REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM SEPTEMBER 2018

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
ACOTT, SUSAN	Chief Executive	Advisory Council of The Staff College (leadership development body for the NHS/Military) **(4)** Substantive Chief Executive at Dartford and Gravesham NHS Trust (DGT). A memorandum of understanding has been signed to mitigate the risks with the substantive role and the interim role. No longer a Board member at DGT. Discussed and accepted at the Board meeting held on 6 October 2017 **(5)**	Appointed 1 April 2018
ADEUSI, SUNNY	Non Executive Director	None	1 November 2015 (First term)
CAVE, PHILIP	Director of Finance and Performance Management	Wife works as a Senior Manager for Optum, who run the Commissioning Support Unit (CSU) in Kent, which supports the Clinical Commissioning Group's (CCG's) of East Kent in their contracting **(5)** Non Executive Director of Beautiful Information Limited **(1)**	Appointed 9 October 2017
COOKSON, WENDY	Non Executive Director	Managing Director of IdeasFourHealth Ltd, a consultancy for the healthcare industry **(2)** Sole Shareholder for IdeasFourHealth Ltd **(3)** Trustee of Bede House Charity, a local community charity in Bermondsey, London, from January 2017 **(4)** Member of Health Advisory Board for OCS Group UK **(5)** Non Executive Director of Medway Community Healthcare **(1)**	6 January 2017 (First Term)
LE BLANC, SANDRA	Director of HR	Justice of Peace (East Kent) and I am a specialist advisor for the CQC **(4)** Member – Scheme Advisory Board for the NHS Pension Scheme **(4)**	1 September 2014

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM SEPTEMBER 2018

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
MANSLEY, NIGEL	Non Executive Director	Jeris Associates Ltd **(1) (2) (3)** Chair, Diocesan Board of Finance (Diocese of Canterbury) **(1)**	(First term) 1 July 2017
MARTIN, LEE	Chief Operating Officer	None	Interim from May 2018 Substantive from August 2018
OLLIS, JANE	Non Executive Director	Quvium UK **(1)** The Heating Hub **(1)** Board Member of the Kent Surrey Sussex Academic Health Science Network (AHSN) **(1)**	8 May 2017 (First term)
PALMER, KEITH	Non Executive Director	Managing Director of Silverfox Consultancy Ltd **(1)** Sole shareholder of Silverfox Consultancy Ltd **(3)** Non Executive Director of EKMS **(1)** Non Executive Director of 2Gether Support Solutions **(1)**	1 January 2017 (First term)
REYNOLDS, SEAN	Non Executive Director	Trustee of Building Heroes **(1)**	20 August 2018 (First term)
SHUTLER, LIZ	Director of Strategic Development and Capital Planning/Deputy Chief Executive	Nil	January 2004
SMITH, SALLY	Chief Nurse and Director of Quality	Nil	Interim from 1 April 2015 Substantive from 28 July 2015

REGISTER OF DIRECTOR INTERESTS – 2018/2019 FROM SEPTEMBER 2018

NAME	POSITION HELD	INTERESTS DECLARED	FIRST APPOINTED
SMITH, STEPHEN	Chair	Non Executive Director of NetScientific Plc **(1)** Chairman of Biotechspert Ltd **(1)** Non Executive Director of uMed Ltd **(1)** Non Executive Director of Draper and Dash **(1)** Chairman of Signum Health Ltd **(1)** Trustee of Pancreatic Cancer UK **(1)** Stephen Smith Ltd **(1)** Chair of Scientific Advisory Board **(4)** Pancreatic Cancer UK **(4)** Non Executive Director of Great Ormond Street Hospital **(1)** (overlap agreed by NHS Improvement until the end of May 2018) Trustee of Epilepsy Society **(4)**	1 March 2018
STEVENS, PAUL	Medical Director	CQC Adviser **(4)** NICE Chair, Chair of the Kidney Disease Guideline and Quality Standards Groups **(4)** Executive Member of Kidney Disease Improving Global Outcomes **(4)** Non Executive Director of Beautiful Information Limited **(1)**	June 2013
WILDING, BARRY	Senior Independent Director	Trustee of CXK, a Charity in Ashford inspiring people to thrive **(4)**	11 May 2015 (Second term)

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

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

UNCONFIRMED MINUTES OF THE EIGHTY-EIGTH MEETING OF THE BOARD OF DIRECTORS THURSDAY 4 OCTOBER 2018 AT 9.45 AM BOARDROOM, KENT AND CANTERBURY HOSPITAL

PRESENT:

Professor S Smith	Chair	StS
Ms S Acott	Chief Executive Officer	SAc
Mr S Adeusi	Non-Executive Director	SA
Mr P Cave	Director of Finance and Performance Management	PC
Ms W Cookson	Non-Executive Director	WC
Mr N Mansley	Non-Executive Director	NM
Mr L Martin	Chief Operating Officer	LM
Ms J Ollis	Non-Executive Director	JO
Mr K Palmer	Non-Executive Director	KP
Mr S Reynolds	Non-Executive Director	SRe
Ms L Shutler	Director of Strategic Development and Capital Planning/Deputy Chief Executive (joined at 9.55 am)	LS
Dr S Smith	Chief Nurse and Director of Quality	SSm
Dr P Stevens	Medical Director	PS

IN ATTENDANCE:

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

MEMBERS OF THE PUBLIC AND STAFF OBSERVING:

Mrs J Cole
Dr J Purday
Mr J Ransley
Mr K Rogers
Mr J Smith
Mrs J Whorwell

MINUTE NO.		ACTION
93/18	**CHAIRMAN'S WELCOME** The Chair welcomed attendees to the meeting. The Chair reported that the patient who had been due to present to the Board at the meeting held that day as part of the patient experience report was unfortunately unwell and would was unable to attend. Their presentation would be rescheduled to attend a future Board meeting.	

