below the national average of 93.76% Work with our community colleagues needs to be continued in order to address this. Incident reporting is static but May has seen a rise in STEIS reportable incidents (incidents with moderate harm or worse). Although associated with low harm we have also reported 2 never events (although one of these should be down-graded to a near miss following investigation)	J F M A May	 Paul Stevens

Well Led	The Trust generated a consolidated deficit in month of £3.2m which is in line with the planned position. Within this the Trust delivered £1.8m of CIP in May which was £0.7m higher than the target, bringing the YTD total CIP delivered to £2.9m which is £0.9m ahead of plan. The Trust has secured an aligned incentive contract with the East Kent Commissioning group which reduces income risk for the 2019/20 financial year.	The Trust's CIP target of £30m represents a significant challenge to deliver as it is the maximum the Trust considered achievable and will required concerted efforts on driving efficiency and cost consciousness throughout the Trust. The CIP plan increases throughout the year therefore it is crucial that the Trust continues working up savings schemes for 2019/20 focusing on delivery of planned target and moving Red and Amber schemes to Green. Total cash borrowed remains at £96.5m which will require paying back when the Trust is delivering a surplus.	J F M A May	 Susan Acott
Workforce	The trust has experienced a net gain in staffing over the course of the last year. The combination of increased levels of recruitment , reduction in turnover and lower vacancy rate has placed the trust in a stronger position. Bank fill has also increased thereby providing more regular substantive nurses to provide safer care for our patients.	The increase in sickness absence is a concern which is being addressed within the care groups by focussed interventions by the HR department in conjunction with local managers. Work is in hand to reduce the high cost agency spend but this remains an area of concern and high priority as we introduce a revised agency contract for medical staff this month.	J F M A May	 Andrea Ashman

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Caring

		Jan	Feb	Mar	Apr	May	Green	Weight
Patient Experience	Mixed Sex Breaches	34	21	8	3	0	>= 0 & <1	10 %
	Number of Complaints	85	60	77	79	68		
	AE Mental Health Referrals	87	62	87	98	75		
	IP FFT: Recommend (%)	96	97	97	96	96	>= 95	30 %
	IP FFT: Not Recommend (%)	1.4	1.0	1.2	1.5	1.8	>= 0 & <2	30 %
	IP Survey: Overall, did you get the care	44.9	43.2	46.8	43.1	45.6		
	Complaint Response in Timescales %	84.2	90.9	95.5	89.1	84.9	>= 85	15 %
	Compliments	1813	1668	1890	2946	2553	>= 1	

East Kent Hospitals University NHS Foundation Trust

Effective

		Jan	Feb	Mar	Apr	May	Green	Weight
Beds	DToCs (Average per Day)	54	66	76	97	94	>= 0 & <35	30 %
	Bed Occupancy (%)	92	94	94	94	94	>= 0 & <92	60 %
	IP - Discharges Before Midday (%)	14	15	17	19	19	>= 35	10 %
	IP Spells with 3+ Ward Moves	571	463	509	469	508		
Clinical Outcomes	FNoF (36h) (%)	73	63	61	72		>= 85	5 %
	Readmissions: EL dis. 30d (12M%)	3.8	3.6	3.8	4.0	3.8	>= 0 & <2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	16.2	15.7	16.1	16.4	16.6	>= 0 & <15	15 %
	Audit of WHO Checklist %	99	98	99	100	96	>= 99	10 %
	4hr % Compliance from Presentation to Stroke Ward				41	35		
Demand vs Capacity	DNA Rate: New %	8.1	7.4	7.5	7.6	7.7	>= 0 & <7	
	DNA Rate: Fup %	8.6	8.0	8.5	100.0	100.0	>= 0 & <7	
	New:FUp Ratio (1:#)	2.2	2.1	2.2	2.1	2.1	>= 0 & <7	
Productivity	LoS: Elective (Days)	3.2	3.3	3.3	2.9	3.2		
	LoS: Non-Elective (Days)	6.5	6.3	6.3	6.6	6.5		
	Theatres: Session Utilisation (%)	79	80	81	82	80	>= 85	25 %
	Theatres: On Time Start (% 15min)	40	46	42	46	43	>= 90	10 %
	Non-Clinical Cancellations (%)	1.8	1.0	1.4	1.4	1.2	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	18	16	17	10	10	>= 0 & <5	10 %

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Responsive

		Jan	Feb	Mar	Apr	May	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	77.93	77.56	81.53	80.54	84.26	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	74.20	73.85	78.23	77.13	81.22	>= 95	1 %
Cancer	Cancer: 2ww (All) %	96.52	98.31	97.87	97.70	96.53	>= 93	10 %
	Cancer: 2ww (Breast) %	97.22	98.31	92.76	93.64	93.81	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	95.63	97.73	96.06	97.54	95.72	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	97.78	96.49	94.74	84.31	94.12	>= 94	5 %
	Cancer: 31d (Drug) %	98.28	97.27	100.00	100.00	99.18	>= 98	5 %
	Cancer: 62d (GP Ref) %	68.21	76.88	81.56	78.44	80.18	>= 85	50 %
	Cancer: 62d (Screening Ref) %	100.00	76.92	82.61	100.00	91.89	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	84.00	86.67	76.47	80.00	85.71	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.72	99.49	99.59	99.29	99.45	>= 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 (%)	76.10	77.89	80.03	79.15	80.66	>= 92	100 %
	RTT: 52 Week Waits (Number)	38	27	8	3	4	>= 0	

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Safe

		Jan	Feb	Mar	Apr	May	Green	Weight
Incidents	Clinical Incidents: Total (#)	1,683	1,435	1,465	1,589	1,459		
	Serious Incidents (STEIS)	9	9	11	11	17		
	Harm Free Care: New Harms (%)	99.4	99.2	99.1	99.6	99.3	>= 98	20 %
	Falls (per 1,000 bed days)	5.05	5.54	5.10	5.97	5.36	>= 0 & <5	20 %
Infection	Cases of C.Diff (Cumulative)	36	38	42	8	16	<= Traj	40 %
	Cases of MRSA (per month)	0	1	0	0	0	>= 0 & <1	40 %
Mortality	HSMR (Index)	94.6	95.3	95.2			>= 0 & <90	35 %
	Crude Mortality NEL (per 1,000)	34.7	35.6	27.5	29.3	30.4	>= 0 & <27.1	10 %
Observations	VTE: Risk Assessment %	92.4	92.6	93.1	94.1	93.7	>= 95	20 %

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Well Led

		Jan	Feb	Mar	Apr	May	Green	Weight
Data Quality & Assurance	Uncoded Spells %	0.4	0.4	0.6	0.3	1.2	>= 0 & <0.25	25 %
Finance	Forecast £m	-42.2	-42.2	-42.1	-36.6	-36.6	>= 0	10 %
	Total Cost £m (Trust Only)	-54.6	-54.2	-54.3	-54.6	-56.2	>= 0	20 %
	Cash Balance £m	8.7	11.8	18.7	21.6	18.8	>= 5	20 %
	I&E £m (Trust Only)	-3.2	-5.6	-2.9	-4.9	-3.2	>= 0	30 %
Health & Safety	RIDDOR Reports (Number)	2	2	4	1	4	>= 0 & <3	20 %
Staffing	Agency %	8.4	9.0	9.3	7.5	7.2	>= 0 & <10	
	Bank Filled Hours vs Total Agency Hours	58	59	61	65	68		1 %
	Shifts Filled - Day (%)	98	96	96	100	99	>= 80	15 %
	Shifts Filled - Night (%)	106	105	106	107	105	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	11	11	12	12	11		
	Staff Turnover (%)	14.4	14.2	14.5	14.2	14.2	>= 0 & <10	15 %
	Vacancy (Monthly) %	10.8	10.2	9.8	8.7	8.7	>= 0 & <10	15 %
	Sickness (Monthly) %	4.5	4.4	4.2	4.1	4.4	>= 3.3 & <3.7	10 %
Training	Appraisal Rate (%)	80.4	81.1	80.4	80.7	77.2	>= 85	50 %
	Statutory Training (%)	93	93	94	95	95	>= 85	50 %

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Mortality

May	HSMR (Index)	95.8 (2.3%)		Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.
May	SHMI	1.06 (4.4%)		"Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data."

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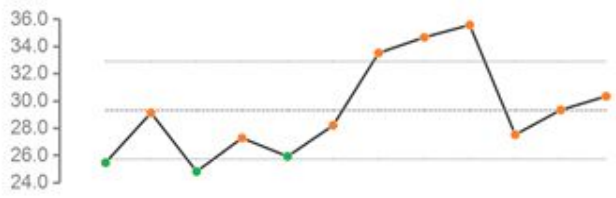
Strategic Theme: Patient Safety

May

Crude Mortality NEL (per 1,000)

29.3
(-7.3%)



"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:

For the 130 trusts included in the SHMI from 1 January 2018 to 31 December 2018:

• There were approximately 9.2 million discharges, from which 293,000 deaths were recorded either while in hospital or within 30 days of discharge. This includes deaths from other causes as well as deaths related to the reason for the hospital admission.

• Although, as can be seen, our SHMI has risen in successive reports we are one of the 103 trusts with the number of deaths within the expected range. 11 trusts had a higher than expected number of deaths. Of these 11 trusts, 5 also had a higher than expected number of deaths for the same period in the previous year. 16 trusts had a lower than expected number of deaths. Of these 16 trusts, 13 also had a lower than expected number of deaths for the same period in the previous year.

In this report we also have SHMI data split by site for the first time, this shows that the SHMI for K&CH was lowest (0.87), the SHMI at the 2 acute sites was 1.09 at Margate and 1.10 at Ashford.

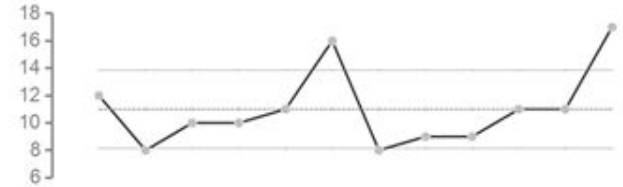
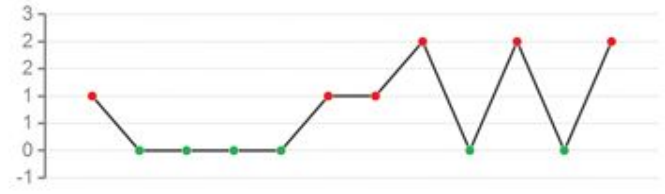
We are still being hampered by both palliative care coding (22% of our deaths have a palliative care code and only 9 of the other 130 Trusts have a lower percentage of deaths with a palliative care code) and also by depth of coding.

The SHMI model uses the Charlson comorbidity index which in turn is derived from knowledge of ischaemic heart disease, heart failure, peripheral vascular disease, cerebrovascular disease, dementia, obstructive airways disease, connective tissue disease, previous or current history of peptic ulceration, liver disease, chronic kidney disease and current or past history of solid tumour, lymphoma or leukaemia. Together these constitute depth of coding and again our depth of coding is one of the lowest, which does not fit with what is know about the demography of the East Kent population.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Serious Incidents

May	Serious Incidents (STEIS)	132 (78.4%)		"Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."
May	Never Events (STEIS)	9 (50.0%)		"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:

During May 2019, 18 new Serious Incidents (SIs) were reported and three SIs closed.

At the end of May 2019 there were 98 SIs open, of which 13 were breaching, 17 non-closure responses were required and 25 were awaiting a closure decision by the CCGs. The remaining 43 were within timeframes or extensions had been granted by the CCGs.

The weekly Executive led SI panel continue to support rigorous analysis of SIs and the development of improvement plans focused on systems and mitigation of Human Factors. The panel ensures the Care Groups are managing delays in investigations and responses to the CCGs.

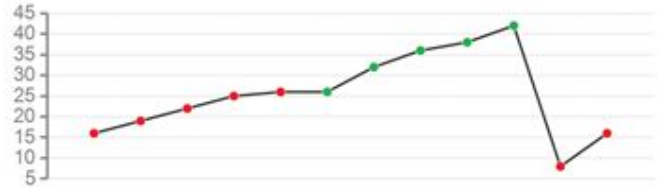
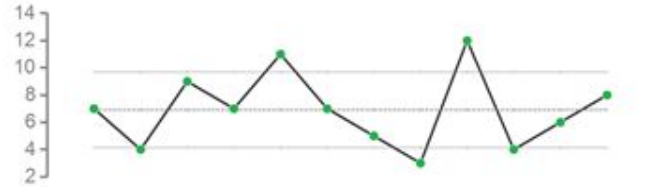
Practical support is provided by the Corporate Patient Safety team to investigation teams to improve the quality of investigations and reduce delays where possible.

Learning from SIs is shared through Lead investigator presentation to the Executive SI panel enabling constructive critique, cross Care Group learning and senior leadership oversight of emerging risks. Newsletters sharing the stories and learning from SIs are shared with staff via Care Group Governance mechanisms and the RiskWise newsletter which is circulated Trustwide. The Corporate Patient Safety team and specialists with a Trustwide remit also share learning when out in practice, during training delivery and at QII hub learning events.

NHS East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Infection Control

May	Cases of MRSA (per month)	5 (-16.7%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
May	Cases of C.Diff (Cumulative)	16 (100.0%)		"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."
May	E. Coli	83 (3.8%)		"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."

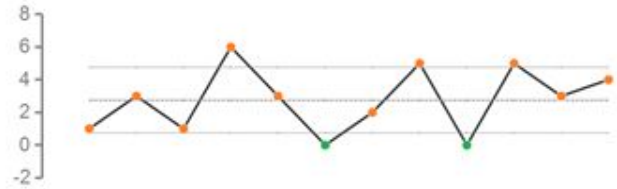
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

May

MSSA

33
(0.0%)



"The total number of MSSA bacteraemia recorded, post 48hrs.

Highlights and Actions:

C.difficile

C.difficile data is presented as the cumulative number of cases and resets to zero each April. Since April this year the reported numbers now include all C. difficile identified48 hours or more following admission (not 72 hours as in previous years) plus any patient identified with C. difficile who was previously an inpatient within the preceding4 weeks. This means that comparative data is absent and that any colour coding is rendered inaccurate.

MRSA

Year to date there have been no hospital onset MRSA bacteraemias.

All actions are as previously reported and include active participation in the Kent & Medway national pilot aimed at reduction of gram negative bloodstream infections.

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Strategic Theme: Patient Safety

Harm Free Care

May	Harm Free Care: New Harms (%)	99.0 (0.4%)		Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

May

Harm Free Care:All Harms (%)

92.0
(0.0%)

"Percent of inpatients deemed free from harm as measured by the Safety Thermometer audit ie free from old and new harms:
- Old and new pressure ulcers (categories 2 to 4) - Injurious falls - Old and new UTI - Old and new DVT, PE or Other VTE.
Data source - Safety Thermometer (old and new harms)."

Highlights and Actions:

Overall Harm Free Care (HFC) relates to the Harms patients are admitted with as well as those they acquire in our care. The Safety Thermometer for May19 (92.39%) shows improvement since last month (91.93%) but remains below national average (93.83%). A marked improvement 100% is shown in Urgent and Emergency Care (91.40% Apr-19). Actions include:

- Implemented pressure ulcer decision form to allow for more robust investigations of all hospital acquired pressure ulcers - Reduce all reported pressure ulcers by 10% on all metrics.
- Focussing on lying and standing blood pressures, non-prescribing of medication which increases falls and mobility assessment and provision of walking aids. An audit has been undertaken to measure current practice of these actions, to enable an action plan to address the CQUIN targets, to include therapies and pharmacy.
- A Kent & Medway wide UTI pathway has been developed following publication of national guidance (PHE, NICE) and implementation will be focused to include roll out of the new catheter passport.

Harm Free Care experienced in our care (New Harms only) at 99.30% remains similar to last month (99.61% Apr-19). The prevalence of New VTE's; New Pressure Ulcers; Falls with Harm and Catheters and New UTI's with Harm continues to remain below the national average for Acute Hospitals.

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Strategic Theme: Patient Safety

Pressure Damage

May	Pressure Ulcers Cat 3/4 (per 1,000)	0.01 (105.9%)		"Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

May 2019

There were a total of 59 category 2 and above hospital acquired pressure ulcers reported, an increase of 11 from April 2019. Forty eight of these were category 2 ulcers, an increase of 10. The rate has increased from April 2019 (1.163/1000 in May 2019 1.038/1000 bed days in April 2019). Six involved medical devices.

There were 2 confirmed category 3 pressure ulcers, 3 less than last month. There was a drop in rate compared to April 2019 (0.55/1000 bed days in May 2019 0.144 in April 2019). 1 of these was identified as moderate harm and requires further investigation at WHH (2 less than last month). There were no confirmed category 4 pressure ulcers

Nine potential deep ulcers were reported 2 more than last month. 6 were potential deep tissue injury and 3 were unstageable ulcers. Although unstageble ulcers equalled last month the bed day rate dropped slightly (0.083 in May 0.087/100 in April). Only one of these was deemed moderate risk and requires an RCA.

31 reported incidents were due to Moisture Associated Skin Damage an increase of 7 from April 2019.

Actions

- Joint Nursing and Allied health professional network meeting took place between Primary and secondary care provider with the focus on streamlining patient pathways
- Training has taken place on areas of concern at WHH
- Bi-annual TV link nurse study took place with over 70 attendees
- ward based 'trolley dash' education session trust wide held by dressing companies to improve care of wounds
- TVNs trialling medical photography on Ipad in conjunction with medical imaging
- Joint work with infection control regarding improving mattress auditing
- Meeting between lead TVN from EKHUFT and KCHFT to improve joint working
- Review of datixs reported by KCHFT to look for trends of particular wards of concern

Recommendations:

- To alter SKINS and repositioning regime to make documentation easier for staff to complete
- Extend education to Multi-disciplinary team ie. Drs and allied health professionals.
- Carry out targeted work on Unstageable ulcers to look at trends and implement bespoke action plan
- Work with Manual handling on slide sheet project to reduce sacral pressure ulcers
- Continue to work with wards to improve availability of pressure relieving equipment
- Undertake chair cushion trials

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Falls

May

Falls (per 1,000 bed days)

5.33 (-4.1%)

"Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

Falls incidents have decreased in May. There were a total of187 patient falls (199 in April) including 42 at K&CH (52 in April), 57 at QEQMH (51 in April) and , 88 at WHH (96 in April). There have been no falls resulting in moderate and above harms

QEQM of note:
7 falls on AMU A and St Augustine's.

K&CH of note:
7 falls on Harbledown (one patient fell 2 times).
7 falls on Kingston.

WHH of note:
9 falls on Richard Stevens (one patient fell 3 times).
7 falls on Cambridge J.
7 falls on Cambridge K (1 patient fell 3 times).
7 falls on Oxford (1 patient fell 3 times).

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

Patient Safety Month: Desktop visuals for falls prevention have been created. These include the high impact actions for falls prevention included in the falls CQUIN and post fall care. They will also be displayed as posters in the QII hubs during June.

A small gap analysis audit has been completed to measure actual falls versus reported falls. This demonstrated that all falls were reported, indicating that there is an open reporting culture around falls.

Risks: The Falls Team continue to declare risks relating to the achievement of the CQUIN, due to the lack of resources to deliver quality improvement via the FallStop programme. A business case was presented to include 2 band 4 practitoners to continue to deliver the FallStop programme, ensuring 7 day cover across all sites and to support the 2019-2020 Falls CQUIN. This was declined but is being reviewed by the General and Specialist Medicine Care Group.

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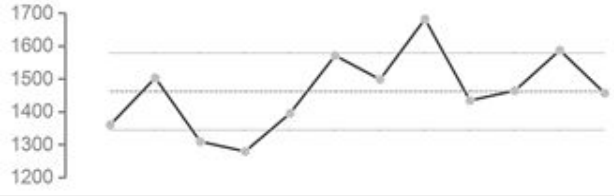
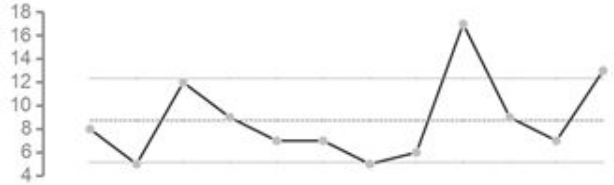
Strategic Theme: Patient Safety

Incidents

May	Clinical Incidents: Total (#)	17,550 (6.2%)		"Number of Total Clinical Incidents reported, recorded on Datix.
May	Blood Transfusion Incidents	105 (-26.6%)		"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."
May	Medicines Mgmt. Incidents	1,827 (6.4%)		"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."

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Highlights and Actions:

A total of 1456 clinical incidents have been logged as occurring in May-19 compared with 1588 recorded for Apr-19 and 1493 in May-18.
In May-19, 19 incidents have been reported on StEIS. Six serious near miss incidents have been reported. Comparison of moderate harm incidents reported: 12 in May-19 and 26 in Apr-19, and 5 in May-18.
Over the last 12 months incident reporting remains constant at K&C, but is increasing at WHH and QEQM.

IPR report for Medicine management – May 2019

As of 14/06/2019 the total number of medication related incidents reported in May 2019 was 182 showing an increase in the trajectory of reporting of incidents. These included 132 no harm, 46 low harm and 4 moderate harm incident. The severity of medication related incidents reported in May 2019 shows that 72.5% of medication related incidents reported were no harm incidents. There was no medication related incident reported in May 2019 that required RCA investigation or incidents sTEIS reported.
There were 54 incidents in May 2019 categorised as 'omitted medicine/ingredient', representing 29.7% of all medication related incidents reported in May. The data produced by the Medication Safety Thermometer in May 2019 was taken from 25 wards across the sites, and has shown that the percentage of patients with an omitted dose of medication was 19.5% and the percentage of patients with a missed critical medicine was 8.1% in May.
There have been a range of Medication Safety posters have been used as Trust wall paper displays to highlight the key medication safety issues. The Medicine Patch rotation chart is being piloted on 3 wards in the Trust with the hope that this will reduce the risk of incidents around removal of patches. Some wards have adopted the recommendation that nurses should check charts at the end of the shift to ensure that all medications have been signed for to reduce blank spaces in drug charts being the primary cause of missed doses.
Regular foundation and core medical doctor teaching sessions on Medication Safety have been arranged throughout the end of this and the new academic year.

Blood transfusion (submitted by the Blood Transfusion Coordinator)

There were 13 Blood Transfusion related incidents in May 2019 (6 in April 2019 and 8 in May 2018).

Of the 13 incidents 12 were graded as no harm and 1 as low harm.

Five of the incidents fell in the category 'Treatment / procedure inappropriate / wrong' these incidents included a patient receiving two units of albumin without the product being second checked, a patient having blood antibodies which was not highlighted at pre assessment, a patient receiving a blood transfusion without the appropriate observations, a vial of anti D being drawn up for the wrong patient and then wasted and lastly a patient having a transfusion stopped and the unit placed under the pillow as the patient went to endoscopy.

The only other incident of note was a unit of platelets being given out by the laboratory without being issued and a compatibility label attached; this was then signed for by the porter and then checked on the ward and transfused to a patient. Although the patient did require a platelet transfusion these platelets were not the ones that were ordered for the patient and did not fully meet their requirements.
No other themes were identified.
Reporting by site: at 5 QEQM, 4 WHH and 3 at K&CH

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Strategic Theme: Patient Safety

Friends & Family Test

May	IP FFT: Response Rate (%)	36 (3.0%)		"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
May	IP FFT: Recommend (%)	97 (0.2%)		

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

May

IP FFT: Not Recommend (%)

1.3 (-15.9%)

"Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

A total of 5588 responses were received. Overall response rates improved across inpatients and day cases and fell in ED and maternity. Response rate for the EDs was 15.78% (16.23% Apr-19), inpatients 38.21% (33.77% Apr-19), maternity; birth only 17.09% (33.19% Apr-19) and day cases 26.56% (26.06% Apr-19).

The Trust star rating in May is 4.54 (4.54 Apr-19). 90.78% of responders would recommend us to their friends and family and 5.36% would not. Recommendations by patients improved in ED, maternity, outpatients and day cases but fell slightly in inpatients. Inpatients, including paediatrics, who would recommend our services 96.06% (96.18% Apr-19), EDs 82.5% (78.7% Apr-19), maternity 98.9% (98.7% Apr-19), outpatients 92.3% (91.8% Apr-19) and day cases 94.8% (94.57% Apr-19).

Care, Staff attitude and Implementation of care are the three top positive themes for May-19. The three top negative themes for the trust were Care, Staff Attitude and waiting times demonstrating the importance of good patient communication with a positive staff attitude and improving patient waiting times.

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

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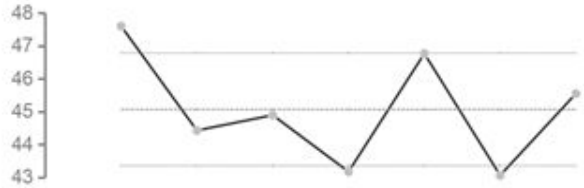
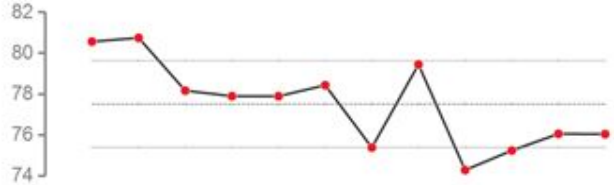
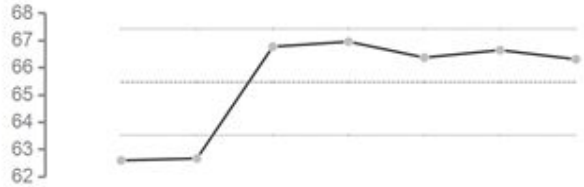
Strategic Theme: Patient Safety

Patient Experience 1

May	IP Survey: Overall, did you get the care that matters to you?	44.8		Inpatient Survey: Patients views on if they got the overall care that mattered to them as a %
May	IP Survey: Are you aware of nurse in charge of you each shift? (%)	77 (-1.7%)		IP Survey: Are you aware of nurse in charge of your care each shift? (%)
May	IP Survey: Encouraged to get up and wear own clothes (%)	66		Responses taken from the Inpatient Survey. Question: "Have you been encouraged to get up during your hospital stay and wear your own clothes?"

Highlights and Actions:

Our inpatient survey enables our patients to record their experience in real-time. This month we received 3147 completed inpatient surveys, an increase from 2958 last month.

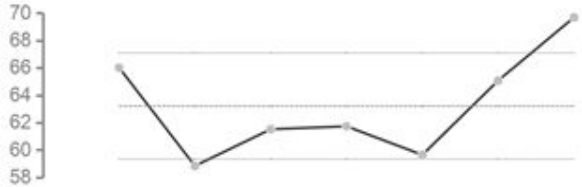
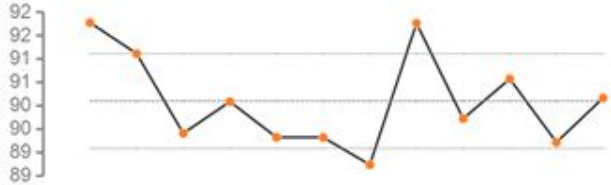
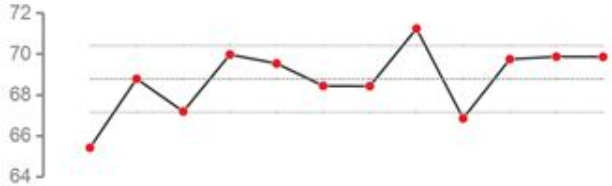
New questions were added into the survey in Nov-18 to enable close monitoring of four key areas where our performance in the 2017 national inpatient survey (published in May-18) was below the national average. Baseline performance in patients getting the care that matters to them, ensuring patients are aware of which nurse is in charge of their care, ensuring patients have been encouraged to get up during their hospital stay and wear their own clothes and ensuring that patients received enough help from staff to eat their meals demonstrated significant opportunity for improvement.

This month an improvement is seen in two out of four of these important elements of patient experience. This local survey supports our improvement priorities, with progress monitored through the Patient Experience Committee.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 2

May	IP Survey: Help from Staff to Eat Meals (%)	64		Responses taken from the Inpatient Survey. Question: "Did you get enough help from staff to eat your meals?"
May	Cleanliness %	90 (-0.5%)		Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Hospital Food? %	69 (-1.8%)		Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Highlights and Actions:

Patient experience is additionally reported per ward within the heat map and focused work continues to promote this reporting. All inpatient wards within the trust continue to report their performance (against the patient experience metrics) through the inpatient survey this month.

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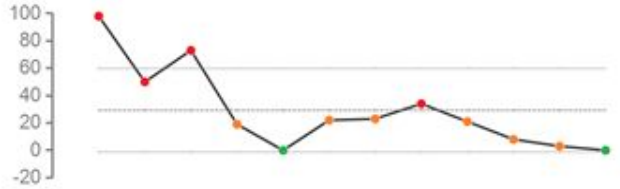
Strategic Theme: Patient Safety

Mixed Sex

May	Mixed Sex Breaches	351 (-71.6%)		"Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

There were 5 mixed sex accommodation occurrences in total, affecting 55 patients.

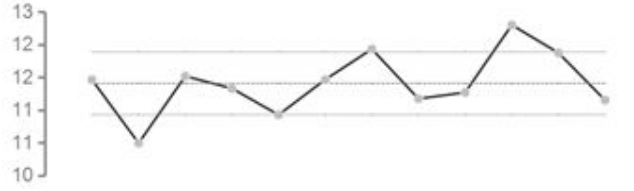
Incidence of mixed sex accommodation breaches occurred in WHH CCU (4) and K&C HDU (1), which was justifiable based on clinical need. This information has been reported to NHS England.

Rigorous work continues in achieving compliance with the national definition of mixed sex accommodation. The Privacy and Dignity and Eliminating mixed sex accommodation Policy is updated to reflect National guidance.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Safe Staffing

May	Shifts Filled - Day (%)	97 (-1.8%)		Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Shifts Filled - Night (%)	105 (-1.5%)		Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.
May	Care Hours Per Patient Day (CHPPD)	11 (-2.5%)		Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

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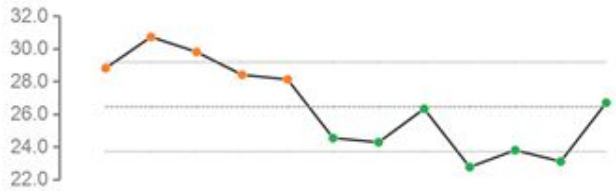
Strategic Theme: Patient Safety

May

Midwife:Birth Ratio (%)

26.4
(-6.9%)



The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.

Highlights and Actions:

Percentage fill of planned (funded establishment) and actual (filled shifts) by hours is required to be reported monthly by registered nurse and care staff, by day and by night, in line with National Quality Board expectations. Reported data is derived from the Healthroster system which shows an average overall fill rate of101.9% compared to 102.9% in Apr-19.

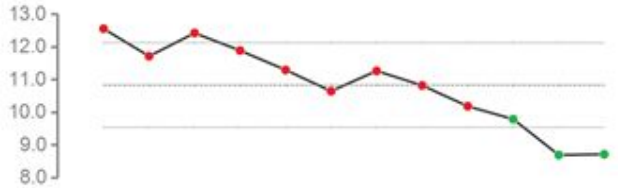
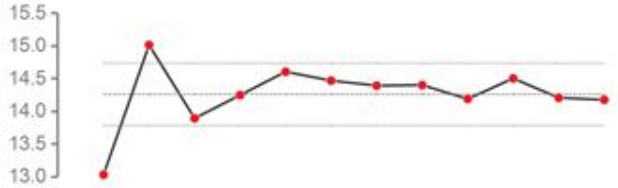
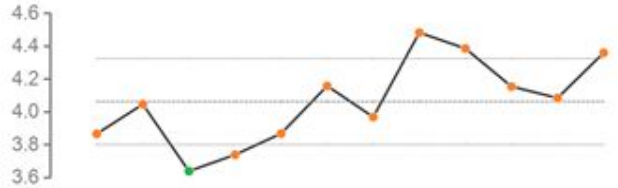
Care Hours per patient day (CHPPD) relates actual staffing to patient numbers and includes registered staff and care staff hours against the cumulative total of patients on the ward at 23.59hrs each day during the month. CHPPD is similar to Apr-19 and within the control limits. The range is from around 5.0 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required.

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

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Gaps & Overtime

May	Vacancy (Monthly) %	10.8 (-6.1%)		Monthly % 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."
May	Staff Turnover (%)	14.3 (7.6%)		"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
May	Sickness (Monthly) %	4.1 (8.4%)		Monthly % of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months

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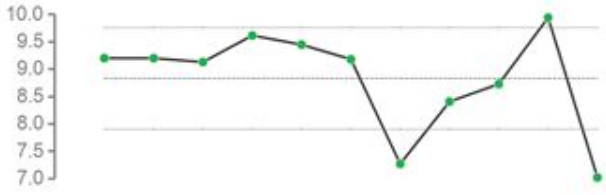
Strategic Theme: Human Resources

May

Overtime %

8.8
(1.8%)



% of Employee's that claim overtime.

Highlights and Actions:

Gaps and Overtime

The vacancy rate decreased to 10.8% (last month 12.8%) for the average of the last 12 months, which is an improvement on last month and last year. However, the monthly rate increased slightly to 8.65% (up from 7.99%). There are currently approximately 690 WTE vacancies across the Trust (640 WTE last month). More work is being undertaken to target hard to fill vacancies, particularly within nursing and Medical specialties. There are approximately 450 WTE candidates in the recruitment pipeline - i.e. those who have been offered positions and are gaining pre-employment clearances. This includes approximately 200 Nursing and Midwifery staff (including ODPs) and 100 Medical and Dental staff. For information, 59 WTE New Qualified Nurses have also been appointed. The Resourcing team have recruited approximately 1,800 new members of staff in the last 12 months. Although the vacancy rate increased this month, the last 12 months has seen an establishment increase of 440 WTE.

The Turnover rate in month decreased to 11.7% (last month 11.8%), although the 12 month average increased to 14.3% (14.2% last month). Focus remains on hard to recruit roles to replace agency, but also to identify new ways and methods of attracting to hard to recruit roles. Exit data is reviewed to highlight any areas of concern. Turnover remains highest in Urgent & Emergency Care at 15.9%.

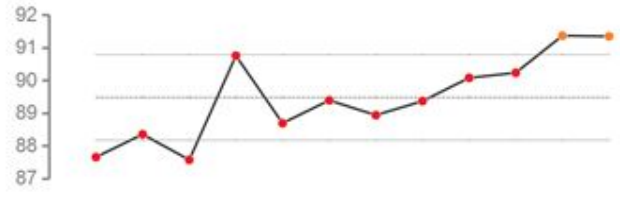
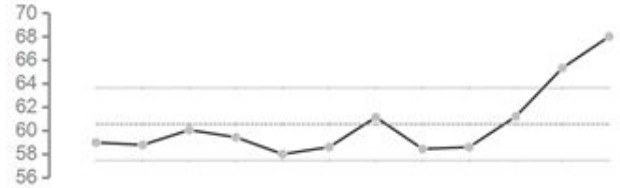
The in month sickness absence position for April was 4.08% - which is an decrease from4.16% in March. The 12 month average increased to 4.1%, and work is underway between the Employee Relations team and HRBPs to look into areas of high sickness absence to ensure all cases are being managed effectively. Care Groups have developed sickness absence reduction plans, with a focus on long term sickness absence and an integrated approach to proactively managing absence with Occupational Health through case conferencing and regular contact. This includes supporting stress, anxiety and compassion fatigue through Respect & Resilience workshops, Mindfulness Courses and Mental Health First Aid training.

Overtime as a % of wte decreased significantly last month, from approximately 10.0% to 7.0%, and is the lowest rate for the last 12 months. The average over the last 12 months decreased to 8.8% from 9.0% last month, although continues to show an upward trend. All metrics are reviewed and challenged at a Care Group level in the monthly Executive Performance Reviews.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Temporary Staff

May	Employed vs Temporary Staff (%)	89.5 (0.9%)		"Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
May	Agency %	7.8 (20.2%)		% of temporary (Agency and Bank) staff of the total WTE
May	Bank Filled Hours vs Total Agency Hours	61 (5.4%)		% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff

Highlights and Actions:

Temporary Staff

Total staff in post (WTE) increased in May to 7286.17 (up from 7282.99 WTE in March), which left a vacancy factor of approx. 689 wte across the Trust.

The average percentage of employed staff vs temporary staff over the last12 months increased to 89.5% (89.3% last month), and remains an improvement over the previous 12 months. As a result of this, the percentage of agency staff of the total WTE for the Trust decreased to approximately7%, from 8% in the previous month, and 10% the month before. This was also partly as a result of an increase in Bank filled hours against total agency hours.

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.

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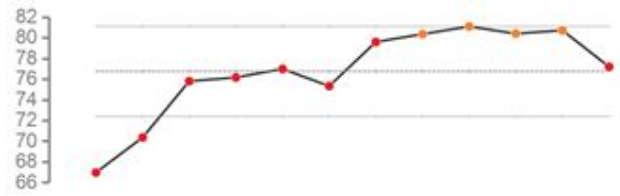
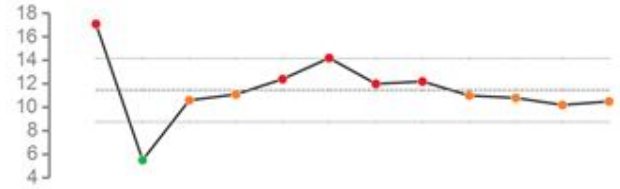
Strategic Theme: Human Resources

Workforce & Culture

May	Statutory Training (%)	94 (1.7%)		"The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months. "
May	Appraisal Rate (%)	76.8 (-3.4%)		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.
May	Time to Recruit	11 (-17.8%)		"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."

Highlights and Actions:

Workforce & Culture

Average Statutory training 12 month compliance remains on an upwards trajectory, and increased to 94% in month for May (92% in April). This remains above the target of 85%. Care Groups are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements.

The Trust staff average appraisal rate decreased to77% in month for May (81% in April), with Clinical Support Services achieving 86% compliance and Surgery & Anaesthetics achieving 84% compliance. Care Groups are working on plans to complete outstanding appraisals as well as to avoid a further drop in appraisal rates for those due to be renewed in coming months.

The average time to recruit is 10 weeks, which is an improvement on last month, and an improvement on the previous 12 months. The 12 month average time to recruit was 11 weeks, which is an improvement of 1 week on the previous average. The Resourcing Team are on track to reduce time to recruit to below8 weeks to ensure recruitment time meets the demands of our services. To support this reduction, the team are now fully established and Advisors have been allocated to Care Groups to support improvements.