94/18 **APOLOGIES FOR ABSENCE**

Apologies for absence had been received from Sandra Le Blanc (SLB), Director of Human Resources; and Barry Wilding (BW), Non-Executive Director. It was noted that AA was in attendance deputising for SLB.

95/18 **DECLARATION OF INTERESTS**

There were no new declarations of interest.

96/18 **MINUTES OF THE PREVIOUS MEETING HELD ON 6 SEPTEMBER 2018**

PS observed that the second paragraph of the patient experience story where it referenced 'would have been more easily managed' should read 'could have'.

There were no other comments.

The Board **APPROVED** the minutes of the previous meeting held on 6 September 2018.

97/18 **MATTERS ARISING FROM THE MINUTES ON 6 SEPTEMBER 2018**

The Chair reported that updates had been provided on all the actions and that these had been closed.

NM enquired whether there was any update following the workshop held on the report from the Care Quality Commission (CQC) and the action plan that had been produced. SSm stated that the purpose of the workshop had been to review the 'must do' actions, which had been facilitated by the Trust's Head of Transformation. A further workshop had been held regarding the departmental audits and the ward audits. The Improvement Plan was being finalised, this had been shared with the NHS Improvement (NHSI) Improvement Director and would be submitted to the CQC the following week.

Concerning the patient story that had been presented at the previous Board meeting, SSm reported that she and PS had been in contact with Mr White. An invitation had been extended for Mr White to meet with some of the Trust complaints staff, around improving the complaints process for staff to see and understand the distress and impact on the patient experience when the Trust does not respond in a timely manner to complaints. Mr White had been seen by the Respiratory and Gastroenterology Consultants following outpatient appointments.

The Board **NOTED** the updates provided on the actions.

98/18 **CHAIR'S REPORT**

The Chair reported that the CQC had carried out their inspection and that the Trust had been rated as 'requires improvement'. The Trust needed to implement improvements to achieve a 'good' rating in the next inspection, which would require a cultural change in the Trust. The Board was committed to improving its services provided to patients and implementing the changes required to improve the CQC

rating. It was important to note that all the Trust's hospitals had, been rated 'good' for 'caring'. A range of improvement programmes would be put in place, that would also include an Away Day involving all the Executive Directors, Non-Executive Directors and the new Clinical Directors of the Care Groups.

The Chair commented that the Trust was taking forward 'Listening into Action', which was a very effective tool. The Trust now undertook a range of site visits undertaken by the Executive Directors, Non-Executive Directors and Governors, and responses were now available to the issues raised at these visits. AF stated that it had taken time to gather the responses and that the information regarding these visits had been circulated to the Board and Governors. The Executive Management Team will be presented with reports on the outcomes of the visits and the actions required, these will also be shared and discussed at the next Council of Governors' meeting.

JO noted the research and innovation conference that had recently been held, and emphasised the importance of recognising the successful research undertaken across the Trust. 2,400 patients would be recruited to clinical trials for the year.

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

99/18 **CHIEF EXECUTIVE'S REPORT**

SAc reported that the Trust had gone live with the new Allscripts Patient Administration System (PAS). There had been no major issues during the implementation period and the Trust was working through some common issues that were expected with new systems. Allscripts had been responsive to issues raised and were working closely with the Trust. The Director of ICT would be presenting at a future Finance and Performance Committee (FPC) on the implementation of PAS.

The Sustainability and Transformation Partnership (STP) had made a recommendation for three hyper acute stroke units in Kent, in Ashford, Dartford and Maidstone. The formal decision would be taken by the joint committee of the Clinical Commissioning Groups (CCGs) in January 2019. It had also been recommended that a decision was made around the consolidation of vascular services into a single arterial centre and Canterbury was recommended. This decision will also be made in January as there was material patient benefits.

SAc had attended the NHS Employers Policy Board and an NHS Confederation System Architecture round table event the previous month.

The Trust had successfully secured £6.42m national funding to create more space in the EDs at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQMH) for the provision of new observation wards.

The Transformation and Improvement Group would be the main focus of all the improvement work of the Trust that will now include financial improvement.

Development of 2gether Support Solutions as a wholly owned subsidiary of the Trust was now complete and all the relevant staff had now been transferred. Interviews for the Chair would be taking place shortly.

JO enquired about short-term changes to forecast targets for national constitutional standards. SAc commented that this was being discussed, as it was considered by some that the 4 hour A&E target was not the right target, as emphasis needed to be on patient outcomes. There was increased focus around the cancer targets, and achieving these would require a shift in the Trust's diagnostic capacity as well as sharing of resources.

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

100/18 **PATIENT EXPERIENCE STORY**

This item was deferred to a future Board meeting.