East Kent Hospitals University NHS Foundation Trust

Activity vs. Internal Business Plan

Key Performance Indicators

May

	May-19				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	14,478	15,673	(-1,195)	-8%	29,625	30,161	(-536)	-2%	29,625	29,848	(-223)	-1%	<=0%
Referral Non-Primary Care	14,490	15,558	(-1,068)	-7%	29,882	29,673	209	1%	29,882	29,949	(-67)	0%	<=0%
OP New	18,293	17,542	751	4%	35,733	32,784	2,949	9%	35,733	35,452	281	1%	>=0%
OP Follow Up	39,142	40,391	(-1,249)	-3%	78,062	76,539	1,523	2%	78,062	79,578	(-1,516)	-2%	>=0%
Elective Daycase	6,762	6,371	391	6%	12,847	12,448	399	3%	12,847	12,965	(-118)	-1%	>=0%
Elective Inpatient	1,187	1,321	(-134)	-10%	2,261	2,638	(-377)	-14%	2,261	2,454	(-193)	-8%	>=0%
A&E	19,882	18,767	1,115	6%	38,955	36,251	2,704	7%	38,955	36,171	2,784	8%	>=0 & <5%
Non-Elective Inpatient	7,789	6,784	1,005	15%	15,103	13,232	1,871	14%	15,103	13,460	1,643	12%	>=0 & <5%
Chemotherapy	1,323	1,315	8	1%	2,559	2,494	65	3%	2,559	2,452	107	4%	>=0%
Critical Care	1,698	2,049	(-351)	-17%	3,514	3,819	(-305)	-8%	3,514	3,747	(-233)	-6%	>=0%
Dialysis	7,514	7,174	340	5%	14,875	14,014	861	6%	14,875	13,722	1,153	8%	>=0%
Maternity Pathway	1,164	1,160	4	0%	2,209	2,278	(-69)	-3%	2,209	2,233	(-24)	-1%	>=0%
Pre-Op Assessments	3,124	3,859	(-735)	-19%	6,193	7,274	(-1,081)	-15%	6,193	6,881	(-688)	-10%	>=0%
Diagnostic	497,678	475,690	21,988	5%	969,678	936,129	33,549	4%	969,678	922,733	46,945	5%	<=0%
Other	5,357	5,502	(-145)	-3%	10,118	10,679	(-561)	-5%	10,118	10,327	(-209)	-2%	>=0%

East Kent Hospitals University NHS Foundation Trust

May 2019

Summary Performance

Elective Care

In May Primary Care referrals were 8% (-1,195) below planned levels. The decrease was observed across a number of specialties, most notably in Cardiology, Ophthalmology, Gastroenterology and Paediatrics. Rapid Access referral levels are comparable to last year, this remains slightly lower than the YTD plan which had assumed a small level of growth. Non Primary Care referrals were also below expected levels by 7% (-1,068) in month.

The Trust achieved the new outpatient plan in May with appointments 4% above planned levels generating a YTD variance 9% above plan. Physiotherapy (-234) and Gastroenterology (-148) continue to underperform the business plan.

The Trust under-performed the follow up plan in May (-3%) but remains above planned levels YTD (+2%). The biggest drivers behind the under-performance are Ophthalmology, Physiotherapy, Community Paediatric, Neuro-Disability and Community Paediatrics.

Daycase admissions hit plan and delivered in May increasing YTD performance to 3% above plan (+399). Daycase productivity delivered in May increased from the previous month by 11%.

Elective Admissions are 14% (-377) behind the plan in the YTD with General Medicine (-209), Trauma and Orthopaedics (-95) and General Surgery (-61) contributing to the largest underperformance.

Non Elective Care

Emergency Attendances are 7% above plan in the YTD which represents an 8% increase on the numbers received during the same period last year. 28.1 % of the attendances are converting to inpatients, this is generating a YTD increase of 12% against previous years.

East Kent Hospitals University NHS Foundation Trust

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	2,235	3,045	-27%	-810
130 - Ophthalmology	2,174	2,582	-16%	-408
101 - Urology	1,238	1,543	-20%	-305
420 - Paediatrics	892	1,189	-25%	-297
301 - Gastroenterology	1,262	1,523	-17%	-261
291 - Community Paediatric Neuro-Disa	314	178	76%	136
191 - Pain Management	390	248	57%	142
104 - Colorectal Surgery	1,637	1,471	11%	166
110 - Trauma & Orthopaedics	1,887	1,636	15%	251
340 - Respiratory Medicine	1,132	766	48%	366
Total	**29,625**	**30,161**	**-2%**	**-536**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	3,894	6,500	-40%	-2,606
430 - HCOOP	275	559	-51%	-284
651 - Occupational Therapy	329	468	-30%	-139
328 - Stroke Medicine	246	120	105%	126
650 - Physiotherapy	2,347	2,219	6%	128
300 - General Medicine	690	516	34%	174
100 - General Surgery	825	527	57%	298
130 - Ophthalmology	2,872	2,507	15%	365
502 - Gynaecology	1,676	1,151	46%	525
340 - Respiratory Medicine	2,036	399	410%	1,637
Total	**29,882**	**29,673**	**1%**	**209**

OP New

Specialty	Activity	Plan	Var (%)	Significance
650 - Physiotherapy	3,202	3,436	-7%	-234
301 - Gastroenterology	1,078	1,226	-12%	-148
655 - Orthoptics	403	244	65%	159
215 - Paediatric ENT	259	35	642%	224
330 - Dermatology	2,221	1,926	15%	295
104 - Colorectal Surgery	1,417	1,115	27%	302
420 - Paediatrics	1,616	1,259	28%	357
502 - Gynaecology	2,573	2,141	20%	432
110 - Trauma & Orthopaedics	2,773	2,221	25%	552
130 - Ophthalmology	3,398	2,770	23%	628
Total	**35,733**	**32,784**	**9%**	**2,949**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	7,963	8,657	-8%	-694
650 - Physiotherapy	10,110	10,462	-3%	-352
291 - Community Paediatric Neuro-Disa	780	1,103	-29%	-323
290 - Community Paediatrics	3,892	4,156	-6%	-264
410 - Rheumatology	1,691	1,405	20%	286
330 - Dermatology	3,339	3,016	11%	323
502 - Gynaecology	2,630	2,304	14%	326
140 - Maxillo Facial	1,930	1,590	21%	340
800 - Clinical Oncology	7,515	7,145	5%	370
655 - Orthoptics	1,518	709	114%	809
Total	**78,062**	**76,539**	**2%**	**1,523**

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Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	691	899	-23%	-208
140 - Maxillo Facial	387	493	-21%	-106
340 - Respiratory Medicine	152	246	-38%	-94
320 - Cardiology	502	565	-11%	-63
101 - Urology	1,434	1,337	7%	97
303 - Clinical Haematology	711	607	17%	104
110 - Trauma & Orthopaedics	901	790	14%	111
800 - Clinical Oncology	1,152	1,035	11%	117
301 - Gastroenterology	352	143	147%	209
410 - Rheumatology	249	20	1165%	229
Total	**12,847**	**12,448**	**3%**	**399**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	183	392	-53%	-209
110 - Trauma & Orthopaedics	557	652	-15%	-95
100 - General Surgery	144	205	-30%	-61
120 - Ear, Nose & Throat	81	122	-33%	-41
320 - Cardiology	18	43	-58%	-25
140 - Maxillo Facial	39	59	-34%	-20
340 - Respiratory Medicine	9	22	-58%	-13
501 - Obstetrics	11	0		11
420 - Paediatrics	56	45	26%	11
811 - Interventional Radiology	52	19	167%	33
Total	**2,261**	**2,638**	**-14%**	**-377**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
420 - Paediatrics	1,392	1,563	-11%	-171
300 - General Medicine	3,874	4,045	-4%	-171
560 - Midwifery	317	465	-32%	-148
501 - Obstetrics	822	895	-8%	-73
320 - Cardiology	338	409	-17%	-71
110 - Trauma & Orthopaedics	647	717	-10%	-70
340 - Respiratory Medicine	117	166	-29%	-49
430 - HCOOP	1,440	1,402	3%	38
101 - Urology	758	663	14%	95
180 - Accident & Emergency	2,954	417	608%	2,537
Total	**15,103**	**13,232**	**14%**	**1,871**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	969678	936129	4%	33,549
A&E	38955	36251	7%	2,704
Pre-Op	6193	7274	-15%	-1,081
Dialysis	14875	14014	6%	861
Other	10118	10679	-5%	-561
Critical Care	3514	3819	-8%	-305
Maternity Pathway	2209	2278	-3%	-69
Chemotherapy	2559	2494	3%	65

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4 Hour Emergency Access Standard

Key Performance Indicators

81.22%

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Green
4 Hour Compliance (EKHUFT Sites) %*	82.55%	79.18%	80.04%	77.15%	80.89%	81.74%	79.36%	74.20%	73.85%	78.23%	77.13%	81.22%	95%
4 Hour Compliance (inc KCHFT MIUs)	85.67%	82.95%	83.52%	81.02%	83.88%	84.50%	82.25%	77.93%	77.56%	81.53%	80.54%	84.26%	95%
12 Hour Trolley Waits	0	0	0	0	0	0	0	0	0	0	0	0	0
Left without being seen	2.05%	2.75%	2.44%	3.52%	3.09%	2.77%	3.03%	3.02%	3.56%	3.67%	4.03%	3.49%	<5%
Unplanned Reattenders	9.31%	9.84%	9.91%	10.23%	9.82%	9.56%	9.46%	9.59%	9.82%	9.83%	10.70%	9.98%	<5%
Time to initial assessment (15 mins)	92.8%	94.4%	91.4%	72.8%	71.4%	70.9%	65.0%	66.3%	66.3%	65.6%	66.9%	68.3%	90%
% Time to Treatment (60 Mins)	51.7%	42.7%	48.1%	45.7%	50.7%	52.7%	48.7%	50.5%	47.9%	44.9%	44.0%	45.9%	50%

2019/20 Trajectory (NHSI return)

-0.7 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Green
Trajectory	76.4%	81.9%	85.6%	84.2%	86.6%	85.3%	89.7%	92.1%	91.0%	84.9%	87.5%	86.2%	
Performance	77.1%	81.2%											

The above table shows the ED performance, including the health economy MIU activity and also with EKHUFT only performance.

Summary Performance

May performance for the organisation against the 4 hour target was 81.22%; against the NHS Improvement trajectory of 81.9%.This represents an improvement in performance compared to the previous month of 4.1% (from 77.13%), and an increase compared to the same month last year (80.8% in 2018). There were no 12 Hour Trolley Waits in May. The proportion of patients who left the department without being seen was 3.49%. The unplanned re-attendance position remains high at 9.98%. Time to treatment within 60 minutes remained below 50% at 45.9%.

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Issue

- Patient flow is blocked due to the high >7 day and >21 day patients and DTOC patients.
- Community capacity is limited and is preventing discharge.
- High number of presentations – 7% above plan year to date and 8% above last year.

Action

- Review all >7 day patients to agree clinically the next steps.
- KMPT recovery plan for rapid transfer service is underway.
- Diversion actions implemented for SECAMB.
- LoS action plan in place.

Timescale

- LoS actin plan – 1 month to implement.

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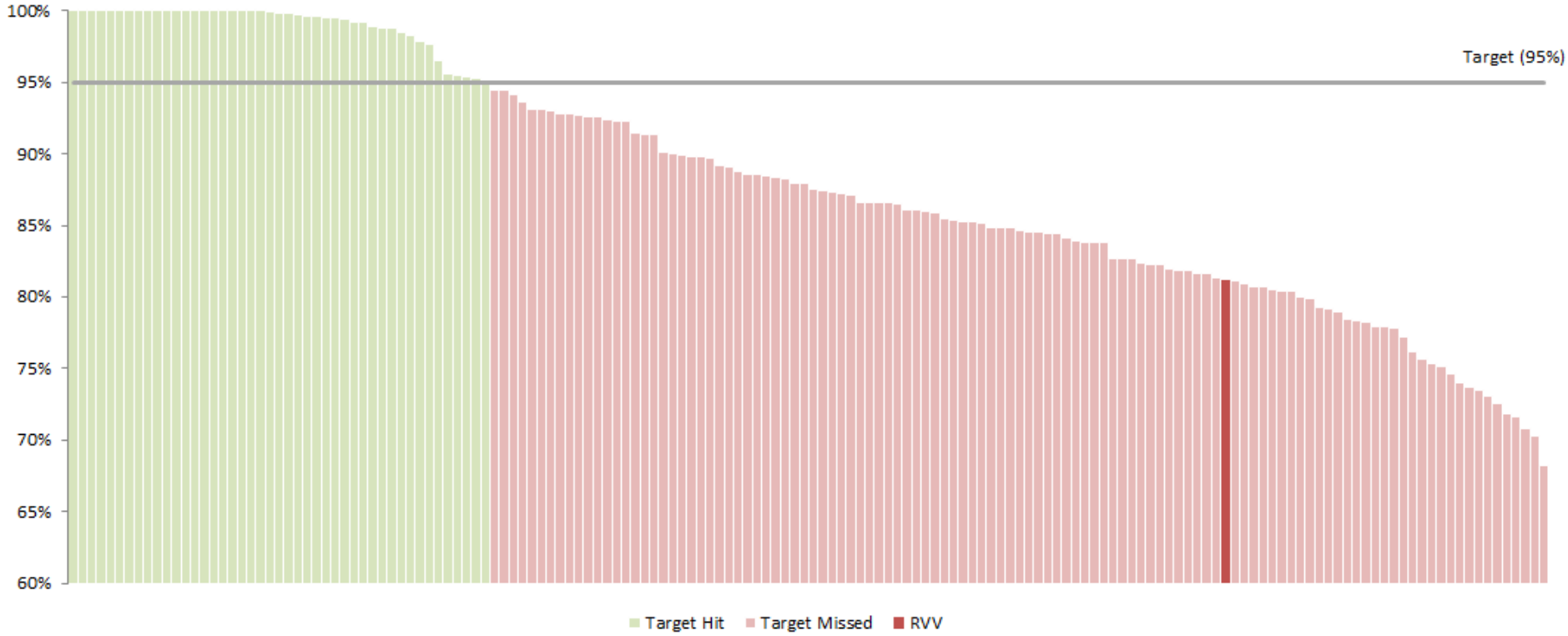
May 2019 | National A&E Benchmarking

East Kent Hospitals University NHS Trust ranked 124 of 158 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2019-20/



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Cancer Compliance

Key Performance Indicators

80.18 %

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Green
62 Day Treatments	64.88%	65.38%	65.79%	68.84%	75.85%	70.95%	82.08%	68.21%	76.88%	81.56%	78.44%	80.18%	>=85%
>104 day breaches	34	36	24	12	9	4	8	10	8	7	10	6	0
Demand: 2ww Refs	3,243	3,204	3,100	2,874	3,483	3,307	2,656	3,414	3,228	3,320	3,213	3,442	3046 - 3367
2ww Compliance	94.20%	94.97%	93.64%	91.08%	83.43%	93.29%	96.73%	96.52%	98.31%	97.87%	97.70%	96.53%	>=93%
Symptomatic Breast	94.12%	93.13%	84.17%	94.39%	68.46%	83.33%	95.00%	97.22%	98.31%	92.76%	93.64%	93.81%	>=93%
31 Day First Treatment	96.25%	95.52%	95.41%	97.50%	97.40%	97.07%	97.66%	95.63%	97.73%	96.06%	97.54%	95.72%	>=96%
31 Day Subsequent Surgery	82.22%	94.44%	95.56%	96.00%	93.33%	100.00%	97.22%	97.78%	96.49%	94.74%	84.31%	94.12%	>=94%
31 Day Subsequent Drug	99.03%	99.15%	98.96%	97.75%	99.19%	98.06%	98.85%	98.28%	97.27%	100.00%	100.00%	99.18%	>=98%
62 Day Screening	100.00%	80.00%	93.94%	87.76%	87.50%	85.71%	87.50%	100.00%	76.92%	82.61%	100.00%	91.89%	>=90%
62 Day Upgrades	80.65%	84.62%	95.24%	72.73%	80.77%	90.00%	70.00%	84.00%	86.67%	76.47%	80.00%	85.71%	>=85%

2019/2020 Trajectory

-5.53 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Green
STF Trajectory	85.52%	85.71%	85.33%	85.96%	86.31%	85.97%	85.71%	86.19%	86.06%	85.71%	85.51%	85.65%	Apr
Performance	78.44%	80.18%											Apr

A Cancer Recovery Plan is in place with an aim to improve performance and ensure that the cancer standards are sustainably delivered across all tumour sites.

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62 Day Performance Breakdown by Tumour Site

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
01 - Breast	95.5%	93.8%	80.8%	89.2%	73.9%	72.4%	89.2%	67.4%	84.3%	86.0%	85.0%	76.7%
03 - Lung	76.5%	70.8%	72.3%	57.1%	52.2%	59.4%	93.5%	64.5%	81.8%	93.3%	57.9%	65.5%
04 - Haematological	50.0%	70.6%	13.3%	63.2%	50.0%	71.4%	75.0%	38.5%	33.3%	62.5%	70.0%	54.5%
06 - Upper GI	78.6%	90.3%	66.7%	59.1%	70.6%	64.7%	100.0%	61.1%	75.0%	60.9%	83.3%	69.4%
07 - Lower GI	63.4%	68.3%	75.0%	65.0%	84.8%	41.4%	57.1%	62.9%	73.8%	64.7%	61.5%	72.7%
08 - Skin	97.1%	97.8%	97.1%	100.0%	100.0%	91.7%	96.7%	94.9%	98.2%	100.0%	95.7%	98.1%
09 - Gynaecological	42.1%	52.0%	72.7%	84.0%	69.7%	100.0%	80.0%	80.0%	71.4%	76.5%	80.0%	78.6%
10 - Brain & Nervous System				100.0%								
11 - Urological	38.8%	39.4%	51.5%	52.1%	70.5%	67.8%	78.4%	64.8%	81.1%	76.2%	85.5%	87.5%
13 - Head & Neck	93.3%	60.0%	60.0%	56.3%	100.0%	50.0%	85.7%	52.4%	42.1%	92.6%	40.0%	33.3%
14 - Sarcoma	100.0%	0.0%			100.0%		100.0%	50.0%	50.0%		100.0%	0.0%
15 - Other	40.0%	100.0%	50.0%	66.7%	0.0%		33.3%	0.0%	40.0%	25.0%	0.0%	66.7%

Summary Performance

May 62 day performance is currently 80.18% against the improvement trajectory of 85.71%, validation continues until the beginning of July in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,620 and there were 6 patients waiting 104 days or more for treatment or potential diagnosis.

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Issue

- Joint organisational pathways are too long and outside national standards.
- Patient pathway management.
- Continued detailed tracking of patients.

Actions

- COO and CEO calls and letters to partner trusts.
- Director of Operations to recheck training and coaching of administration staff.
- PTL tracking to be completed and monitored.

Timescales

- Joint pathway – October 2019. Recruitment needed in oncologists.
- Further development on pathway management underway.
- Senior staff assisting to ensure PTL tracking is underway.

Over 104 day patients has 6 patients waiting:

- Patient 1 – on a Lower GI pathway and will be treated in June 19.
- Patent 2 - on a Lung pathway and will be having radiotherapy and treated in June 19.
- Patient 3 – on a Lung pathway and will be having surgery at another Trust and treated in June 19.
- Patient 4 – on an Upper GI pathway and treated with chemotherapy in June 19.
- Patient 5 – on a Urology pathway and will be having an Oncology appointment and treated in June 19.
- Patient 6 – on a Urology pathway and will be having Brachytherapy and treated in June 19.

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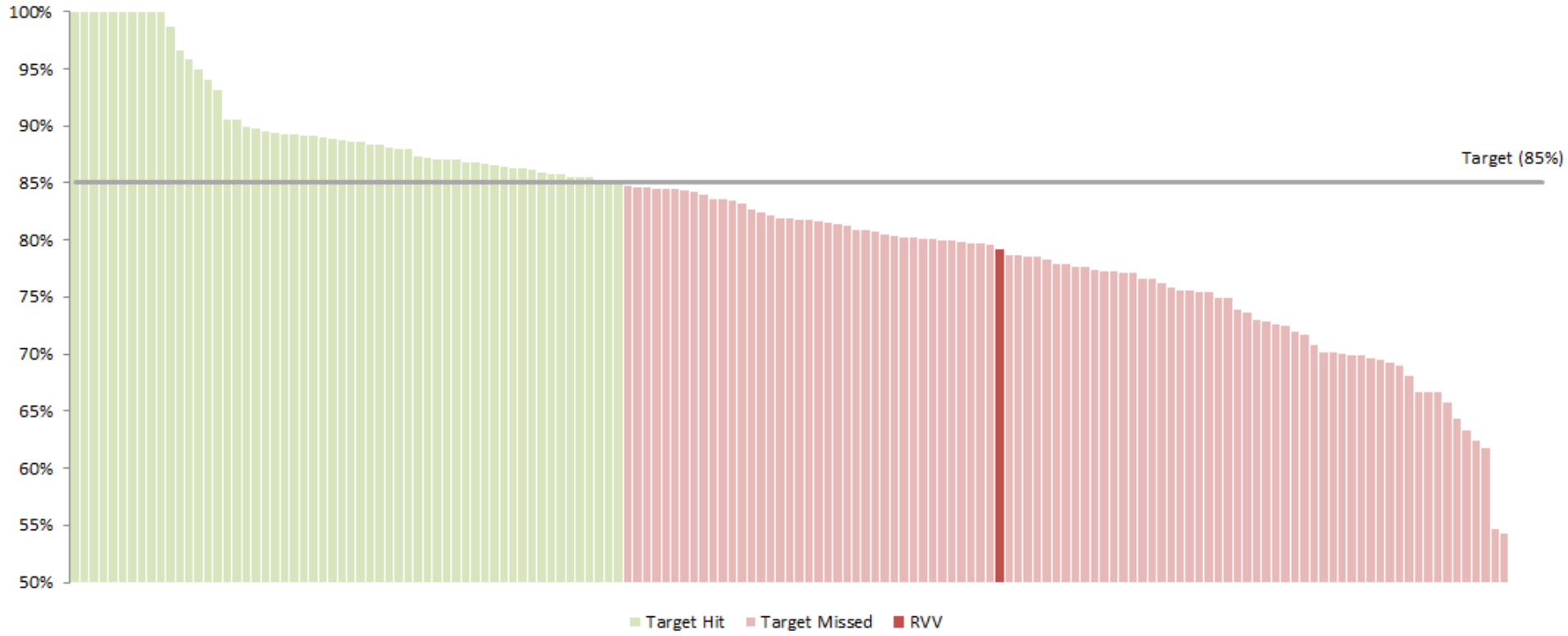
April 2019 | National 62 Day Cancer Benchmarking

East Kent Hospitals University NHS Trust ranked 98 of 153 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/Cancer Waiting Times Data Extract (Provider) Provisional



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18 Week Referral to Treatment Standard

Key Performance Indicators

80.66 %

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Green
Performance	79.02%	79.65%	79.06%	76.27%	74.88%	72.16%	72.42%	76.10%	77.89%	80.03%	79.15%	80.66%	>=92%
52w+	201	167	125	129	120	102	74	38	27	8	3	4	0
Waiting list Size	53,411	53,193	53,552	54,712	55,607	54,492	53,169	50,134	48,743	48,695	45,867	46,359	<38,938
Backlog Size	11,207	10,824	11,212	12,983	13,966	15,170	14,662	11,984	10,776	9,723	9,564	8,964	<2,178

2019/2020 Trajectory

1.66 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Green
Performance Trajectory	78.00%	79.00%	80.00%	80.00%	78.00%	80.00%	81.00%	82.00%	79.00%	80.00%	81.00%	82.00%	
Performance	79.15%	80.66%											

4

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Green
52w Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	Apr
Performance	3	4											

The 18 week performance is above the agreed trajectory, with further reduction in 52 week wait patients (4) and further reduction in backlog size.

Issue

- Long waiting patients: booking agreements are too long.
- Waiting list size has grown.
- 18 week compliance needs detailed management.

Actions and timescale

- Each 52 week patient has an appointment/admission plan in place.
- Referrals have decreased and continued monitoring is in place.
- Training for managers and administrative staff by NHSI will commence to provide further RTT development.

Over 52 week patient breaches

Patient 1 – Ophthalmology patient who has a TCI date and will be treated on the 27 June 2019.
Patient 2 - Ophthalmology patient who has a TCI date and will be treated on the 12 June 2019.
Patient 3 - Gynaecology patient who has been discharged back to her GP on the 5 June 2019.
Patient 4 – ENT patient who has a TCI date and will be treated on the 19 June 2019.

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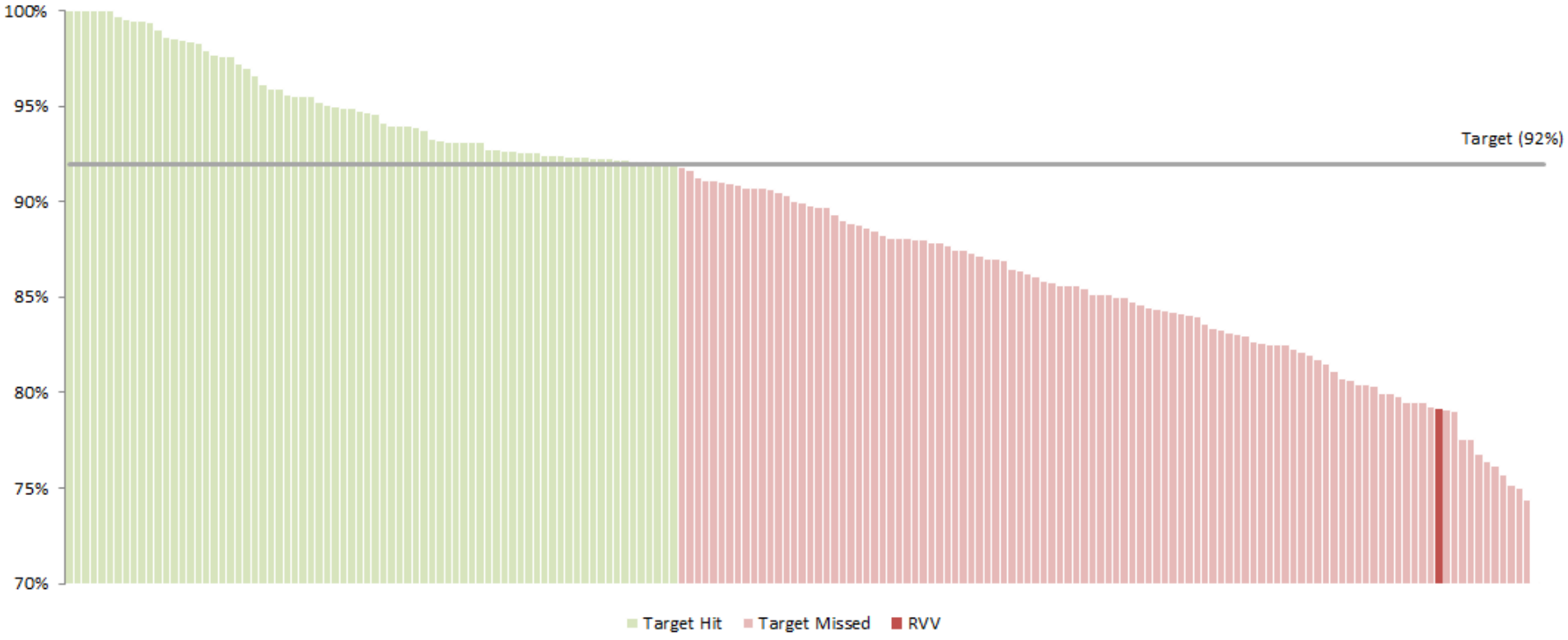
April 2019 | National RTT Benchmarking

East Kent Hospitals University NHS Trust ranked 171 of 184 trusts

Datasource: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2019-20/Incomplete Provider



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Key Performance Indicators

99.45 %

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Green
Performance	99.09%	98.44%	98.03%	98.57%	99.31%	99.65%	99.56%	99.72%	99.49%	99.59%	99.29%	99.45%	>=99%
Waiting list Size	16,350	16,888	15,126	12,750	12,820	13,329	12,235	12,949	14,210	15,058	15,517	15,228	<14,000
Waiting > 6 Week Breaches	149	264	298	182	88	46	54	36	73	61	110	84	<60

2019/20 Trajectory

0.35 %

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF Trajectory	99.11%	99.11%	99.11%	99.11%	99.11%	99.10%	99.10%	99.10%	99.11%	99.11%	99.11%	99.11%
Performance	99.29%	99.45%										

Summary Performance

The standard has been met for May 19 with a compliance of **99.45%**. As at the end of the month there were **84** patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 45
- Cardiology: 25
- Urodynamic: 14
- Sleep Studies : 0
- Cystoscopy : 0
- Colonoscopy : 0
- Gastroscopy : 0
- Flexi Sigmoidoscopy : 0

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Issue

- Maintenance and sustainability of radiology equipment.
- Increased volume in last three months.

Action and timescale

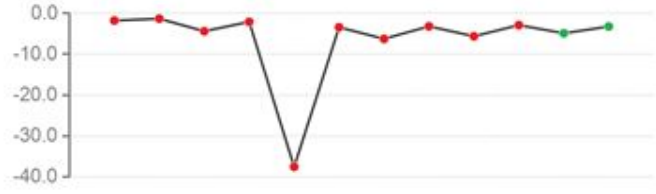
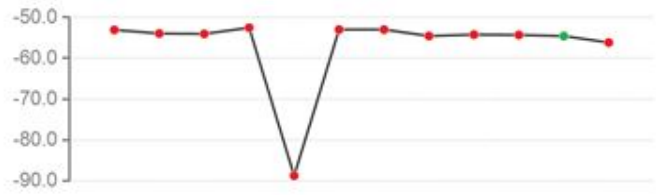
- Development of a radiology improvement plan.
- Development of an outpatients improvement plan.
- Development of an endoscopy improvement plan.

All for delivery in 2019/20 financial year.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Finance

Finance

May	I&E £m (Trust Only)	-8.1 (-33.9%)		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 significant I&E movement in October 2018 is caused by a £34.3m impairment due to revaluation of Trusts assets prior to transfer to 2Gether which is excluded from our NHSI I&E performance evaluation.
May	Cash Balance £m	18.8 (-12.9%)		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.
May	Total Cost £m (Trust Only)	-56.2 (2.9%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.Mth 7 includes a £34.7m impairment, see I&E note above.

NHS
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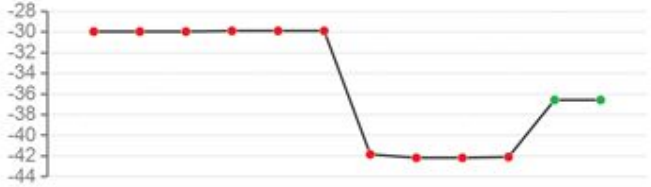
NHS Foundation Trust

Strategic Theme: Finance

May

Forecast £m

-36.6
(0.0%)



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

Highlights and Actions:

The Trust generated a consolidated deficit in month of £3.2m which is in line with the planned position. The year-to-date deficit of £7.9m is £0.1m ahead of plan. The final year-end forecast remains in line with the planned position of a consolidated £37.5m deficit excluding technical adjustments.

The main drivers of the in-month position were:
- EKHUFT Clinical income overperformance of £0.2m driven by £0.8m of overperformance in emergency activity due to 7.5% higher than planned levels YTD which has led to an increase in admissions in the new Observation Bays at QEQM and WHH. This overperformance is partially offset by £0.5m of underperformance in outpatient activity due to lower than planned referral rates.
- EKHUFT Pay underspend of £0.5m due to £0.7m of overspends in mainly medical agency staffing due to continued operational pressures, being entirely offset by £1.2m underspend in bank & substantive pay categories.
- EKHUFT Non-pay overspend against plan of £0.7m. The main drivers for the overspend are non-clinical supplies and services and drugs which are adverse to plan by a total of £1.6m in month and £1.9m YTD. The overspend on non-clinical supplies relates to the subjective impact of a change control notice with 2gether which transferred over the management of EME non pay and Modular Theatre rental budgets to them along with funding for 2019-20 pay inflation.
- The subsidiaries position was on plan on month, but further work is required to ensure that key drivers of the position are understood and reported each month.

Overall clinical income was £0.2m favourable to plan, although the East Kent CCG contract was in line with the plan excluding high cost drugs which was above plan by £0.4m, this was offset by an underperformance against plan with the NHSE specialised services contract of £0.3m driven by lower than anticipated NICU and ITU activity.

The target for the year is £30m. The Trust has achieved £2.8m of savings YTD against a plan of £2.1m. Within this £0.5m of savings were delivered non-recurrently.

The forecast CIP achievement for the year is £30m, but as the target increases throughout the year the Trust is maintaining confirm and challenge meetings to ensure robust delivery plans are in place. As at the time of reporting, c.70% of schemes forecast were delivered or 'green' rated. Care Groups, supported by the PMO, continue working up schemes for 2019/20 focusing on delivery of planned target and moving Red and Amber schemes to Green.

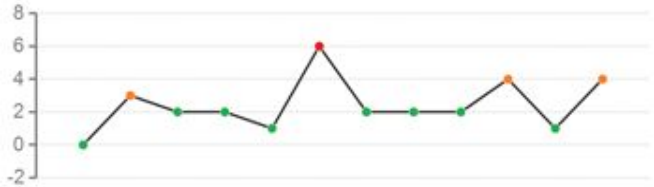
This focus on delivering the financial position is being maintained by a combination of monthly Executive Performance Review meetings and Confirm and Challenge meetings led by the Chief Operating Officer and Finance Director.

The Trust's cash balance at the end of May was £18.8m which is £6.2m above plan. The Trust did not borrow any cash in May therefore total Trust borrowings remained at £96.5m

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 1

May	H&S HASTA All Scores	73 (-12.3%)		Overall Health And Safety Toolkit Audit (HASTA) compliance score – by Care Group, Specialty & Site
May	RIDDOR Reports (Number)	29 (11.5%)		"RIDDOR reports sent to HSE each month.(please note that Riddor uses the Field inc_dnotified (HSE date) rather than inc_dreported (Reported date)

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Strategic Theme: Health & Safety

May	Health & Safety Training	95 (-3.3%)		H&S Training includes all H&S and risk avoidance training including manual handling

Highlights and Actions:

In May Health and Safety HASTA scores achieved 74% cumulatively. The annual audit schedules are now in place and have been signed off at the Strategic Health and Safety Committee. All Care Groups and the Corporate areas have now identified Health and Safety leads. A monthly meeting is now in place to support the new leads in their roles.

RIDDORS

In May there were 4 reportable RIDDORS. Two were Trust staff and two were2gether Support Service staff.
The incidents were a sprained back, a shoulder strain/sprain, a stress fracture and a strangulated hernia, all resulting in absence from work for more than 7 days which means they are RIDDOR reportable.

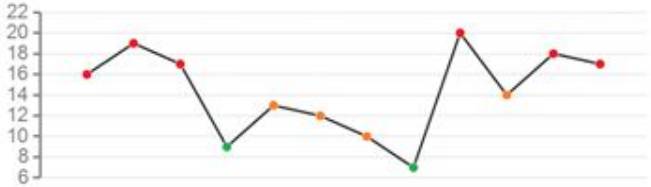
Health and Safety Training

There has been a consistently good performance of mandatory training modules by staff with a 94.57% compliance for May. Cumulative performance has recorded a 95.27% compliance.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Health & Safety

Health & Safety 2

May	Accidents	428 (5.4%)		"Accidents excluding sharps (needles etc) but including manual handling.
May	Violence & Aggression	472 (-6.7%)		"Violence, aggression and verbal abuse.
May	Sharps	172 (8.2%)		"Incidents with sharps (e.g. needle stick).

Highlights and Actions:

In May there were 36 accidents which was a marginal increase 1 when compared with April's figures.

The number of incidents reported due to violence and aggression and verbal abuse was 33 which is a reduction of 7 from April 2019. The majority of these being reported as aggressive behaviour by patients to members of staff.

The Trust's MAYBO training is now in place for2019/20 with spaces for 200 staff to attend.
There are also 3 Conflict Resolution training sessions in place running every month.

The number of sharps incidents recorded for May was 17 which is marginally less than April by 1. All incidents were sustained whilst performing patient procedures.

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Strategic Theme: Use of Resources

Balance Sheet

May	CIPS £m	2.9 (76.9%)		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.
May	Cash borrowings £m	8.1		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.

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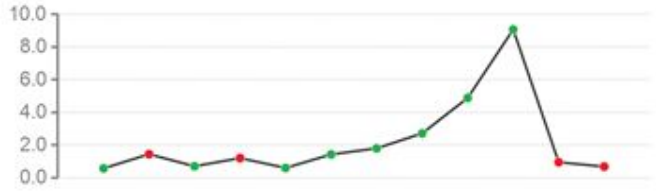
Strategic Theme: Use of Resources

May

Capital position £m

1.6
(-28.3%)



Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow.

Highlights and Actions:

DEBT
Total invoiced debtors have reduced in May by£3.9m to £18.2m. The largest debtors at 31st May were 2gether Support Solutions £3.9m and NHS England £1.9m. Work is on-going to ensure streamlined processes and minimise intra-company debt.

CAPITAL
Total YTD expenditure up to May is£1.5m which is £0.2m above plan. This is mainly due to legacy spend from 2018/19 schemes in A&E and equipment replacement. It is expected that spend will fall back in line with the YTD plan for Month 3.

EBITDA
The Trust is reporting a year to date deficit EBITDA of£4.3m.

CASH
The closing cash balance for the Trust as at 31st May was £18.8m, £6.2m ahead of plan.

FINANCING
£413k of interest has been incurred year-to-date in respect of the drawings against working capital facilities.

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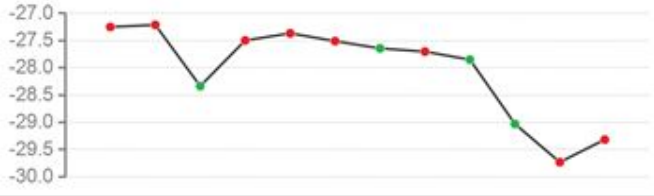
Strategic Theme: Use of Resources

Pay Independent

May	Payroll Pay £m	-29.3 (-1.4%)		Payroll Pay (Permanent+Overtime). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Agency Spend £m	-3.1 (6.2%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
May	Independent Sector £k	-344 (-22.4%)		Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Highlights and Actions:

Pay performance is favourable to May plan by £0.5m. This was driven by an agency overspend of £0.7m due to above plan usage of agency staff for medical and nursing cover offset by underspends on substantive and bank staffing costs of £1.2m.