101/18 **MEDICAL DIRECTOR'S REPORT**

Infection prevention and control continued to be an area of concern, particularly healthcare associated infections. The Trust's MSSA bacteraemia rate is below the regional average. The Trust is continuing with actions to address C. difficile infection (CDI) and improvements are around good anti-microbial stewardship. PS commented that achieving the CDI trajectory for the current year was dependent on continuous good anti-microbial stewardship and appropriate measures were in place to reduce the number of reported cases.

PS confirmed that routine environmental audits were undertaken and that the Trust regularly carries out culture swabs in different areas. Specialised cleaning processes were undertaken when necessary. The required cleaning programmes were in place and these were not a contributing factor to the number of CDI cases. SSm emphasised that immediate action was taken if any issues were identified following the routine inspection audits.

Included in the report was a section explaining what rebasing Hospital Standardised Mortality Ratio (HSMR) meant. This had resulted in a significant difference in the reported HSMR in the Integrated Performance Report (IPR) presented this month compared to the previous month's figure. He emphasised that the HSMR was not drastically increasing drastically as it appeared.

JO observed that there was an increase in reported incidents of e.coli and enquired whether this was an area of concern within the wider community. PS commented that there was increased community focus to address and reduce the incidence rates.

SAc emphasised the need to identify in future reports the Trust's number of Methicillin-resistant Staphylococcus aureus (MRSA) cases and those that were avoidable and unavoidable.

ACTION: Figures to be provided in future Medical Director's report on the number of MRSA cases along with those that were avoidable and unavoidable. PS

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

102/18 **QUALITY COMMITTEE – CHAIR REPORT**

- **INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2017/18**
- **QUARTERLY QUALITY STRATEGY REPORT**
- **COMPLAINTS UPDATE**

NM enquired about the deterioration in performance against the 4 hour A&E standard. LM reported that there was a direct correlation between bed occupancy, super-stranded and stranded patients in relation to the performance in the ED. The discharge levels were not as high as they should be and the Trust was working on improving its discharge plans. Work was also being taken forward with partners around improving community capacity to facilitate discharging patients that do not need to be in hospital. As well as on-going work around the frailty pathway.

LM stated that the Trust was working on its winter plan that was progressing well to ensure that robust plans were in place, discussions concerning integration were on-going.

PS noted that the Infection Prevention and Control Annual Report had been presented at the Quality Committee and Patient Safety Board and was recommended for Board approval.

The Board:

i) discussed and **APPROVED** the Quality Committee Chair Report;

ii) **NOTED** the Quarterly Quality Strategy Report;

iii) **NOTED** the complaints update;

iv) **APPROVED** the Infection Prevention and Control Annual Report 2017/18.

103/18 **FINANCE AND PERFORMANCE COMMITTEE (FPC) – CHAIR REPORT**

SA reported that in relation to the Cost Improvement Programme (CIP) the Trust was reporting £25.8m green schemes.

Good progress has been made around improving the performance in ED and other National Constitutional Standards in relation to access targets and a comprehensive improvement programme is in place. The Trust is awaiting formal feedback from NHS Improvement (NHSI) around defining a financial special measures (FSM) exit strategy.

SRe observed that a business case without an affordability statement was not a business case. PC emphasised the need to consider the measures that needed to be put in place to deliver the financial plan when producing business cases.

SA emphasised the importance of focussing on the run rate and ensuring a steady reduction.

JO enquired whether there were any barriers to implementing the frailty patient pathway model. LM reported that there had been a meeting held recently and main issue was around clarify whether joint contracts could be done for both frailty practitioners and clinical leads. There was an STP frailty document. The biggest concern was trying to clarify whether joint contracts could be done for both frailty practitioners and clinical leads. SAc observed that a crucial issue was the impediments caused by the organisations. PS explained that delivering the concept that it was possible to do a huge amount of what was done to people who needed to be in bed but not necessarily in a Trust's bed was an impediment. It was not the case that all resources could be shifted from acute to community, and there would be some overlap.

NM observed that page 3 in the report noted that medical staff in urgent care and long-term conditions were above establishment, and asked the reasons for this. PC explained that the number of middle-grade doctors had increased but that the budget had not kept pace with this increase, the numbers of whole time equivalents at the middle-grades provided a safe service. Contracts had been negotiated with the Commissioners to fund the appropriate number of whole time equivalent middle-grades.

The Board discussed and **APPROVED** the FPC Chair Report.

104/18 **CORPORATE REPORTING**

- **INTEGRATED PERFORMANCE REPORT (IPR)**

SSm reported that the Trust remained positive in relation to its falls rate, the harm-free care metric had now returned to positive, and work was underway to improve staffing recruitment.

SSm reported that complaint response times were green, the number of former complaints had reduced but the number of Patient Advice and Liaison Service (PALS) queries had increased. The Deputy Chief Nurse was reviewing the long standing complaints and the actions required to be addressed to resolve and close these complaints. Vacancies in the patient experience team are being recruited to.

Concerning compliance with the A&E four-hour wait standard, LM noted that the trajectory was based on a number of internal and external improvements, which would be agreed through the Emergency Department (ED) Improvement Board. Work was also being undertaken to address stranded and super-stranded patients around improving patient flow and performance. There was an issue around the lack of space in the EDs that had been built to accommodate around 120 patients per day, but on average received 250 patients. Building works would commence to address this and provide observation areas.