Total expenditure on pay in May was £33.7m, a £0.1m reduction from April.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Improvement Journey

		Jan	Feb	Mar	Apr	May	
MD02 - Emergency Pathway	ED - 4hr Compliance (incl KCHFT MIUs) %	77.93	77.56	81.53	80.54	84.26	>= 95
	ED - 1hr Clinician Seen (%)	50	48	45	42	45	>= 55 & <55
MD04 - Flow	DToCs (Average per Day)	54	66	76	97	94	>= 0 & <35
	IP - Discharges Before Midday (%)	15	15	17	19	19	>= 35
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	68.21	76.88	81.56	78.44	80.18	>= 85
MD07 - Maternity	Staff Turnover (Midwifery)	13	13	13	13	13	>= 0 & <10
	Vacancy (Midwifery) %	5	6	6	7	7	>= 0 & <7
MD08 - Recruitment & Staffing	Staff Turnover (%)	14.4	14.2	14.5	14.2	14.2	>= 0 & <10
	Staff Turnover (Nursing)	14	13	14	13	13	>= 0 & <10
	Staff Turnover (Medical)	14	13	14	13	13	>= 0 & <10
	Vacancy (Nursing) %	15	14	14	13	14	>= 0 & <7
	Vacancy (Medical) %	12	11	10	9	9	>= 0 & <7
MD09 - Workforce Compliance	Appraisal Rate (%)	80.4	81.1	80.4	80.7	77.2	>= 85
	Statutory Training (%)	93	93	94	95	95	>= 85

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Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 1hr Clinician Seen (%)	% of A&E attendances seen within 1 hour by a clinician	>= 55 & <55	
	ED - 4hr Compliance (incl KCHFT MIUs) %	No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge for only Acute Sites (K&C, QEQM, WHH, BHD). No Schedule - Snapshots run in the job: Information_KPIs_Run_Unify_Snapshot_Metrics	>= 95	1 %
Beds	Bed Occupancy (%)	This metric looks at the number of beds the Trust has utilised over the month. This is calculated as funded beds / (number of patients per day X average length of episode stay). The metric now excludes all Maternity, Intensive Treatment Unit (ITU) and Paediatric beds and activity.	>= 0 & <92	60 %
	DToCs (Average per Day)	The average number of delayed transfers of care	>= 0 & <35	30 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	IP Spells with 3+ Ward Moves	Total Patients with 3 or more Ward Moves in Spell		
Cancer	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: 2ww (All) %	Two week wait (urgent referral) services (including cancer), as stated by The NHS Operating Framework. % of patients seen within two weeks of an urgent GP referral for suspected cancer (CB_B6)	>= 93	10 %
	Cancer: 62d (GP Ref) %	Cancer 62 day waits, as stated by NHS Operating Framework. % of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.	>= 85	50 %

Cancer	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	4hr % Compliance from Presentation to Stroke Ward	4hr % Compliance from Presentation to Stroke Ward, as per BPT		
	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist to ensure completion. After each procedure, the recovery staff check that each of the surgical checklists have been carried out. This compliance monitors against a random set of 10 patients each day from this process.	>= 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 - selecting 'Prompt Surgery%'. Reporting one month in arrears to ensure upload completeness to the National Hip Fracture Database.	>= 85	5 %
	Pharm: Drug Cupboards Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug cupboards locked	>= 90 & <90	5 %
	pPCI (Balloon w/in 150m) (%)	% Achievement of Call to Balloon Time within 150 mins of pPCI.	>= 75	5 %
	Readmissions: EL dis. 30d (12M%)	Percentage of patients that have been discharged from an elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	>= 0 & <2.75	20 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked	>= 90 & <90	5 %
	Pharm: Fridge Temps (%)	Data taken from Medicines Storage & Waste Audit - percentage of wards recording temperature of fridges each day	>= 100	5 %
	Pharm: Fridges Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of fridges locked	>= 95	5 %
	Pharm: Resus. Trolley Check (%)	Data taken from Medicines Storage & Waste Audit - percentage of resus trolley's checked	>= 90 & <90	5 %
	Readmissions: NEL dis. 30d (12M%)	Percentage of patients that have been discharged from a non-elective admission and been readmitted as a non-elective admission within thirty days. This is acccording to an external methodology, which has been signed off by the Contract & Procurement Team. This is a rolling twelve month figure.	>= 0 & <15	15 %
	Stroke Brain Scans (24h) (%)	% stroke patients receiving a brain CT scan within 24 hours.	>= 100	5 %
Culture	Staff FFT - Work (%)	"Percentage of staff who would recommend the organisation as a place to work - data is quarterly and from the national submission. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 60	50 %
	Staff FFT - Treatment (%)	Percentage of staff who would recommend the organisation for treatment - data is quarterly and from the national submission.		40 %

Data Quality & Assurance	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	>= 0 & <0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %
	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.	>= 0 & <7	
	DNA Rate: New %	New appointments where the patient did not attend (appointment type=1, appointment status=3) as a % of all new appointments.	>= 0 & <7	
	New:FUp Ratio (1:#)	Ratio of attended follow up appointments compared to attended new appointments	>= 0 & <7	
Diagnostics	Audio: Incomplete Path. 18wks (%)	AD02 = % of Patients waiting under 18wks on an incomplete Audiology pathway	>= 99	
	DM01: Diagnostic Waits %	The percentage of patients waiting less than 6 weeks for diagnostic testing. The Diagnostics Waiting Times and Activity Data Set provides definitions to support the national data collections on diagnostic tests, a key element towards monitoring waits from referral to treatment. Organisations responsible for the diagnostic test activity, report the diagnostic test waiting times and the number of tests completed.The diagnostic investigations are grouped into categories of Imaging, Physiological Measurement and Endoscopy and covers 15 key diagnostic tests.	>= 99	100 %
	Audio: Complete Path. 18wks (%)	AD01 = % of Patients waiting under 18wks on a completed Audiology pathway	>= 99	
Finance	Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March of the relevant financial year. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	10 %
	Total Cost £m (Trust Only)	Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.Mth 7 includes a £34.7m impairment, see I&E note above.	>= 0	20 %
	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.	>= 5	20 %
	I&E £m (Trust Only)	The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.The significant I&E movement in October 2018 is caused by a £34.3m impairment due to revaluation of Trusts assets prior to transfer to 2Gether which is excluded from our NHSI I&E performance evaluation.	>= 0	30 %
Health & Safety	Sharps	"Incidents with sharps (e.g. needle stick).	>= 0 & <10	5 %
	Accidents	"Accidents excluding sharps (needles etc) but including manual handling.	>= 0 & <40	15 %
	H&S HASTA All Scores	Overall Health And Safety Toolkit Audit (HASTA) compliance score – by Care Group, Specialty & Site	>= 95	

Health & Safety	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %
	RIDDOR Reports (Number)	"RIDDOR reports sent to HSE each month.(please note that Riddor uses the Field inc_dnotified (HSE date) rather than inc_dreported (Reported date)	>= 0 & <3	20 %
	Violence & Aggression	"Violence, aggression and verbal abuse.	>= 0 & <25	10 %
Incidents	Clinical Incidents closed within 6 weeks (%)	Percentage of Clinical Incidents closed within 6 weeks		
	Clinical Incidents: Minimal Harm			
	Clinical Incidents: Severe Harm			
	Harm Free Care: New Harms (%)	Percent of Inpatients deemed free from new, hospital acquired harm (ie, free from new: pressure ulcers (categories 2 to 4); Injurious falls; Urinary Tract Infection; Deep Vein Thrombosis, Pulmonary Embolism or Other VTE: Data source - Safety Thermometer. Arrow indicates average of last 12 months data.	>= 98	20 %
	Medication Incidents with Harm	Number of Medication Incidents recorded on Datix with a Moderate/Severe/Death Harm		
	Medication Missed Critical Doses	Number of missed doses for critical drugs / medications		
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls		0 %
	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."		
	All Pressure Damage: Cat 2	"Number of all (old and new) Category 2 pressure ulcers. Data source - Datix."	>= 0 & <1	
	Blood Transfusion Incidents	"The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Clinical Incidents: Moderate Harm			
	Clinical Incidents: No Harm	"Number of Non-Clinical Incidents, recorded on DATIX, per 10,000 FTE hours. Bandings based on total numbers of incidents (corporate level) is: Score1: <= 140, Score2: > 140 & <= 147, Score3: > 147 & <= 155, Score4: > 155 & <= 163, Score5: > 163"		
	Clinical Incidents: Total (#)	"Number of Total Clinical Incidents reported, recorded on Datix.		
	Falls (per 1,000 bed days)	"Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <5	20 %
	Falls: Total	"Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix."	>= 0 & <3	0 %

Incidents	Harm Free Care:All Harms (%)	"Percent of inpatients deemed free from harm as measured by the Safety Thermometer audit ie free from old and new harms: - Old and new pressure ulcers (categories 2 to 4) - Injurious falls - Old and new UTI - Old and new DVT, PE c Other VTE. Data source - Safety Thermometer (old and new harms)."	>= 94	10 %
	Medication Missed Doses	Number of missed medication doses recorded on Datix		
	Medicines Mgmt. Incidents	"The number of medicine management issues sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	Never Events (STEIS)	"Monthly number of Never Events. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."	>= 0 & <1	30 %
	Pressure Ulcers Cat 3/4 (per 1,000)	"Number of avoidable Category 3/4 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	Serious Incidents Open	Number of Serious Incidents currently open according to Datix		
Infection	Bare Below Elbows Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95 & <95	
	Blood Culture Training	Blood Culture Training compliance	>= 85	
	Cases of C.Diff (Cumulative)	"Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01). Arrow represents YTD position with the % showing variance against the last month."	<= Traj	40 %
	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	>= 0 & <1	40 %
	MSSA	"The total number of MSSA bacteraemia recorded, post 48hrs.	>= 0 & <1	10 %
	C. Diff (per 100,000 bed days)	Number of Clostridium difficile infections (CDIs), as defined by NHS National Operating Framework, for patients aged 2 or more (HQU01), recorded at greater than 72h post admission per 100,000 bed days	>= 0 & <1	
	C. Diff Infections (Post 72h)	"The number of Clostridium difficile cases recorded at greater than 72h post admission. Data source - VitalPAC (James Nash)."	>= 0 & <1	0 %
	Commode Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95 & <95	
	E. Coli	"The total number of E-Coli bacteraemia recorded, post 48hrs. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <44	10 %
	E. Coli (per 100,000 population)	The total number of E-Coli bacteraemia per 100,000 population.	>= 0 & <44	
	Infection Control Training	Percentage of staff compliant with the Infection Prevention Control Mandatory Training - staff within six weeks of joining and are non-compliant are excluded	>= 85	
	MRSA (per 100,000 bed days)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT, cases per 100,000 bed days	>= 0 & <1	

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."	>= 0 & <27.1	10 %
	HSMR (Index)	Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.	>= 0 & <90	35 %
	Number of Deaths that were >50% Avoidable	Number of deaths that were more than 50% likely to have been Avoidable (Categories: 'Definitely Avoidable','Strong evidence of avoidability','Probably avoidable (more than 50:50)')		
	SHMI	"Summary Hospital Mortality Indicator (SHMI) as reported via HSCIC includes in hospital and out of hospital deaths within 30 days of discharge. Latest quarter identifies last reported 12 month period. Please note this metric has recently been changed to reflect HSCIC, not CHKS. Arrow indicates average of last 12 months data."	>= 0 & <0.95	15 %
	Number of SJR's Completed	Number of Structured Judgement Reviews (Mortality Case Record Reviews) completed		
Observations	VTE: Risk Assessment %	"Adults (16+) 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	A&E FFT: Not Recommended (%)	A&E FFT: Not Recommended (%)		
	A&E FFT: Recommended (%)	A&E FFT: Recommended (%)		
	AE Mental Health Referrals	A&E Mental Health Referrals		
	Cleanliness %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaints acknowledged within 3 working days	Complaints acknowledged within 3 working days		
	Complaints Open <= 30 Days	Number of complaints open for less than 30 days		
	Complaints Open > 90 Days	Number of Complaints open for more than 90 Days		
	Complaints Open 31 - 60 Days	Number of Complaints open between 31 and 60 Days		
	Complaints Open 61 - 90 Days	Number of Complaints open between 61 and 90 Days		
	Complaints received with a 45 Day time frame agreed	Number of complaints received with a agreed time frame of 45 days		

Patient Experience	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	IP FFT: Recommend (%)		>= 95	30 %
	IP FFT: Response Rate (%)	"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 22	1 %
	IP Survey: Encouraged to get up and wear own clothes (%)	Responses taken from the Inpatient Survey. Question: "Have you been encouraged to get up during your hospital stay and wear your own clothes?"		3 %
	IP Survey: Help from Staff to Eat Meals (%)	Responses taken from the Inpatient Survey. Question: "Did you get enough help from staff to eat your meals?"		3 %
	Mixed Sex Breaches	"Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	A&E FFT: Response Rate (%)	A&E FFT: Response Rate (%)		
	Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	15 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Complaints received with a 30 Day time frame agreed	Number of complaints received with an agreed time frame of 30 days		
	Compliments	Number of compliments received	>= 1	
	IP FFT: Not Recommend (%)	"Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <2	30 %
	IP Survey: Are you aware of nurse in charge of you each shift? (%)	IP Survey: Are you aware of nurse in charge of your care each shift? (%)	>= 89	4 %
	IP Survey: Overall, did you get the care that matters to you?	Inpatient Survey: Patients views on if they got the overall care that mattered to them as a %		
	Maternity FFT: Not Recommended (%)	Maternity FFT: Not Recommended (%)		

Patient Experience	Maternity FFT: Recommended (%)	Maternity FFT: Recommended (%)		
	Maternity FFT: Response Rate (%)	Maternity FFT: Response Rate (%)		
	Number of Complaints	"The number of Complaints recorded overall . Data source - Patient Experience Team"		
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 Compliance	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 80 & <80	
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		
	Theatres: On Time Start (% 15min)	The % of cases that start within 15 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	>= 0 & <5	10 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	>= 0	
	RTT: Incompletes (%)	% of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways, as stated by NHS Operating Framework. CB_B3 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	>= 92	100 %
Staffing	Agency & Locum Spend	Total agency spend including NHSP spend		
	Agency Orders Placed	"Total count of agency orders placed.	>= 0 & <100	
	Agency Staff WTE (Bank)	WTE Count of Bank Hours worked		
	Clinical Time Worked (%)	% of clinical time worked as a % of total rostered hours.	>= 74	2 %
	Employed vs Temporary Staff (%)	"Ratio showing mix of permanent vs temporary staff in post, by using the number of WTEs divided by the Funded Establishment. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 92.1	1 %
	Local Induction Compliance %	"Local Induction Compliance rates (%) for temporary employee's to the Trust.	>= 85	

Staffing

Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	>= 0 & <28	2 %
Overtime (WTE)	Count of employee's claiming overtime		1 %
Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %
Stability Index (excl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate– WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		
Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate– WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		
Staff Turnover (Midwifery)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Midwives. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in directior of arrow and %) against the previous 12 months."	>= 0 & <10	
Time to Recruit	"Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
Total Staff Headcount	Headcount of total staff in post		
Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	>= 0 & <100	5 %
Vacancy (Nursing) %	"% Vacant positions against Whole Time Equivalent (WTE) for Nurses. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
1:1 Care in labour	The number of women in labour compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	>= 99 & <99	
Agency %	% of temporary (Agency and Bank) staff of the total WTE	>= 0 & <10	
Agency Filled Hours vs Total Agency Hours	% hours worked which were filled by the NHSP against the total number of hours worked by agency staff		
Agency Staff WTE (NHSP)	WTE Count of NHSP Hours worked		
Bank Filled Hours vs Total Agency Hours	% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff		1 %
Bank Hours vs Total Agency Hours	% hours worked by Bank (Staffflow) against the total number of hours worked by agency staff		

Staffing	Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.		
	NHSP Hours vs Total Agency Hours	% hours worked by NHSP against the total number of hours worked by agency staff		
	Overtime %	% of Employee's that claim overtime.	>= 0 & <10	
	Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %
	Sickness (Monthly) %	Monthly % of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 3.3 & <3.7	10 %
	Staff Turnover (%)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	15 %
	Staff Turnover (Medical)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Medical Staff. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in directior of arrow and %) against the previous 12 months."	>= 0 & <10	
	Staff Turnover (Nursing)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Nurses. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
	Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
	Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
	Vacancy (Medical) %	"% Vacant positions against Whole Time Equivalent (WTE) for Medical Staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
	Vacancy (Midwifery) %	"% Vacant positions against Whole Time Equivalent (WTE) for Midwives. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	
	Vacancy (Monthly) %	Monthly % Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	15 %
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 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	

Training	Statutory Training (%)	"The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months. "	>= 85	50 %

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REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**INTERIM CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**RISK MANAGER**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: CORPORATE RISK REGISTER (BY RESIDUAL RISK RANKING) DATED 21 JUNE 2019** **APPENDIX 2: HIGHEST MITIGATED STRATEGIC RISKS DATED 21 JUNE 2019**

BACKGROUND AND EXECUTIVE SUMMARY

This report provides the Board of Directors with an update of the full Corporate/Highest Mitigated Strategic Risks as at 21 June 2019. The risks rated as "high" post mitigation (residual) on the Strategic and the full Corporate Risk Register were last reviewed by the Board on 6 June 2019. The highest mitigated risks on the Strategic and Corporate Risk Registers were last reviewed by the Integrated Audit and Governance Committee (IAGC) on 11 April 2019. The highest mitigated Quality risks will be reviewed and discussed at the Quality Committee on 25 June 2019.

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

Current Risk Register Heat Map (by Residual risk score)

Corporate Risks (15)

Strategic Risks (17)

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Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register

1 Following the approval of the risks to the 2019/20 Strategic Objectives work is on-going with the Executive Directors to identify the controls to the risks, actions and timescales for completion through monthly meetings.

Risks approved for closure on the Strategic Risk Register

2 There were three risks approved for closure on the strategic risk register as the risks are better articulated in the newly identified strategic risks. These are as follows:

SRR 2 – Failure to maintain the quality and standards of patient care. The controls and actions have been transferred to SRR 17 – The Care Groups may not deliver the improvement trajectories associated with the annual objectives.

SRR 10 – Non-delivery of a timely Sustainability and Transformation Partnership (STP) that can be resourced. The controls and actions have been transferred to SRR 26 – The Trust will be unable to make the changes to service needed if the Pre-Consultation Business Case (PCBC) is not signed off by external bodies.

SRR 12 – Insufficient capacity and capability of the leadership team (Executive and Care Group Clinical Directors) to develop and deliver key strategies and recovery plans. The controls and action shave been transferred to SRR 24 – If leadership and management is not effective staff may not be engaged to deliver a high quality, caring service.

Corporate Risk Register

Changes to residual risk scores

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

Risk Ref.	Risk Title	Residual Score May 19	Residual Score Jun 19	Direction of travel	Target Score
CRR 58	Failure to embed Risk Management within the Care Groups *The reporting of significant risks to Care Groups is now reported monthly through the Quality and Risk meeting chaired by an Executive. These reports are reviewed and discussed at the monthly Quality Committee meetings.*	**12 Moderate**	**8 Moderate**		**4 Low**

There was one change made to target risk scores during the period under review. CRR 36 – Risk of inadequate Child Safeguarding action due to training compliance not being at 85% Trust-wide has increased from 4 (low) to 9 (moderate).

Risks approved for closure on the Corporate Risk Register

4 There were no risks approved for closure on the Corporate Risk Register.

New Corporate Risks added to the Corporate Risk Register

5 There was one new risk added to the Corporate Risk Register. CRR 71 – Patients may be harmed if there is non-compliance with indicators within the medication safety thermometer, the Medicines Policy and national best practice.

Risks approved for merging on the Corporate Risk Register

6 There were no risks proposed for merging.

Key issues for the Board of Directors attention and/or discussion

7 CRR 40 – Lack of robust antenatal and new-born screening programmes was downgraded from the Corporate Risk Register to the Care Group risk register in March 2019. Further assurance to this risk has been provided in an annual report to Public Health England for the 2018/19 financial year. A quality assurance visit was extremely helpful and enabled the team to focus their efforts on improving the screening service and making them safe. It enabled effective collaborative working between the maternity team with colleagues in child health, radiology, and the laboratories, which has facilitated progress immensely.

There have been significant numbers of screening incidents and the team have been commended for their transparency in reporting them. The team now need to focus on ensuring that action plans are completed and that they continue to disseminate the learning from these across the teams. They look forward to implementing the outstanding Quality Assurance (QA) recommendations and improving key performance indicators further to make the Antenatal and Newborn Screening services in EKHUFT the very best they can be. A full copy of the report is available on the 4risk system.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The attached risk registers reflects the corporate risks and the highest mitigated strategic risks facing the Trust and the mitigating actions in place.
LINKS TO STRATEGIC OBJECTIVES:	The corporate and strategic risks align to all of the Strategic Objectives: • **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great**

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	Place to Work for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the full corporate risks and the highest mitigated strategic risks for the Trust.
RESOURCE IMPLICATIONS:	None specifically other than identified in the Risk Register.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	The Risk Group and the Clinical Executive Management Group reviews any new corporate risks and the scoring of these existing risks. The IAGC review the Corporate Risks and the Board Assurance Framework.
SUBSIDIARY IMPLICATIONS:	None specifically other than identified in the Risk Register.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to:

1. Review the Corporate Risks and Highest Mitigated Strategic Risks Report that are appended; and

2. Consider the sufficiency of the corrective actions identified in relation to the risks and provide positive challenge where necessary.

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 68	10/05/2019	Risk to the delivery of the operational constitutional standards and undertakings Risk Owner: Lee Martin Delegated Risk Owner: Latest Review Date: 19 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed and controls updated by COO	Cause: Inability of organisation to meet constitutional standards due to unplanned demand, workforce or infrastructure availability including equipment failure. Effect: Patients are delayed in their pathway Possible harm to patients There is non-compliance against access standards and our agreed trajectories Negative impact on workforce Reputational damage Greater overview and scrutiny by regulators/MP's Financial impact Wider health economy implications	HIGH (Risk not within appetite)	I = 5 L = 5 Extreme (25)	Adequate	Full business continuity plans are not currently in place in all key areas to give the full assurance aligned to the constitutional standards	I = 5 L = 4 Extreme (20)	Monitoring and regularly updating the Access Policy in line with standards Person Responsible: Lesley White To be implemented by: 28 Jun 2019		I = 5 L = 2 Moderate (10)
									Regular validation of PTL waiting list Person Responsible: Marc Farr To be implemented by: 28 Jun 2019		
									Planned preventative maintenance led by Estates through managed service contracts Person Responsible: Natalie Acheson To be implemented by: 31 Jul 2019		
									Planned preventative maintenance led by Estates through managed service contracts Person Responsible: Victoria Harrison To be implemented by: 31 Jul 2019		
									Planned preventative maintenance led by Estates through managed service contracts Person Responsible: Matthew Pomeroy To be implemented by: 31 Jul 2019		
									Planned preventative maintenance led by Estates through managed service contracts Person Responsible: Sarah Collins To be implemented by: 31 Jul 2019		
									Planned preventative maintenance led by Estates through managed service contracts Person Responsible: Sarah Hyett To be implemented by: 31 Jul 2019		
									To have a strong workforce plan and retention plan for the year linked to the operational business plan Person Responsible: Andrea Ashman To be implemented by: 31 Jul 2019		
									Education and training programme that follows an agreed matrix or training tree throughout each Care Group to give confidence that everybody understands the Access Standards and compliance against the Access Policy including use of PAS Allscripts Person Responsible: Lesley White To be implemented by: 31 Jul 2019		
									Deliver the actions to improve and sustain ED performance through the weekly meetings chaired by the COO including implementation of the improvement plan Person Responsible: Lee Martin To be implemented by: 31 Jul 2019	**14 May 2019** **Rhiannon Adey** Matt Pomeroy, Director of Operations asked to update current plan to reflect new structure and team developments.	
									Ensure maintenance contracts are in place for all high risk equipment Person Responsible: Natalie Acheson To be implemented by: 30 Aug 2019		
									Ensure maintenance contracts are in place for all high risk equipment Person Responsible: Christine Hudson To be implemented by: 30 Aug 2019	**05 Jun 2019** **Rhiannon Adey** Update from Chris Hudson - Business case is being devised for managed equipment between Marion Clayton, Chris Hudson and Colin Fell. The business case will be written by end of July 2019.	
									Ensure maintenance contracts are in place for all high risk equipment Person Responsible: Victoria Harrison To be implemented by: 30 Aug 2019		
									Oversee improvement plan for RTT which incorporates production plans, business plan and operational implementation plan Person Responsible: Mary Tunbridge To be implemented by: 30 Aug 2019	**14 May 2019** **Rhiannon Adey** Daily oversight on the RTT and the constitutional standards and escalation to the COO when things are off track	
									Oversee cancer improvement plan to delivery Person Responsible: Sarah Collins To be implemented by: 30 Sep 2019		

									Implement timed pathways and track to delivery for cancer Person Responsible: Sarah Collins To be implemented by: 30 Sep 2019		
									Recruitment of acute physicians and specialty doctors establishment Person Responsible: Syed Gilani To be implemented by: 30 Sep 2019	**27 May 2019** **Rhiannon Adey** Update on behalf of Syed Gilani - The JD's for all staff groups have been revamped and already 2 AP have been recruited. Our ED recruitment plan is continuing to progress well. Several Middle Grade Doctor appointments have been made and work continues to get us to full establishment. We have also advertised for special interest consultant posts as part of our medical recruitment strategy.	
									Director of Performance to monitor and challenge the plans for all patients over 30 weeks and agree an improvement trajectory for each specialty as appropriate Person Responsible: Lesley White To be implemented by: 31 Mar 2020		
									COO to COO escalation to progress patients pathways as and when appropriate Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		
									Daily performance telephone call with Operations Director for Cancer Services, outpatient booking managers and General Managers to monitor and resolve any capacity issues Person Responsible: Lesley White To be implemented by: 31 Mar 2020		
									Care Groups are implementing weekly performance meetings with their General and Service Managers to monitor RTT performance Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		
									Escalation of specific care groups if they are off track with particular standards Person Responsible: Mary Tunbridge To be implemented by: 31 Mar 2020		
									Escalation via COO if patient pathways are delayed Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		
									Review of current pathways to ensure that they comply with Cancer Network best practice timed pathways Person Responsible: Andrew Nordin To be implemented by: 31 Mar 2020		

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 28	06/07/2016	Lack of timely recognition of serious illness in patients presenting to the Emergency Departments Risk Owner: Paul Stevens Delegated Risk Owner: Syed Gilani Latest Review Date: 15 May 2019 Latest Review By: Paul Stevens Latest Review Comments: Issues with flow through the emergency care pathway need to be resolved to mitigate this risk	Cause: * Delay in assessment and evaluation of patients due to overcrowding in the Emergency Departments and lack of flow through the Emergency Care Pathway *Increased and unplanned local demand for emergency services that the Trust is unable to meet with the resources and infrastructure available *Over time the demography, comorbidity and acuity of ED attendees has changed, together with the rise in number of attendees, resulting in an increased requirement for conversion to admission *Inability to recruit into consultant and middle grade posts *Lack of availability of GP at the front door *Failure of the NHS 111 to provide appropriate advice * Surge resilience plans do not meet unprecedented demand * Lack of robust escalation plans * Failure to respond appropriately to the Operational Pressure Escalation Framework Effect: * Poor Patient experience * Harm to Patients * Difficulties with staff recruitment and problems with staff retention * Breach of licence (Contract Performance Notice) * Regulatory concerns * Failure to retain STF funding * Reputational damage	HIGH (Risk not within appetite)	I = 5 L = 5 Extreme (25)	Limited	Escalation process unclear Not fully implemented across WHH and QEQM sites Not tested the response enough evaluation awaited Limited assurance until: Overall Trust inpatient stranded metric is less than 300 and peak number of discharges from the Trust occurs 2	I = 5 L = 4 Extreme (20)	Recruitment of acute physicians and specialty doctors establishment Person Responsible: Syed Gilani To be implemented by: 31 Dec 2018 revised to 28 Jun 2019	**27 May 2019** **Syed Gilani** Update on behalf of Syed Gilani - The JD's for all staff groups have been revamped and already 2 AP have been recruited. Our ED recruitment plan is continuing to progress well. Several Middle Grade Doctor appointments have been made and work continues to get us to full establishment. We have also advertised for special interest consultant posts as part of our medical recruitment strategy.	I = 4 L = 3 Moderate (12)
									Resolution of over-crowding within the A&E departments leading to improved flow, improvement in ambulance handover and time to first clinician review metrics Person Responsible: Syed Gilani To be implemented by: 31 Mar 2018 revised to 30 Sep 2018 revised to 31 Dec 2018 revised to 28 Feb 2019 revised to 27 Sep 2019	**27 May 2019** **Rhiannon Adey** Update on behalf of Syed Gilani - 100% of our current triage staff have been trained and assessed against the competency assessment. This will help with safer and effective streaming of patients right at triage. Work underway for the successful invoking of a UTC at both ED's this winter. our band 6 & 7 nurses are currently undertaking shift leadership coaching and training in systems and processes. We have recently piloted a standardised model of 2 hourly board rounds. These have been developed to ensure each patient receives timely care and assist with reviewing capacity throughout the department, in conjunction with Rapid Response, Clinical Site Managers and ED staff. Both observation wards are beginning to be well established. This has greatly helped flow through both ED's and helped with overcrowding.	
									Introduction and implementation of new Trust Clinical Standards Person Responible: Paul Stevens To be implemented by: 31 Dec 2019	**19 Jun 2019** **Paul Stevens** New Trust Clinical Standards have been drafted and agreed by the Medical Director and shared with Care Group Clinical Directors, Director of Pharmacy, Chief Nurse and COO.	

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 71	12/06/2019	Patients may be harmed through poor medicines management Risk Owner: Paul Stevens Delegated Risk Owner: Latest Review Date: 19 Jun 2019 Latest Review By: Paul Stevens Latest Review Comments: Risk reviewed and actions added	Cause: Poor culture towards medicines precription and administration at ward and department level Inadequate clinical pharmacy staffing to support medicines optimisation including medicines reconciliation Pressures at patient level with staffing Paper based systems which are reliant on individual staff with relevant competencies to check and provide assurance that the use of medicines is safe and effective, Poor knowledge of drug interactions Failure to appreciate drug allergies Effect: Patient harm Patient experience Increased length of stay	HIGH (Risk within appetite)	I = 4 L = 5 Extreme (20)	Adequate	None identified	I = 4 L = 4 High (16)	Ensure sustained compliance at >90% with the medicines storage metrics (fridge temperature, drug fridge locaked, medicine cupboards locked, drug trolleys locked and secured when not in use, resuscitation trolley checked, IV fluids in a locked area, ambient temperature monitored) Person Responsible: Amanda Hallums To be implemented by: 31 Mar 2020		I = 4 L = 2 Moderate (8)
									Implement the insulin safety action plan Person Responsible: Stonny Joseph To be implemented by: 31 Mar 2020		
									Implementation of electronic prescribing Person Responsible: Will Willson To be implemented by: 30 Oct 2020		
									Implement 7 day pharmacy services Person Responsible: Will Willson To be implemented by: 31 Mar 2021		
									Improve medicines reconcilliation on admission and discharge to 75% Person Responsible: Will Willson To be implemented by: 31 Mar 2021		
									Sustained reduction in missed doses below the national acute trust average for at least 6 months Person Responsible: Jackie Shaba To be implemented by: 30 Apr 2021		
									Sustained reduction in missed critical doses below the national acute trust average for at least 6 months Person Responsible: Jackie Shaba To be implemented by: 30 Apr 2021		
CRR 65	20/02/2018	Risk of prosecution by the CQC for a breach of parts 20(2)(a) and 20(3) of the Duty of Candour regulation without first serving a Warning Notice Risk Owner: Paul Stevens Delegated Risk Owner: Jonathan Purday Latest Review Date: 03 Jun 2019 Latest Review By: Jonathan Purday Latest Review Comments: There remains concerns particularly with the medical care groups of non-compliance but in general compliance would seem to be improving. We are visiting Coventry later this month who have a different more reactive model for clinical incident review which has led to improved compliance in D of C.	Cause: * Continued poor compliance with Duty of Candour * Delay or uncertainty regarding the severity of the incident reported contributes to lack of compliance * A lack of clarity regarding responsibility for completing the formal letters confirming the Duty of Candour conversation * Concerns regarding the 'right' time to fulfil requirements – this is more of a concern when there has been a delay in identifying the incident or completing the Duty of Candour conversation * Concerns that the patient or family questions cannot be answered immediately * Limited formal Duty of Candour training available * Low training attendance for Duty of Candour training Effect: * Reputational damage * Missed opportunities to engage with patients and families regarding an adverse event leading to complaints and subsequent claims * Professional misconduct * Breach of contractual obligations to provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs (a 'reportable patient safety incident' is one which could have or did result in moderate or severe harm or death). * Potential fines for non-compliance	HIGH (Risk within appetite)	I = 4 L = 4 High (16)	Limited	Incomplete compliance from Care Groups	I = 4 L = 4 High (16)	Implement the Duty of Candour Action Plan for General and Specialist Medicine Person Responsible: Richard Kingston To be implemented by: 29 Mar 2019	**24 May 2019** **Rhiannon Adey** Governance Matron in post who starts 27 May. This appointment plus our governance teams divesting themselves of the urgent and emergency care work should result in improvement.	I = 4 L = 2 Moderate (8)
									Implement the Duty of Candour Action Plan for Urgent and Emergency Care Person Responsible: Syed Gilani To be implemented by: 31 Mar 2019	**15 May 2019** **Paul Stevens** This care group have also now recruited to their governance structure which should enable timely completion of DoC.	

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 51	11/04/2017	Patient safety may be compromised as a result of the move of acute medicine, acute geriatric medicine and Stroke from the K&C site Risk Owner: Paul Stevens Delegated Risk Owner: Jonathan Purday Latest Review Date: 03 Jun 2019 Latest Review By: Jonathan Purday Latest Review Comments: No change in current risk. It has been 2 years since the move of medicine from the Canterbury site. The clinical strategy is yet to reach the consultation stage.	Cause: *Temporary transfer of acute medicine, geriatric medicine and Stroke from the K&C site *On K&C site we may not have the right level of medical cover for all the specialties that remain on the site *Ambulance handover delays *Patients transferring between sites *Imbalance between substantive consultants and locum consultant posts leading to unsatisfactory trainee doctors education experience Effect: *Potentially avoidable moderate or severe harm or death *Overcrowding at WHH & QEQM (negative bed position) *Reputational damage *Legal challenge *Regulatory concerns *Additional costs required for changes to services	SIGNIFICANT (Risk within appetite)	I = 5 L = 4 Extreme (20)	Adequate	None identified	I = 5 L = 3 High (15)	Fully implement the acute medical model on WHH & QEQM sites Person Responsible: Richard Kingston To be implemented by: 05 Apr 2018 revised to 29 Jun 2018 revised to 30 Sep 2018 revised to 31 Dec 2018	**15 May 2019** **Paul Stevens** The emergency care pathway model of care was discussed at CEMG and then subsequently in the senior doctors group on the 08/05/2019. Actions from these 2 meetings were to describe the key clinical standards to be adhered to and to use these to then inform	I = 5 L = 2 Moderate (10)
									Redouble efforts with system partners to reduce the numbers of stranded patients from the current figure of 434 and the super stranded from the current figure of 157 by at least 25% Person Responsible: Lee Martin To be implemented by: 31 Jul 2019	**15 May 2019** **Paul Stevens** As at 15/05/2019 the number of stranded patients averages 453 and super stranded 198	
									Implement acute frailty assessment units at WHH and QEQMH front doors and a slightly different set up in conjunction with the community in K&CH Person Responsible: Richard Kingston To be implemented by: 01 Nov 2019	**24 May 2019** **Rhiannon Adey** The frailty model is currently being implemented and a meeting was held on 22 May to get the frailty assessment pathway at QEQM restarted. In addition we are going out to advert for acute frailty practitioners to support this and are working with the cross trust lead for frailty to implement an integrated model of care for frail patients.	
									Implementation of the East Kent Clinical Strategy through the STP process Person Responsible: Elizabeth Shutler To be implemented by: 28 Feb 2018 revised to 30 Apr 2018 revised to 30 Nov 2018 revised to 29 Mar 2019 revised to 27 Mar 2020	**01 May 2019** **Rhiannon Adey** Public consultation timeline is under review	
CRR 56	02/08/2017	Inadequate critical care capacity Risk Owner: Amanda Hallums Delegated Risk Owner: Vanessa Purday Latest Review Date: 10 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by Interim Chief Nurse and Director of Quality	Cause: *Significant growth in emergency demand nationally for critical care beds insufficient to meet acuity *More people surviving with comorbidities * Increased activity of the PPCI service in WHH - out of hospital cardiac arrests who require increased length of stay Effect: *Potential harm to patients/patient safety concerns *Cancellations of elective surgery *Nursing patients outside the foot print of the Critical Care Unit, theatre recovery and ED *Increase in non-medical transfers between sites *Inability to recruit and retain medical and nursing staff *Delays in admitting patients *Financial loss - no funding if patients are not in a critical care beds *Reputational damage	SIGNIFICANT (Risk within appetite)	I = 3 L = 5 High (15)	Limited	None identified	I = 3 L = 5 High (15)	Deliver the agreed business case to increase capacity Person Responsible: Julie Barton To be implemented by: 31 Mar 2019	**10 May 2019** **Rhiannon Adey** Recruitment is on-going, critical care service is to develop a model of care looking at alternative roles with agreed competencies.	I = 2 L = 3 Low (6)
									Working with Strategic Directorate to clearly outline options for delivery of critical care service with a focus on recruitment Person Responsible: Vanessa Purday To be implemented by: 31 Jul 2019		
									New models of care are being considered by the Care Group. Person Responsible: Vanessa Purday To be implemented by: 30 Apr 2020	**10 May 2019** **Rhiannon Adey** Nursing and clinical leads (supported by the strategy team) are focusing on recruitment strategies as well as matching the skills required to deliver the service - by exploring new posts, such as Advanced Nurse Practitioners	
CRR 70	10/06/2019	Patients may not receive optimal care based on a clearly articulated clinical plan due to the requirement to maintain patient flow on a site Risk Owner: Amanda Hallums Delegated Risk Owner: Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Inadequate assessment and communication Effect: May result in patients being transferred inappropriately to another site. Patients may be harmed Sub-optimal patient experience	SIGNIFICANT (Risk within appetite)	I = 3 L = 4 Moderate (12)	Limited	Multiple transfer policies in place	I = 3 L = 4 Moderate (12)	Reinforcing the use of SBAR prior to transfer Person Responsible: Amanda Hallums To be implemented by: 31 Dec 2019		I = 3 L = 2 Low (6)
									Audit transfer documentation Person Responsible: Amanda Hallums To be implemented by: 31 Dec 2019		
									A singular Transfer Policy is being developed Person Responsible: Jonathan Purday To be implemented by: 31 Dec 2019		

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 60	10/10/2017	Potential negative impact during transition from paper health records to T3 (Transformation Through Technology) Risk Owner: Elizabeth Shutler Delegated Risk Owner: Lindsey Shorter Latest Review Date: 10 Jun 2019 Latest Review By: Robert Nelson Latest Review Comments: CEMG June meeting cancelled. Action implementation date adjusted. Other actions updated.	Cause: *New Trust-wide clinical transformation programme (T3 Programme) that introduces new technology to replace paper health records. This includes ePrescribing; functionality to record the management and treatment of patients; functionality to manage and document patient activity through theatres; Order Comms (requests and results for pathology etc.) and Clinical documentation. *Lack of engagement between supplier and clinicians *Supplier fails to understand clinical requirements *Lack of capacity of the Programme and operational teams *Resistance to change Effect: *Sub-optimal system with potential gaps and/or loss of Patient information leading to: *Potential harm to Patients *Regulatory concerns *Reputational damage *Financial loss *Failure to realise benefits	SIGNIFICANT (Risk within appetite)	I = 4 L = 4 High (16)	Adequate	None identified	I = 4 L = 3 Moderate (12)	Complete an impact assessment on the overall T3 Programme timeline for the Order Communications Workstream in relation to complexities in Pathology (specifically the Apex to Sunrise interface) Person Responsible: Lindsey Shorter To be implemented by: 28 Jun 2019	**10 Jun 2019** **Robert Nelson** Agenda item at T3 Programme Board on Thursday 21 June 2019.	I = 4 L = 3 Moderate (12)
									To agree the resources and requirements from the Care Groups and Corporate areas in relation to a safe deployment of T3. Person Responsible: Lindsey Shorter To be implemented by: 28 Jun 2019	**10 Jun 2019** **Robert Nelson** CEMG agenda item postponed to July meeting. Implementation date adjusted to reflect this.	
									The programme is configuring and building the system ready for Go Live in November 2019. Person Responsible: Lindsey Shorter To be implemented by: 30 Nov 2019	**10 Jun 2019** **Robert Nelson** This action is dependent on the existing actions and will be updated following their implementation.	
CRR 16	24/04/2016	Poor complaints management leading to delays in responses and learning not embedded Risk Owner: Amanda Hallums Delegated Risk Owner: Jane Christmas Latest Review Date: 10 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by Interim Chief Nurse and Director of Quality	Cause: - The processes in the Care Groups and within the Patient Experience Team have resulted in delays across the whole pathway. - The Care Groups do not always deal with complaints as a priority - Failure at Care Group level to triage i.e. those that can be resolved through telephone call or prompt investigation Effect: - The ability of the Trust to respond within the 30 days of receipt or 45 days for those identified as complex i.e. multi-agency - Trust response failing to meet complainant expectation. - Complaints being reopened due to inadequate response - Reputational loss	HIGH (Risk within appetite)	I = 3 L = 5 High (15)	Adequate	Some staffing difficulties. Audit results showed some anomalies in record keeping. The ability of the PET to provide timely training is affected by the time spent on complaint responses. There is a delay in getting accurate and up to date training information. The completion of Duty of Candour requirements on Datix is not undertaken consistently; there is a delay in updating the duty requirements, which may have been fulfilled but the evidence of completion is not consistently visible. Roll out to Care Groups yet to be fully completed	I = 3 L = 4 Moderate (12)	Implementation of detailed action plan. Person Responsible: Jane Christmas To be implemented by: 31 Dec 2018 revised to 31 Mar 2019	**25 Mar 2019** **Jane Christmas** Improvement in acknowledgement within 3 working days, registering 100% in January & February 2019. Heightened monitoring (including 2 weekly follow up of all older cases with senior leads for the care group) remains in place. The scope of these meetings was extended during Jan 2019 to include all complaints 45 + working days (rather than previous 60+ days) and this marks an increase in improvement ambition. Staff resource diverted to RSO to support winter pressures remains a risk to required improvement, weekly monitoring in place and daily review of staff resource / allocation to manage competing service demands. Business case for additional staff support into the RSO to mitigate this risk, outcome pending.	I = 3 L = 3 Moderate (9)
									A training programme needs to be developed and implemented for staff according to a training needs analysis. Person Responsible: Jane Christmas To be implemented by: 31 Mar 2017 revised to 30 Jun 2017 revised to 31 Aug 2017 revised to 31 Mar 2018 revised to 30 Sep 2018 revised to 31 Mar 2019	**25 Mar 2019** **Jane Christmas** Training programme framework identified - implementation pending organisational change (confirmation of governance structures within care groups which is led by the COO). Risk to the quality of complaints process has been escalated to the executive lead.	
									Independent review of the complaints process is being commissioned. Person Responsible: Jane Christmas To be implemented by: 31 May 2019	**03 Jun 2019** **Rhiannon Adey** Independent review has been commissioned and will be undertaken in June.	