PS reported that performance in medicine safety was good.

ACTION: Number of complaints and the acknowledgement and response times to be included in the complaints information in the IPR. SSm

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

105/18 **CHARITABLE FUNDS COMMITTEE – CHAIR REPORT**

KP provided an update on the Charitable Funds Committee for the Board to note the applications for grants that had been approved. Three grants required approval from the Board. . The Board noted the benefits to patients in approving the funding for the provision of equipment.

The Committee also received a verbal briefing on2tgether Support Solutions in relation to the transfer of assets. It was confirmed that there would be no change in terms of the operation of the equipment.

A prioritisation plan and charity funding plan had been presented and approved. This included a split of the charitable funds, £1m for medical equipment, £300,000 for estates and £200,000 for staff and wellbeing. This would decrease the charity funds to £1.5m.

The Board:

i) discussed and **NOTED** the CFC Chair Report;

ii) **APPROVED** the funding of MRI compatible ventilator £31k, patient monitor £60k and infusion pump £22k;

iii) **APPROVED** as set out in the Prioritisation Plan and Charity Funding Plan, for the charitable funds to be split, £1m for medical equipment, £300k for estates and £200k for staff and wellbeing.

106/18 **ANY OTHER BUSINESS**

There were no other items of business raised for discussion.

107/18 **QUESTIONS FROM THE PUBLIC**

Mr Smith asked a question regarding the use of antibiotics. The Trust was 13% below their target and expressed concern about the Trust's response in relation to sepsis and its inclusion in the Medical Director's report. PS responded that, concerning sepsis, the Trust had met the targets for screening and provision of treatment. He agreed about the overuse of broad spectrum antibiotics, and stated that a mobile guide was available with clear guidance on the correct specific antibiotic for each infection. It was possible to report on the number of sepsis cases but emphasised that there might be inaccuracies in the numbers as this was dependent on clinical coding of the patient notes and sepsis recording.

ACTION: Look at reporting the numbers of sepsis cases in future Medical Director's reports. PS

Mrs Whorwell recalled an example of a physically disabled patient following a stroke had been admitted to the William Harvey Hospital who had communicated to a nurse that was treating them that they were causing them pain, but the nurse had dismissed her comment. The patient had insisted that they were in pain, and the nurse provided no apology. She highlighted the importance around the language used when treating patients as well as acknowledging the need for patients to be

treated with respect and dignity. The patient had not reported her concerns as was worried that her treatment might be adversely affected as a result.

ACTION: Ensure the message is disseminated to all the nursing teams reiterating that all staff must work to the Trust's values and treat patients with respect, compassion and dignity. SSm

Mrs Cole expressed concern with regards to elderly patients being kept at Queen Elizabeth the Queen Mother Hospital in Margate and at William Harvey Hospital in Ashford. This was in relation to the services being moved from the Kent and Canterbury Hospital and that patients would be transferred closer to home when their health improved. This was especially concerning given the poor transport facilities and relatives and friends being able to travel to visit patients. SAc commented that the issue was around some patients who were in hospital beds and awaiting the provision of community care in care homes before they could be discharged.

Mrs Cole observed an issue with the choose-and-book system for orthopaedic outpatient appointments as three weeks had passed and had still not received a date for her appointment. The Board considered the issue described and that this might be because the process had had manual intervention. The Chief Operating Officer would have a discussion with Mrs Cole following the Board meeting.

The Chair closed the meeting at 12.10 pm.

Date of next meeting in public: Thursday 1 November 2018 in the Boardroom, William Harvey Hospital, Ashford

Signature _____

Date _____

EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING – 1 NOVEMBER 2018

ACTION POINTS FROM THE PUBLIC MEETING OF THE BOARD OF DIRECTORS MEETING HELD ON 4 OCTOBER 2018

ACTION NUMBER	DATE OF MEETING	MINUTE NUMBER	ACTION DESCRIPTION	LEAD	DUE BY	PROGRESS
B/007/18	04.10.18	101/18 Medical Director's Report	Figures to be provided in future Medical Director's report on the number of MRSA cases along with those that were avoidable and unavoidable	PS	November 2018	This data will be provided in the Integrated Performance Report (IPR) commentary in future. **Action closed.**
B/008/18	04.10.18	104/18 Integrated Performance Report (IPR)	Number of complaints and the acknowledgement and response times to be included in the complaints information in the IPR.	SSm	November 2018	Included in the narrative. The Information Team have been asked if the data can be provided as a Statistical Process Control (SPC) in the main body and this is being worked on. **Action closed.**
B/009/18	04.10.18	107/18 Questions from the Public	Look at reporting the numbers of sepsis cases in future Medical Director's reports.	PS	November 2018	This will be made more explicit, is already included in the Summary Hospital Mortality Indicator (SHMI) data. This is six months in arrears because SHMI also includes all deaths that occur within 30 days of hospital admission. **Action closed.**
B/010/18	04.10.18	107/18 Questions from the Public	Ensure the message is disseminated to all the nursing teams reiterating that all staff must work to the Trust's values and treat patients with respect, compassion and dignity	SSm	November 2018	Taken through the Heads of Nursing meeting and Matron and Ward Manager meetings. **Action closed.**

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Major Trauma

Dr Natasha Newton FRCA
Trauma Director EKHUFT

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What is Major Trauma?