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 41	07/11/2016	Failure to manage Patients with challenging behaviour (Dementia and other mental health challenges) Risk Owner: Amanda Hallums Delegated Risk Owner: Sally Hyde Latest Review Date: 10 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by Interim Chief Nurse and Director of Quality	Cause: *Increased number of long-stay Patients/delayed discharge *National shortage of Mental Health Nurses *Mental Health Liaison and Crisis teams are unable to recruit into their current vacancies and have relied on agency cover to maintain their rotas. *There is a national shortage of in-patient mental health beds Effect: *Potential harm to Patients, Staff and Visitors *Patients with recognised mental health disorders may not be treated in a timely way. *There is an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. *Other patients are put at risk of harm from violent episodes. *Patients who require in-patient Mental Health Services are managed in acute facilities which are not fit for this purpose.	SIGNIFICANT (Risk within appetite)	I = 3 L = 5 High (15)	Adequate	May not be possible to recruit dual qualified personnel Staff not always available Actual hours of cover yet to be agreed and there will be a lead time of 6 weeks while rotas are agreed with clinical staff. Existing cover, despite increased funding in 2015/16, only provides 08:00 to 16:00. No additional local funding identified for 2016/17 within current commissioning intentions. Capacity may be an issue Audit usage of smart tool Policy to be published.	I = 3 L = 3 Moderate (9)	Monitor compliance with the Smart tool usage through the Safeguarding & Dementia teams Person Responsible: Sally Hyde To be implemented by: 31 Jan 2017 revised to 31 Aug 2017 revised to 31 Oct 2017 revised to 30 Apr 2018 revised to 30 Sep 2018 revised to 30 Nov 2018 revised to 29 Mar 2019	**29 Mar 2019** **Sally Hyde** SMART+ tool has been show cased at the Hubs. Ward visits have taken place to highlight its purpose. A few amendments are being made to the document to update it and reflect feedback. WHH A&E staff have received training how to use it. Mental health team are delivering training across the Trust highlighting the need for use.	I = 3 L = 2 Low (6)
									Plans being formulated to ensure 24 hour cover across the Trust by 2020. Mental Health Commissioner locally is leading the commission intentions up to this date. Person Responsible: Lee Martin To be implemented by: 31 Mar 2019	**19 Mar 2019** **Sally Smith** This work is in progress.	
									Implementation of the new guidance for caring for mental health patients in an acute hospital Person Responsible: Lee Martin To be implemented by: 31 Mar 2019	**19 Mar 2019** **Sally Smith** We are joining up the SafeAssist work, Specialling policy work, and Nurse Pool work to describe the model and agree the contract.	
									KMPT to deliver training to high risk departments. Kate Button and Maddy McCarthy liaising with Sally Hyde Person Responsible: Sally Hyde To be implemented by: 31 May 2019	**08 Mar 2019** **Sally Hyde** Mental Health Improvement Group in place. Training delivery opportunities identified. KMPT attending sessions organised with Dr Kim Manley for A&E staff. Also teaching on De-escalation training days.	
									Review of the policy and action cards to manage challenging behaviour in the clinical areas. The review includes the services that support staff in the workplace and the development of the services and/or contract required to keep people safe. Person Responsible: Jane Christmas To be implemented by: 31 Aug 2018 revised to 31 Dec 2018 revised to 30 Jun 2019	**19 Mar 2019** **Sally Smith** This action has developed into a new action which will be described. A review of the whole service that supports staff with people who display challenging behaviour is underway that includes the action cards. This will be completed by the Summer.	
CRR 34	09/09/2016	Inadequate Health & Safety (H&S) systems embedded within the Care Groups Risk Owner: Elizabeth Shutler Delegated Risk Owner: Marion Clayton Last Updated: 26 Feb 2019 Latest Review Date: 01 May 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Trust needs to build on the external audit which was undertaken by RSM Tenon in February 2019 which achieved partial compliance. Work is moving forward with the Care Groups prioritised by highest risk areas.	Cause: * Failure to address H&S issues/incidents/themes within Divisions * Lack of appropriate H&S systems *Inconsistency in H&S processes Effect: *Potential breach of H&S regulations which may result in penalty notices and significant fines *Harm to Staff *Reputational damage *Financial loss *Legal challenge	HIGH (Risk within appetite)	I = 4 L = 4 High (16)	Adequate	Concerns that H&S risk assessments and not H&S risk themes are being recorded on risk registers Concerns that there are gaps in H&S risk records including that some risks are not being actively managed (evidenced by the fact that no actions are recorded against some risks and where actions are recorded no progress note is provided by Action Owners)	I = 4 L = 3 Moderate (12)	Ensure the new Care Groups achieve compliance with the H&S training KPIs. Person Responsible: Marion Clayton To be implemented by: 29 Mar 2019 revised to 31 Mar 2020	**01 May 2019** **Rhiannon Adey** Training schedules were communicated to all care groups and the strategic H&S meeting in April 2019. Training will be prioritised in accordance with need. Attendance at the training meetings will be monitored and any noncompliance of attendance will be escalated as part of the Quality and Risk reviews.	I = 4 L = 2 Moderate (8)
									Strategic H&S Committee will monitor improvement in Care Group Audit scores for the H&S tool kit. Person Responsible: Rachael Westerman To be implemented by: 29 Mar 2019 revised to 29 Mar 2020	**01 May 2019** **Rhiannon Adey** HASTA audit tool has now been configured by the Trust's information performance teams to reflect the new care groups structures and a more user friendly portal has been designed to improve easy access to allow care groups to monitor progress. The compliance to the HASTA will be monitored as a standing agenda item at the Strategic Health and Safety Committee and on a monthly basis at the Executive Performance Reviews.	
									To improve attendance at committees, we are combining Site H&S meetings with Site Governance Meetings, chaired by the Site Director. Person Responsible: Rachael Westerman To be implemented by: 31 Mar 2019	**01 May 2019** **Rhiannon Adey** Due to the changes in care group structures there is no site director role currently in the operational structures. A review of the attendance at site health and safety meetings will take place in quarter one with recommendations of how these meetings need to change to ensure value. A new terms of reference were presented at the strategic health and safety committee due to take place on 25 April 2019 which will also expand membership and monitor attendance.	

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 36	09/09/2016	Risk of inadequate Child Safeguarding action due to training compliance not being at 85% Trust-wide Risk Owner: Amanda Hallums Delegated Risk Owner: Carol Tilling Latest Review Date: 10 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by Interim Chief Nurse and Director of Quality	Cause: *Lack of access to current training data *Failure to prioritise training attendance * Lack of clarity as to what level of training people require (the staff themselves) Effect: *Regulatory concerns *Legal challenge *Reputational loss *Failure to meet performance standard	SIGNIFICANT (Risk within appetite)	I = 4 L = 5 Extreme (20)	Adequate	Reports not received regularly from HR	I = 4 L = 3 Moderate (12)	Care Groups are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. Person Responsible: Ursula Marsh To be implemented by: 31 Mar 2017 revised to 31 Mar 2018 revised to 31 May 2018 revised to 31 Jul 2018 revised to 31 Aug 2018 revised to 31 Mar 2019	**19 Mar 2019** **Sally Smith** Care Group is compliant overall. Awaiting the breakdown compliance for February.	I = 3 L = 3 Moderate (9)
									A cleansing of ESR to ensure accurate reporting Person Responsible: Carol Tilling To be implemented by: 31 Dec 2018 revised to 31 Mar 2019	**19 Mar 2019** **Sally Smith** Care Groups have completed this action.	
									Care Groups are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. Person Responsible: Heather Munro To be implemented by: 31 Mar 2017 revised to 31 Mar 2018 revised to 31 May 2018 revised to 31 Jul 2018 revised to 31 Aug 2018 revised to 31 Mar 2019	**29 May 2019** **Heather Munro** update from email on 23/05/19 to Amanda Hallums Level 1 – 100% as stated Level 2 – 93 % as stated with summary of actions for the remaining 6 Level 3 – 60 of the 151 require this so I have chased the following (this should be less and across other levels if Rotary was allocated to S&A): •Add Professional science – 2 •Add clinical service – 5 •AHP – 5 •Nurses 17 •Medical staff – 31 (and this relates to TNA V different advise) and see last month's email and awaiting update from medical director and yourself Rotary ward is within S&A care group	
									Care Groups are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. Person Responsible: Tara Laybourne To be implemented by: 31 Mar 2017 revised to 31 Mar 2018 revised to 31 May 2018 revised to 31 Jul 2018 revised to 31 Aug 2018 revised to 31 Mar 2019	**19 Mar 2019** **Sally Smith** Awaiting update on February's compliance.	
									Care Groups are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. Person Responsible: Julie Barton To be implemented by: 31 Mar 2017 revised to 31 Mar 2018 revised to 31 May 2018 revised to 31 Jul 2018 revised to 31 Aug 2018 revised to 31 Mar 2019	**19 Mar 2019** **Sally Smith** Trajectory of compliance has been submitted and is being monitored.	
									5 New staff members in safeguarding children team need to undertake train the trainer training to comply with the intercollegiate document to enable them to deliver safeguarding children training independently, therefore increasing capacity to deliver initial and refresher training throughout the Trust. Person Responsible: Carol Tilling To be implemented by: 31 Mar 2020		

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gap	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
CRR 47	07/02/2017	Inability to prevent deterioration in the number of healthcare associated infections Risk Owner: Paul Stevens Delegated Risk Owner: Valerie Harmon Latest Review Date: 19 Jun 2019 Latest Review By: Paul Stevens Latest Review Comments: New action added	Cause: Lack of adherence to basic infection prevention control policies and procedures Effect: * Increased exposure of Patients to Healthcare Associated Infections (HCAIs) such as MRSA, E.coli, C.difficile and Glycopeptide Resistant Enterococcus (GRE). *Potential hospital acquired water borne infection such as Legionella and Pseudomonas *Poor patient outcomes Increased hospital length of stay *Failure to meet targets *Financial loss - financial penalty *Regulatory concerns	HIGH (Risk within appetite)	I = 4 L = 5 Extreme (20)	Adequate	None identified	I = 4 L = 3 Moderate (12)	Prepare and submit a business case to address the shortfall in microbiologist and pharmacist time for antimicrobial stewardship Person Responsible: Stephen Glass To be implemented by: 31 Mar 2020 Implement the 5 National work streams for reduce of HCAI through the Kent & Medway Collaborative - 1. IPC 2. Antibiotic prescribing, 3. Sepsis screening and treatment 4. Diagnostics 5. Immunisation and Vaccinations Person Responsible: Valerie Harmon To be implemented by: 30 Jun 2020	**19 Jun 2019** **Paul Stevens** Update meeting arranged between MD, AMS microbiologist and AMS pharmacist to discuss and agree resource required; to have taken place by end July 2019	I = 4 L = 2 Moderate (8)
CRR 13	23/02/2016	Inability to fund an adequate asset replacement programme for high cost and high risk medical equipment approaching the end of their asset life Risk Owner: Elizabeth Shutler Delegated Risk Owner: Marion Clayton Latest Review Date: 01 May 2019 Latest Review By: Rhiannon Adey Latest Review Comments: A full review of the risk will be undertaken with Head of Clinical Engineering to quantify the risk.	Cause: There has been a reduction in the capital allocation for replacement and updating of high cost essential clinical equipment. Effect: Items of clinical equipment has reached the end of its asset life and requires increased maintenance and support in order to ensure that safety is maintained and reduce the likelihood of failure.	HIGH (Risk within appetite)	I = 3 L = 4 Moderate (12)	Adequate	Not all equipment may be on the F2 database There is a gap in the funding allocation and the amount of equipment that requires replacement.	I = 3 L = 3 Moderate (9)	SIG to sign off the annual medical equipment priority list. Person Responsible: Elizabeth Shutler To be implemented by: 31 May 2019	**01 May 2019** **Rhiannon Adey** A full review of the risk will be undertaken with Head of Clinical Engineering to quantify the risk.	I = 3 L = 2 Low (6)
CRR 58	21/08/2017	Failure to embed Risk Management within the Care Groups Risk Owner: Amanda Hallums Delegated Risk Owner: Helen Goodwin Latest Review Date: 10 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by Interim Chief Nurse and Director of Quality	Cause: *The need for improved engagement from Care Groups in the Trust Risk Management process; this is reflected in the failure to provide assurances on risks escalated to the Corporate Risk Register *Inconsistency in Risk Governance arrangements across Care Groups *Ineffective risk management support structure at Care Group level *Poor usage of risk system (4Risk) *Failure to prioritise risk management training *Lack of knowledge of risk management *Absence of risk registers in some Wards, Specialties and Departments Effect: *Failure to deliver the Trust Strategic Priorities (4Ps - Patients, Provision, People, Partnerships) *Potential patient safety concerns *Financial loss *Regulatory concerns (This risk also links to the revised NHS Improvement Leadership and Improvement Capability Themes (Well-Led) within the Single Oversight Framework (SOF) where risk management is now specifically expressed) *Reputational damage *Legal challenge	HIGH (Risk within appetite)	I = 4 L = 4 High (16)	Adequate	Inconsistent risk governance arrangement across the Care Groups Measures for monitoring adherence to the Risk Leadership Behaviours and the impact on the Risk Leadership element of the Trust's risk maturity assessment needs to be developed and rolled out to Leaders Trust-wide. Risks are not being reviewed consistently on a monthly basis by Risk Owners All local risk register have not been transferred to 4Risk	I = 4 L = 2 Moderate (8)	Care Groups to review their Risk Management Governance arrangements to ensure alignment with the Trust Risk Management Policy Person Responsible: Helen Goodwin To be implemented by: 30 Nov 2018 revised to 28 Feb 2019 revised to 01 Aug 2019	**29 May 2019** **Helen Goodwin** The reporting of significant risks to Care Groups is now reported monthly through the Quality and Risk meeting chaired by an Executive. These reports are reviewed and discussed at the monthly Quality Committee meetings.	I = 4 L = 1 Low (4)
CRR 69	07/02/2019	Detriment to patients with a disability as we are non-compliance with the statutory Accessible Information standards. Risk Owner: Bruce Campion-Smith Delegated Risk Owner: Latest Review Date: 03 May 2019 Latest Review By: Sarah James-Whatman Latest Review Comments: Reviewed at Trust risk group on 15th April, I advised this should be agreed as a Corporate level risk as it impacts every patient at every contact with Clinical services. Exec team have agreed finance for additional resources in principle and this is now being progress through the formal sign off process. The risk is being reviewed at CEMG to consider whether it is agreed as a Trust level risk.	Cause: Accessible Information Standard not implemented Effect: Some disabled patients will not receive information about their care in an understandable format		I = 4 L = 5 Extreme (20)				Full implementation of Accessible Information Standards Person Responsible: Bruce Campion-Smith To be implemented by: 31 Mar 2020 Approval granted to engage a 0.80 WTE project manager to implement this project ASAP. JD written and now under review. TRAC recruitment process begun. Anticipate that EKHUFT will be compliant within one year of appointment of project manager. Person Responsible: Bruce Campion-Smith To be implemented by: 01 Aug 2019 Online British Sign Language (BSL) will be available to all patients and staff allowing vastly improved access to information relating to care. Person Responsible: Bruce Campion-Smith To be implemented by: 01 Aug 2019	**07 Feb 2019** **Bruce Campion-Smith** Current resources prevent implementation without additional staff	I = 3 L = 3 Moderate (9)

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gaps	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 5	20/01/2016	Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime Risk Owner: Philip Cave Delegated Risk Owner: Last Updated: 06 Mar 2019 Latest Review Date: 01 Mar 2019 Latest Review By: Philip Cave Latest Review Comments: At the end of M10 the Trust is £7.4m worse than plan with an expected year-end deficit £12m worse than plan.	Cause: Due to: * Failure to reduce the run rate * Poor planning * Poor recurrent CIP delivery (See Risk Ref. 1037) * Inability to collect income due * Poor cash management * Operational pressures relating to Emergency Care, High Agency usage *Failure to deliver RTT, A&E and cancer targets (See CRR 28) * Political climate (Brexit) and price inflation *Inability to deliver the planned levels of activity and collect the planned levels of income *Workforce pressures including inability to recruit (See SRR 9) *Lack of capacity of Finance and PMO staff *Lack of capacity and capability to deliver operational and financial performance (See SRR 12) *Inability to secure external support for key projects *Demand from CCGs higher or lower than annual plan *Failure to secure all the contractual income due from commissioners (See Risk Ref. 101) *Failure to deliver the CQUIN programme (See CRR 53) *Financial Special Measures governance not embedded *Additional costs of reconfiguring services across sites due to temporary move of acute medicine, acute geriatric medicine and Stroke from the K&C site(See CRR 51) *Negative impact of the new PAS and EMR implementation (See CRR 37) *Inability to resource the Trust's A&E improvement plan (estimated at £9.5 million) Effect: Resulting in * Potential breaches to the Trust's Monitor licence * Adverse impact on the Trust's ability to deliver all of its services * Impact on ability to deliver the longer term clinical strategy * Poor reputation * Impact on organisational form	HIGH (Risk not within appetite)	I = 5 L = 5 Extreme (25)	Adequate	Poor clinical engagement Key operational performance targets (A&E, RTT, Cancer) not being met. Clinical activity not consistently captured, coded and costed. Trust is seeking assurance from NHSE/I about next steps - Commissioners challenge Change in KPIs proving improvement in run rates	I = 5 L = 4 Extreme (20)	Executives to be given objective relating to financial performance Person Responsible: Susan Acott To be implemented by: 31 May 2019	**14 May 2019** **Rhiannon Adey** Appraisals for Executives is underway	I = 5 L = 3 High (15)
									Proposal to be developed to FPC on training for the Trust on budget management Person Responsible: Guy Dentith To be implemented by: 28 Jun 2019	**14 May 2019** **Rhiannon Adey** This is in development	
									Ensure budget holders have read and accepted the Standing Financial Instructions Person Responsible: Guy Dentith To be implemented by: 28 Jun 2019	**14 May 2019** **Rhiannon Adey** Designing a test and developing an easy read version of the Standing Financial Instructions	
									Provide to Finance Committee the robust temporary staffing policy Person Responsible: Andrea Ashman To be implemented by: 28 Jun 2019	**15 Apr 2019** **Andrea Ashman** Temporary staffing policy in draft form, worked up by DHRD. Currently being finalised for presentation via internal governance processes.	
									Care Groups to work with the PMO to identify 90% green CIPs for 2019/20 Person Responsible: Lee Martin To be implemented by: 28 Jun 2019	**14 May 2019** **Rhiannon Adey** Progress is being made and currently at 62% rated as green	
									Executive Performance Reviews to hold Care Groups to account for delivery of financial performance Person Responsible: Lee Martin To be implemented by: 01 Jul 2019	**14 May 2019** **Rhiannon Adey** This is in progress	
									Full implementation of HealthRoster for nursing and dmonstrate 100% compliance on usage Person Responsible: Amanda Hallums To be implemented by: 31 Jul 2019		
									Create and implement a clear workforce document outlining vacnacies, future need and recruitment plan by Care Group Person Responsible: Andrea Ashman To be implemented by: 31 Jul 2019	**15 Apr 2019** **Andrea Ashman** Work underway with HRBPs / resourcing and Beautiful Information to produce charts with accurate / current information. Initial draft expected for June SWC.	
									Full implementation of rostering for medical staffing and demonstrate 100% compliance on usage Person Responsible: Paul Stevens To be implemented by: 31 Jul 2019		
									Design and implement finance function training for clinicians Person Responsible: Lee Martin To be implemented by: 30 Aug 2019	**05 Mar 2019** **Rhiannon Adey** Chief Operating Officer and Finance Director have met to review the Finance reports for the Care Groups. The finance department are developing a standardised training package for delivery to the Care Groups, this is due to commence in April.	