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M25 coach crash: Dozens injured, three seriously

13 August 2018 Share

A total of 41 people were taken to hospital after the coach overturned at the Swanley junction

Dozens of passengers have been taken to hospital - three with serious injuries - after the coach they were travelling in overturned on the M25.

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Canterbury street attack leaves man with fractured skull

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By KentOnline reporter **multimediadesk@thekmgroup.co.uk**

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Published: 15:10, 20 October 2018 | **Updated:** 15:12, 20 October 2018

A man's skull and cheek were fractured in a street attack in the middle of the afternoon.

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Police investigating death of six week old baby from Broadstairs

August 9, 2018 Kathy Bailes News 0

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Her devastated family demanded an investigation that revealed crucial blunders on a short-staffed ward

SHARE

By Martin Fricker
00:00, 11 JUL 2013 | UPDATED 01:41, 11 JUL 2013

NEWS

We care

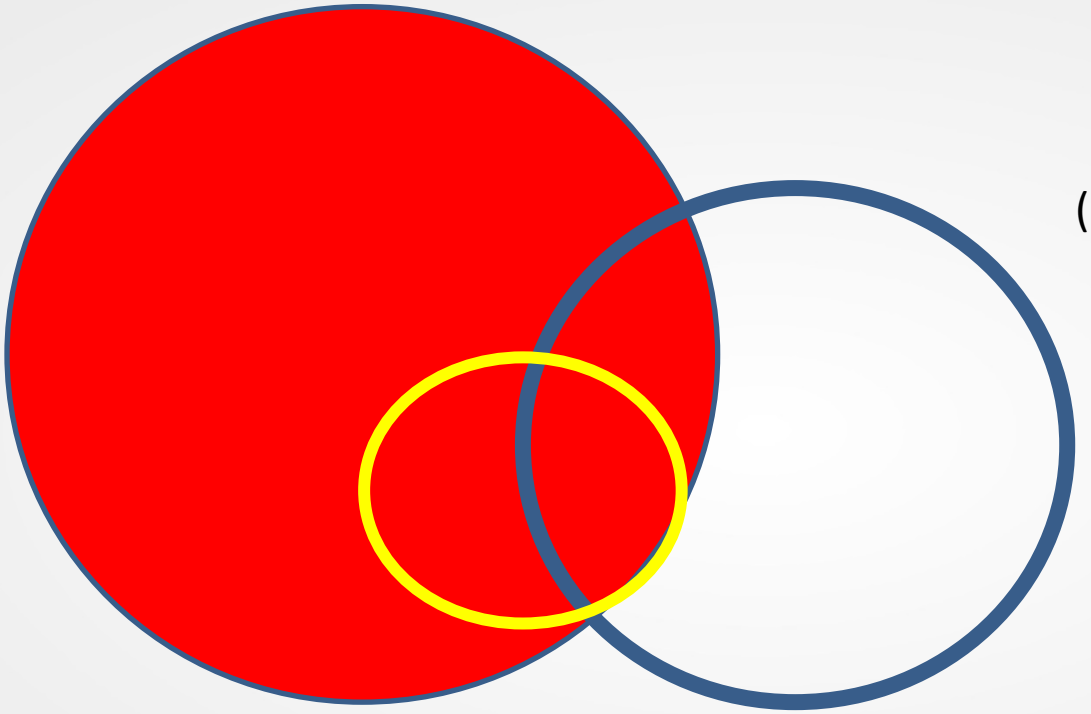
‘Trauma Audit and Research Network (TARN) positive’ Major Trauma (MT)

- 1,200 MT patients per annum across EKHUFT
- 170-230 “Severely injured”
- Around 20 die
  - Deaths:
    - over 70 years
    - 1 in 8 chance death was trauma called
    - 1in16 chance death transferred to King’s College Hospital NHS Foundation Trust

ISS>15 (‘Big sick’)

- All 200 high ISS patients (live and dead)
  - 11% trauma called
  - 54% William Harvey Hospital (WHH)
  - 37% admitted to Queen Elizabeth the Queen Mother Hospital (QEQMH)
  - 9% admitted to Kent & Canterbury Hospital (K&CH)
  - Damage Control Surgery (DCS) patient every 6 weeks
  - ISS > 15 patient every 3 days
  - Dacryocystorhinostomy (DCR) patient every 12-24 hours

90-130 Trauma calls a month at WHH, 6-11 at QEQMH



170-230 TARN positive (ISS>15 patients) across the Trust per annum

Around 10% transferred out or onward referral

Trauma service reputation

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Top trauma network

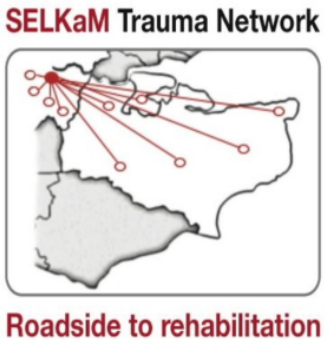
03 May 2017

South East London, Kent and Medway (SELKaM) Major Trauma Network has best survival rates in the country.

SELKaM – the Major Trauma Network that covers south east London and Kent – has been rated the best performing in the country. Performance is measured on survival rates of patients who have been cared for by the service. The SELKaM Network has been the best performing in the country since its launch in April 2014.

12 hospitals are part of the network including King's College Hospital, Princess Royal University Hospital (PRUH), and St Thomas'. King's College Hospital is the hub Major Trauma Centre for the SELKaM trauma network, which serves a population of 5.5 million people across south east London and Kent.

Mr Rob Bentley, SELKaM Network Director and Consultant Cranio-Oral and Maxillofacial Surgeon at King's College Hospital, said:



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National standards

East Kent Hospitals University NHS Foundation Trust

- NHS England Trauma Quality Improvement Network System (TQUiNs)
- PanLondon Criteria
- Annual Peer Review

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Team Trauma

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- Lead Nurse Trauma and Resuscitation
- Operations Manager
- Trauma Audit and Research Co-Ordinator
- Matron
- Emergency Department (ED) consultants
- Consultant Anaesthetics
- Consultant Trauma & Orthopaedic and Consultant General Surgery

- And many, many more

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Challenges

NATIONAL

- Elderly trauma
- Advanced Trauma Life Support (ATLS)

EKHUFT

- QEQMH & MT misconceptions
- Best practice tariff
- Essential & Mandatory Training

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Great saves - cases

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One ask

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Thank you

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REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**CHAIR'S REPORT**
BOARD SPONSOR:	**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;
- To bring any other significant items to note to the Board's attention.

NHS Providers Annual Conference and Exhibition 2018

I attended the annual conference of NHS Providers on 9 October in Manchester, which was attended by NHS Trust Leaders and Stakeholders. This year's event focussed on how providers are adapting and changing as the NHS moves towards integrated health and care systems. Along with exploring the shift to local system working and collaboration around improving care for the public and efficiency. The event provided an opportunity to discuss the latest issues within the NHS sector as well as receiving presentations from expert lead speakers. A keynote address was provided by NHS England's Chief Executive on the key priorities for the health and care system over the next decade that is outlined in his vision for the future. The work of the providers was recognised around continuing to deliver outstanding patient care.

The day included consideration of what the priorities for the long-term plan should be around maintaining performance and transforming services. An interesting panel session was held exploring inclusion and diversity in NHS leadership.

EKHUFT's Medical Forum

I attended the Trust's Medical Forum on 16 October in Canterbury that was opened by the Trust's Medical Director, and closed with a speech from the Trust's Chief Executive. A presentation was provided by the Foundation Dean of the Kent and Medway Medical School (KMMS) updating the forum on progress with the Medical School.

The Care Group Clinical Directors presented on the 3 to 5 year strategies of the new Care Groups around the new structure for EKHUFT being a clinically led organisation. A question and answer session was led by the T3 Clinical Leads regarding electronic patient records and where the Trust is with the T3 programme.

Chairs' and Chief Executives' Induction Day

I attended an interactive event run by NHS Improvement on 16 October in London. This event provided an opportunity to meet peers across the Country and receive presentations from Senior NHS Leaders. A range of topics were covered which included; working within the regulatory environment; working with NHS Improvement and NHS England; system wide leadership and the role of Chairs and Chief Executives; and looking to the future.

Brain Injury Multi-Disciplinary Conference

The ninth East Kent brain injury conference was held on 12 October in the Kent and Canterbury Hospital Education Centre, which was chaired by the Trust's Consultant Physician in Neuro-rehabilitation Medicine/Director of Neuro-rehabilitation Service/Chair of Kent Brain Injury Forum. The event was opened and attendees were welcomed by the Lord Mayor of Canterbury, EKHUFT's Chief Executive, the MP for Canterbury, and the Dean of Kent Health at the University of Kent.

Keynote lectures were provided at the event, which covered:

- Neuro-modulation research in Canterbury from the Kent University Professor for Neuropsychology;
- Professional Virtues in Modern Medicine from the Professor for Philosophy at Warwick University;
- Sight loss as a consequence of traumatic brain injury and mental health implications from the Head of Research and Innovation from the Blind Veterans Charity;
- Service characteristics and resource needs of specialist neuro-rehabilitation units from the South Warwickshire NHS Foundation Trust's Clinical Director and Consultant Physician in Neuro-Rehabilitation;
- Assistive Devices for empowering DisAbled People through robotic Technologies from the Chief Investigator of the ADAPT research project;
- Norwegian Psychomotor Physiotherapy;
- A presentation from the Consultant Clinical and Research Neuro-Physiotherapist on the balance of rehabilitation using robotic walking devices for people living with multiple sclerosis;
- Functional electrical stimulation for foot drop;
- Behavioural disorders secondary to traumatic brain injury from the Lead Clinician for Neuro-Psychiatry Services;
- A Presentation from the EKHUFT's Director of Research and Innovation on where the Trust is with its Research and Innovation (R&I) as well as future R&I opportunities;
- A talk from the Chief Investigator of EDUCAT research project regarding EDUCAT – Empowerment of disabled people through the user co-production of assistive technology;
- An update regarding Deprivation of Liberty;
- A talk from a representative of the Kent Brain Injury Forum.