									Strategy to be developed to use benchmarking tools including Patient Level Costing, Service Line Reporting, Model Hospital, Getting It Right First Time and RightCare. Person Responsible: Guy Dentith To be implemented by: 28 Sep 2019	**14 May 2019** **Rhiannon Adey** This is in development	
									Implement plan for financial budget management training Person Responsible: Guy Dentith To be implemented by: 31 Mar 2020	**14 May 2019** **Rhiannon Adey** Written to all Care Groups with their budgets and asked them to sign off by the end of the month.	
Risk Ref	**Created Date**	**Risk Title**	**Cause & Effect**	**Appetite**	**Inherent Risk Score**	**Overall Assurance Level**	**Assurance Gaps**	**Residual Risk Score**	**Action Required**	**Progress Notes**	**Target Risk Score**
SRR 24	10/06/2019	If leadership and management is not effective staff may not be engaged to deliver a high quality, caring service Risk Owner: Andrea Ashman Delegated Risk Owner: Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Effect:	SIGNIFICANT (Risk within appetite)	I = 5 L = 4 Extreme (20)			I = 5 L = 4 Extreme (20)	Development of senior, middle non-clinical leaders against the EKHUFT leadership framework Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		I = 5 L = 3 High (15)
									Meaningful appraisals to be undertaken annually Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		
									Develop operational leadership and tactical competencies at Clinical Director, Head of Nursing and Director of Operationa level, General Manager and Matron level provided by external facilitator and NHS Elect. Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		
									To finalise the Trust-wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gaps	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 29	10/06/2019	If the Trust does not have a positive culture or ability to recruit and retain staff with the right skills is compromised Risk Owner: Andrea Ashman Delegated Risk Owner: Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Effect:	SIGNIFICANT (Risk within appetite)	I = 5 L = 4 Extreme (20)			I = 5 L = 4 Extreme (20)	Resource mindfulness programmes to invest in health and wellbeing of staff Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		I = 5 L = 2 Moderate (10)
									Raising the profile of workforce equality, diversion and inclusion Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		
									Delivery of cultural change programme at Care Group level Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		
									Increased take up of resilience and respect workshops Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		
									Source and implement a cultural change programme Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		
SRR 26	10/06/2019	The Trust will be unable to make the changes to services needed if the Pre-Consultation Business Case (PCBC) is not signed off by external bodies Risk Owner: Elizabeth Shutler Delegated Risk Owner: Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Effect:	SIGNIFICANT (Risk within appetite)	I = 5 L = 4 Extreme (20)			I = 5 L = 4 Extreme (20)	Lobbying of external bodies by Chief Executive and Chairman Person Responsible: Susan Acott To be implemented by: 31 Mar 2020	**10 Jun 2019** **Susan Acott** Meetings with Anne Eden, Glen Douglas to progress and share context; ensuring the evaluation is completed on time and schedule to the correct quality - several conversations internally and externally to facilitate inc Nuffield Trust	I = 5 L = 3 High (15)
									Influence CCG through STP Governance Process Person Responsible: Elizabeth Shutler To be implemented by: 31 Mar 2020		
SRR 22	07/06/2019	Urgent Treatment Centre may not become established and result in increased demand to ED Risk Owner: Lee Martin Delegated Risk Owner: Latest Review Date: 19 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed and assurance updated by COO	Cause: Lack of engagement between the CCG, GP colleagues and EKHUFT clinicians Lack of appropriate accommodation at the acute hospital site Effect: Increased demand to ED Delivery of the 4 hour Emergency Access Standard Reduced workforce in ED Increased cost of service provision Increased attendance across the health economy	HIGH (Risk not within appetite)	I = 5 L = 4 Extreme (20)	Adequate		I = 5 L = 4 Extreme (20)	Accommodation options are being explored Person Responsible: Lee Martin To be implemented by: 31 Mar 2020	**19 Jun 2019** **Rhiannon Adey** Implementation plan agreed for 3 acute sites	I = 5 L = 3 High (15)
									Pathways are being developed to maximise integration of primary and secondary care staff Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gaps	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 16	27/02/2017	Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes Risk Owner: Susan Acott Delegated Risk Owner: Simon Hayward Latest Review Date: 23 Apr 2019 Latest Review By: Simon Hayward Latest Review Comments: Risk action reviewed and updated following Board sign-off of Annual Objectives	Cause: * Lack of experience / capability in the particular area of change * Lack of capacity of those who need to lead and embed the change * Lack of resources to deliver / implement and sustain change * Trust's lack of appetite for change in some areas to be implemented *Unavailability of the space and physical resources to implement and embed improvements * Mechanism / governance structures for Transformation is not embedded. Effect: * Inability to maintain safe, effective and caring services * Inability to deliver the transformation required to meet Trust objectives * Licence restrictions *Regulatory concerns * Reputational damage	SIGNIFICANT (Risk within appetite)	I = 4 L = 5 Extreme (20)	Adequate	Links to transformation / service improvement from learnings not explicit.	I = 4 L = 4 High (16)	Agree a Transformation programme of work with clear owners and milestones that links to the Trust priorities - link this to the Trust objective planning for 2019 that is being delivered in January 2019 Person Responsible: Simon Hayward To be implemented by: 30 Mar 2018 revised to 30 Sep 2018 revised to 30 Nov 2018 revised to 21 Dec 2018 revised to 22 Feb 2019 revised to 29 Mar 2019	**23 Apr 2019** **Alison Fox** The Board signed off the Annual Objectives on 05 April 2019 and the Operational Plan was submitted to NHS Improvement. As a result the Care Group business planning cycle is being finalised and this will result in a clear plan.	I = 4 L = 2 Moderate (8)
SRR 4	20/01/2016	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities Risk Owner: Elizabeth Shutler Delegated Risk Owner: Elizabeth Shutler Last Updated: 18 Dec 2018 Latest Review Date: 13 Feb 2019 Latest Review By: Elizabeth Shutler Latest Review Comments: The NHSi BC is being submitted in March as planned. The Trust has allocated c£5m (including the standing £2.2m in PEIC) of its capital to infrastructure repairs across a wide range of patient and staff environments. These are due to complete by the end of March 2019 and are being overseen in a bi-weekly capital meeting chaired by the Deputy CEO. This work includes refurbishments to front of house, public toilets, roofs, staff facilities and plant & equipment. Additionally the Trust has secured £7.8m of SALIX funding to carry out infrastructure repairs to key energy and utilities plant and equipment over the next two years along with a successful application to NHSI of £2.2m worth of capital to replace patient and staff lighting for more reliable, safe and efficient LED technology.	Cause: - Backlog of work (£74million); - The financial constraint on capital funding; - The sheer volume and extent of work required Effect: - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	HIGH (Risk within appetite)	I = 4 L = 5 Extreme (20)	Adequate	None identified	I = 4 L = 4 High (16)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee Person Responsible: Elizabeth Shutler To be implemented by: 31 May 2017 revised to 31 Oct 2017 revised to 30 Nov 2017 revised to 28 Feb 2018 revised to 30 Apr 2018 revised to 30 Nov 2018 revised to 31 Dec 2018 revised to 29 Mar 2019 revised to 29 Nov 2019	**01 Mar 2019** **Rhiannon Adey** Public consultation timeline is under review	I = 4 L = 2 Moderate (8)
									The Trust has engaged with NHSI to agree priorities to spend in 18/19 and 19/20. This is with a view to reduce the Trust Backlog position further. Person Responsible: Elizabeth Shutler To be implemented by: 31 Mar 2020	**13 Feb 2019** **Elizabeth Shutler** The NHSi BC is being submitted in March as planned.	
SRR 21	07/06/2019	Due to lack of capacity in tertiary centre patients may breach the 62 day standard waiting on diagnostic or treatement Risk Owner: Lee Martin Delegated Risk Owner: Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Lack of capacity Consultant based decision Effect: Patients wait longer for diagnostics and treatement place	HIGH (Risk within appetite)	I = 4 L = 4 High (16)			I = 4 L = 4 High (16)	Review of current pathways to ensure that they comply with Cancer Network best practice timed pathways Person Responsible: Andrew Nordin To be implemented by: 31 Mar 2020		I = 4 L = 2 Moderate (8)
									COO to COO escalation to progress patients pathways as and when appropriate Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gaps	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 27	10/06/2019	If there are multiple change programmes ongoing there is a risk that the Trust will not have the capacity to successfully deliver the T3 project Risk Owner: Elizabeth Shutler Delegated Risk Owner: Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Effect:	HIGH (Risk within appetite)	I = 4 L = 4 High (16)			I = 4 L = 4 High (16)	Review governance information for the Integrated Care Partnership Person Responsible: Elizabeth Shutler To be implemented by: 31 Mar 2020 East Kent ICP development board terms of reference Person Responsible: Elizabeth Shutler To be implemented by: 31 Mar 2020		I = 4 L = 2 Moderate (8)
SRR 19	07/06/2019	Patients may decline a date within breach and choose to delay their treatment until after their 52 week breach date Risk Owner: Lee Martin Delegated Risk Owner: Latest Review Date: 19 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed by COO and will be recommended for closure at the July CEMG meeting	Cause: The potential number of patients who have waited over 18 weeks for treatment Effect: £2,500 fine for the Trust and a £2,500 fine for the CCG for each month each individual patient breaches	HIGH (Risk within appetite)	I = 4 L = 4 High (16)	Adequate		I = 4 L = 4 High (16)	Director of Performance to monitor and challenge the place for all patients over 30 weeks and agree an improvement trajectory for each specialty as appropriate Person Responsible: Lesley White To be implemented by: 31 Mar 2020 Care Groups are implementing weekly performance meetings with their General and Service Managers to monitor RTT performance. Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		I = 4 L = 2 Moderate (8)
SRR 25	10/06/2019	If staff are not involved in meaningful appraisals they may not feel valued by the Trust resulting in increase in turnover / lack of pride in doing their job Risk Owner: Andrea Ashman Delegated Risk Owner: Latest Review Date: Latest Review By: Latest Review Comments:	Cause: Effect:	HIGH (Risk within appetite)	I = 4 L = 4 High (16)			I = 4 L = 4 High (16)	Conduct a quality audit of 10% of 2018/19 appraisals Person Responsible: Andrea Ashman To be implemented by: 31 Mar 2020		I = 4 L = 2 Moderate (8)

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gaps	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 8	23/02/2016	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust Risk Owner: Andrea Ashman Delegated Risk Owner: Andrea Ashman Latest Review Date: 15 Apr 2019 Latest Review By: Andrea Ashman Latest Review Comments: Actions updated and amended to reflect recent changes	Cause: * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff * Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) * Uncertainty due to the STP plans * Increase in service demand * Potential negative impact that may arise from the publication of the Staff Survey Results. * Reputation of some medical specialties * Split site organisation increases the intensity of on call rotas Effect: * Potential negative impact on patient outcomes and experience * High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups * Patient safety * Service delivery * Turnover * Unsafe staffing * Overtime * Withdrawal of GMC support	SIGNIFICANT (Risk within appetite)	I = 5 L = 5 Extreme (25)	Adequate	Action Plan requires updating following receipt of the Annual NHS Staff Survey Results Plan may not be progressing Programme of work being looked at to reduce time to hire (target to reduce this to 8 weeks). Updated Recruitment Improvement Plan produced which will support delivery of this timescale. Achieved target set by the Board and now moving towards monitoring of the quality of appraisals Funding gap - more bids than can be supported Understanding of process and outcomes	I = 5 L = 3 High (15)	Revise and implement Care Group Great Place to Work Action Plans Person Responsible: Jane Waters To be implemented by: 29 Mar 2019	**12 Jun 2019** **Jane Waters** HRBP's working with Care Group triumvirates to focus on Trust values and behaviours following feedback of staff survey results.	I = 4 L = 2 Moderate (8)
									Develop and agree set of KPIs to measure the effectiveness of the People Strategy which will be reported regularly to the SWC Person Responsible: Andrea Ashman To be implemented by: 31 Jul 2017 revised to 30 Nov 2017 revised to 29 Jun 2018 revised to 31 Oct 2018 revised to 28 Feb 2019 revised to 31 Mar 2019	**05 Feb 2019** **Sarah James-Whatman** Completing a review and refresh of the People Strategy to reflect Trust priorities, Clinical Strategy and Transformation journey. Currently in draft with action plans being developed by end Feb 19.	
									Develop and implement a plan to recruit nurses and Drs from the UK, Europe and other countries Person Responsible: Louise Goldup To be implemented by: 29 Mar 2019 revised to 30 Apr 2019	**05 Feb 2019** **Sarah James-Whatman** Draft recruitment and retention strategy has been developed and will be implemented by 1st April. Procurement process for a dedicated international recruitment agency is underway and is expected to be awarded by 31st March 2019 with campaigns scheduled in Sri Lanka for Specialty Drs in March and nurse, Medical and Sonographer recruitment in June 2019. Established pipeline of Radiographer resources from Italy and this will be offered as a model to STP partners to provide and retina resources for the Region.	
									Workforce remodelling plans to introduce new roles, develop and retain staff and meet the clinical needs of the approved Clinical Strategy and 10 year plan. Person Responsible: Sarah James-Whatman To be implemented by: 30 Aug 2019		
									Work as an STP region to agree common values and approach to recruitment and retention for the stability and safety of patient care within the region Person Responsible: Louise Goldup To be implemented by: 31 Dec 2019		
									Corporate retention Group works in partnership with NHSI to monitor and continue to improve Trust retention rates. A particular emphasis needs to be placed on retention plans for Stroke, ED and General Medicine. Person Responsible: Sarah James-Whatman To be implemented by: 31 Mar 2020		

Risk Ref	Created Date	Risk Title	Cause & Effect	Appetite	Inherent Risk Score	Overall Assurance Level	Assurance Gaps	Residual Risk Score	Action Required	Progress Notes	Target Risk Score
SRR 23	10/06/2019	Integrated frailty pathways cannot be agreed resulting in patients being treated in a traditional hospital based service Risk Owner: Lee Martin Delegated Risk Owner: Latest Review Date: 19 Jun 2019 Latest Review By: Rhiannon Adey Latest Review Comments: Risk reviewed, controls updated and additional action added by COO	Cause: Consultant geriatrician vacancies Lack of consultant engagement Effect: Patients will be admitted and risk decompensating rather than have access to integrated ambulatory and community pathways Adding pressure to bed base Patients decompensating	HIGH (Risk within appetite)	I = 5 L = 3 High (15)	Limited		I = 5 L = 3 High (15)	A joint programme manager will be appointed to implement the service Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		I = 5 L = 2 Moderate (10)
									Pathways are being developed to maximise integrated of primary and secondary care staff Person Responsible: Lee Martin To be implemented by: 31 Mar 2020		
									Implementation plan is being developed Person Responsible: Lee Martin To be implemented by: 31 Jul 2019		

19/067

East Kent Hospitals University NHS Foundation Trust

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**4 JULY 2019**
REPORT TITLE:	**PROGRAMME INITIATION DOCUMENT (PID)**
BOARD SPONSOR:	**CHIEF EXECUTIVE OFFICER**
PAPER AUTHOR:	**KENT AND MEDWAY SYSTEM TRANSFORAMTION PARTNERSHIP**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

As set out in Kent and Medway's (K&M) clinical vision and strategy, 'Quality of life, quality of care', we want the population of Kent and Medway to be as healthy, fit and independent as possible; able to live their best life independently for as long as possible and to access the right treatment, care and support when they need it. However, the commissioning and provision of health and care across K&M continues to face significant challenges, such as scarcity of specialist workforce, rising quality standards, and the need to live within our allocated funding in a sustainable way. In addition, in too many areas commissioning and provision of care is fragmented and greater integration could bring about significant benefits to staff and patients alike. This coupled with changing population need, increased demand and rising expectation of health and care services means that responding to these challenges requires whole system transformation both in terms of the types of services provided to local people and how these services can be most effectively and efficiently organised.

The programme initiation document (PID) explains the direction and scope of the Kent and Medway system transformation programme, which focuses on the development of a county-wide integrated care system (ICS) over the next 21 months. The move towards creating an integrated care system across K&M is in line with the national ambitions set out recently in the NHS Long Term Plan. It builds on the achievements and working relationships developed through the county's System Transformation Partnership (STP) – a collaborative of all the NHS and upper tier local authority organisations in K&M, working together to improve health and care across the county. The document is the reference document for the management and the assessment of the Programme. It outlines the objectives, benefits, scope, delivery method, structure and governance to deliver the proposed changes.

The PID has been developed over a number of months by various stakeholders from across the county, including GPs and members of our Patient and Public Advisory Group (PPAG), and focuses on making changes to enable improved health outcomes and improved experience of health and care services for local people at its core. We are grateful for their input and look forward to continuing to work with them on this over the coming weeks and months.

The PID has been endorsed by the K&M STP Programme Board and is now being presented to all of the constituent organisations for discussion and formal sign-off. In considering the document, it should be noted that this is a major programme of work, which will continue to evolve. As such the PID and associated programme/project plans will be subject to regular review and updating throughout the programme.

19/067

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NHS Foundation Trust

To ensure local people, including our staff, are informed about the proposals, and able to comment on them, a summary document and set of frequently asked questions have been published here www.kentandmedway.nhs.uk/ics. These set out why change is needed and the expected outcomes and benefits that local people, patients and health and care workers across K&M will experience as part of the system transformation programme and delivery of the NHS Long Term Plan.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Local care: to be able to demonstrate and provide assurance on current and on-going development of capacity and capability to accommodate and support shifts in activity from hospitals changes.
LINKS TO STRATEGIC OBJECTIVES:	• **Getting to good:** Improve quality, safety and experience, resulting in **Good** and then **Outstanding** care. • **Higher standards for patients:** Improve the **quality and experience** of the care we offer, so patients are **treated in a timely way** and **access the best care** at all times. • **A great place to work:** Making the Trust a **Great Place to Work** for our current and future staff. • **Delivering our future: Transforming** the way we provide services across east Kent, enabling the whole system to offer **excellent integrated services.** • **Right skills right time right place:** Developing teams with the **right skills** to provide care at the **right time**, in the **right place** and achieve the **best outcomes for patients.** • **Healthy finances:** Having Healthy Finances by providing better, **more effective patient care** that makes resources go further.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	**SRR10** - Non-delivery of a timely STP that can be resourced.
RESOURCE IMPLICATIONS:	There continues to be a resource implication to this work which will be part of the K&M STP budget.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS:	None

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and note the report.