This was a hugely successful event and was attended by eminent speakers from the UK, Norway and France. The conference provided the opportunity of showcasing the Trust's Specialist Neuro-rehabilitation Service in this Region that provides a good clinical service within the provision of a 19 bedded inpatient facility. The Trust recognises and extends its thanks to the staff for their hard work and commitment, as whilst pursing their day to day clinical work they also undertake world class research and innovation work.

Visits

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

Chairman	9 October - NHS Providers Annual Conference and Exhibition, Manchester 11 October – Clinical Strategy Away-Day, Canterbury 22 October – K&CH Visit to Audiology Department 30 October - Kent and Medway Foundation Trust (FT) Governors Conference, Detling
Non-Executive Directors	8 October – Consultant Anaesthetist/Chronic Pain/Intensivist Interview Panel 18 October – Consultant Haematologist with a Special Interest in Haemato-Oncology Interview Panel

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

Chief Executive	4 October – K&CH Higher Specialist Trainees Induction 9 October – WHH Ward Buddying, Cambridge L Ward 9 October – WHH Team Talk 9 October – WHH Staff Forum 11 October – K&CH Team Talk 12 October – K&CH Welcome Statement - 9th Brain Injury Multi-Disciplinary Conference 12 October – QEQMH Team Talk 12 October – QEQMH Ward Buddying, Day Surgery 15 October - Trust Induction, Canterbury 16 October - Medical Forum, Cathedral Lodge, Canterbury 18 October – WHH A&E Delivery Board Meeting 24 October - Paediatric Occupational Therapy Service Parent & Child Bike Group, Ashford Oaks Primary School 24 October – WHH Healthcare of Older People (HCOOP) Business Meeting, Multi-Site 24 October – WHH A&E Liaison Meeting 26 October – WHH GIRFT Visit for Endocrinology
Director of Strategic Development and Capital Planning/ Deputy Chief Executive	2 October – K&CH Joint Site Visit to Outpatients, Pharmacy, Post Room, Medical Physics and League of Friends (LoF) 12 October – QEQMH Staff Forum 19 October - QEQMH Walk the site and Meet Staff in Theatres and Bishopstone Ward 22 October – WHH Ward Buddying on Oxford Ward
Medical Director	5 October – Quality Review, including QEQMH ward visits 12 October – QEQMH Nutrition Round 16 October – Medical Forum with Consultants 18 October – Surgery for Medics – topics and updates session 22 October – Visit to the Electronic Medical Equipment (EME) and Medical Equipment Library 26 October – Endocrinology Getting it Right First Time (GIRFT) Visit 26 October – QEQMH Nutrition Round 30 October – QEQMH General Visit 31 October – Dentistry GIRFT Visit

Chief Nurse and Director of Quality	3 October – WHH ED Walk Around 5 October – K&CH Care Quality Commission (CQC) Quality Review 12 October – QEQMH Ward Visits 12 October – QEQMH October Team Talk 12 October – QEQMH Staff Forum 18 October – WHH Neonatal Intensive Care Unit (NICU) Visit 22 October – WHH Ward Visits 22 October – WHH Schwartz Round 26 October – K&CH Ward Visits 30 October – K&CH Ward Visits
Director of Finance and Performance	26 September – QEQMH Ward Buddying on Cheerful Sparrows Ward (Make/Female) 11 October – BHD Team Talk 16 October – RVHF Team Talk 18 October – WHH Ward Buddying on Richard Stevens Ward 26 October – K&CH Ward Buddying on Marlowe Ward
Chief Operating Officer	QEQM – Weekly Walk the Floor across all the Inpatient Wards and the Emergency Department (ED) WHH – Weekly Walk the Floor in ED K&CH – Weekly Walk the Floor in the Out Patients Department (OPD)

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

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**CHIEF EXECUTIVE'S REPORT**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**ASSISTANT TRUST SECRETARY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

This month's report covers the following:

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

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

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

RECOMMENDATIONS AND ACTION REQUIRED:

To discuss and note the report.

CHIEF EXECUTIVE'S REPORT

1 CEO / Trust Activity

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

1.1 The Prime Minister announced, in March, the development of a 10-year plan for the NHS. I attended a meeting to hear from the Secretary of State and the heads of NHS Improvement and NHS England their points of emphasis on the development of the long term plan. There were key messages regarding a five year revenue settlement, front loaded for the first year, although with an acknowledgement of pressures in terms of pay and high cost drug spend. There is a 1.1% productivity gain needed, improved performance, better use of capital and a plan to return to financial balance as a basis for planning. The Medical Directors' priorities are to be in cancer, respiratory, cardiovascular disease and young children. Whilst people are dying less from these diseases and dying more from things like dementia, there are still the diseases where the causes are clearly understood and where action could reduce prevalence. On the financial side, the messages at the meeting were about changes to the national tariff with money going from provider sustainability fund (PSF) to support the urgent emergency care (UEC) tariff; changes in market forces factor (MFF). In summary, I heard staff, communities, money and quality of care.

1.2 This month I had the pleasure of attending the National Association of Primary Care Conference to give a talk. I used the relationship our clinicians have in Margate to illustrate that breaking down the barriers between primary and secondary care is better for patients and can be much more positive for Multi-Disciplinary Teams (MDTs). Apart from giving a talk, I also learned far more about primary care networks and hubs than I had done locally and it was very positive and informative.

1.3 Several of the Executive Team attended the Trust's Medical Forum of consultants where we had the pleasure and benefit of hearing from Professor Chris Holland, the Dean of the new Kent and Medway Medical School. It was useful to hear the timetable and the emphasis of the curriculum. We also heard from our new Clinical Directors who briefly set out their thoughts on what they wanted to achieve of behalf of their care groups and why they had stepped forward to take the new roles. And, lastly, we heard from Mr Milan Thomas regarding the future benefits of the electronic patient record which is central to our transformation programme T3.

1.4 I would like to take the opportunity of heralding the Kent and Medway Care Record (KMCR) to the Board to continue the IT theme. An outline business case has been developed and site visits have taken place, attended by a variety of clinicians from all organisations in Kent. The next stage of the journey is to go to the market with the tender requirements. The aim of the development is to create a web based solution linking all organisations (clinical and care staff) who provide care to citizens in Kent. The aim is to provide up to date, accurate and relevant information to clinical and care staff wherever they see the patient or have legitimate contact with them. There are many very good solutions now available and many counties are ahead of us now, giving the opportunity for very useful site visits for clinicians to really see what is available.

1.5 Lastly, we continue with our Listening into Action work with key events coming up for ten teams to take forward their improvement ideas. The Deputy CEO will be able to tell the Board of her own involvement in this and to outline the next key events.

2 Trust Seal Activity

2.1 The following describes Trust Seal Activity since my last report to the Board.

- Asset Transfer Agreement 2Gether.
- Operated Healthcare Facilities Agreement 2Gether.
- Estates Management Services Agreement 2Gether.
- Service Cover Agreement 2Gether.
- Kent and Canterbury Premium Lease 2Gether.
- Kent and Canterbury Rent Lease 2Gether.
- William Harvey Premium Lease 2Gether.
- QEQM Premium Lease 2Gether.
- QEQM Rent Lease 2Gether.
- RVH Lease 2Gether.
- Buckland Lease 2Gether.
- Loan Agreement 2Gether.
- Debenture 2Gether.
- Contract between EKHUFT and Medline Industries Limited (Guarantee) Supply of Theatre Consumables.
- Contract Between EKHUFT and Intuitive Surgical (Guarantee) Consumables Davinci Robot.

3 Publications and Policy Developments of Note

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

Susan Acott
Chief Executive

APPENDIX 1

LATEST PUBLICATIONS / RESOURCES

LATEST NHSI PUBLICATIONS

Developing a digital career framework
Across the NHS, pioneering nurses and AHPs are moving into clinical informatics, both in new, groundbreaking roles and by leading the implementation of innovative digital health and care systems as part of their existing roles.
https://improvement.nhs.uk/resources/developing-clinically-focused-digital-workforce/

Data on patient safety incident reporting and how we use incident reports to improve safety
NHSI published their **latest bi-annual official statistics on patient safety incidents** reported to the National Reporting and Learning System (NRLS) by each NHS trust between October 2017 and March 2018, and national patterns and trends on incident reporting between April 2017 and March 2018.
To show how we use these reports to identify and address 'under-recognised' safety issues between October 2017 and March 2018, NHSI also published their **fourth patient safety review and response report**.

Pathology Networks
Since last year NHSI has been working with trusts on the network strategy, using the data we collected to construct the most comprehensive picture of NHS pathology services across the country. Analysis showed there is unwarranted variation in how NHS pathology services are delivered to patients because of how they are organised.

Model Hospital new look and feel now live
NHSI launched the **new look and feel of the Model Hospital**, which includes new features and designs produced in collaboration with NHSI's user community.

Amendment to the medical agency price caps
NHSI has amended the **medical agency price caps** in line with the recently approved pay rise for medical staff. This ensures continued compliance with the **Agency Worker Regulations** and the change applies to those staff on medical contracts (pay groups).

Have your say on the national tariff proposals 2019
This week NHSI published **proposals for the 2019 national tariff**, and have invited feedback. The proposals include a change of the default way of paying for urgent and emergency care (moving away from episodic prices), recalculated market forces factor values and options for how the tariff might be used to fund the new NHS supply chain organisation.

More than words – spoken communication in the NHS
NHSI commissioned a working group to provide a better understanding of issues surrounding both good and poor spoken communication of safety critical information.
NHSI published **a summary of the group's findings** and the six key areas identified as presenting challenges to spoken communication, as well as the group's report.

Wholly owned subsidiaries
NHSI is consulting on proposals to change the way we approve and trusts report subsidiary companies. This will enable us to ensure only business cases that create value for the sector proceed, whilst continuing to respect NHS freedoms and innovation.
Views by Friday 16 November.

Apply for the NHS Energy Efficiency Fund for LED lighting
The government has made £46 million available for trusts to improve and expand the use of LED lighting across your services, to save the NHS money and provide a better-quality experience for patients, staff and visitors. The funding can help you reduce your electricity use, cut your energy bills and deliver the **Carter recommendations**. Sign up for our upcoming webinar to find out more. **Applications by 12pm on Friday 30 November.**

Ward leader's handbook
Directors of nursing can use NHSI's **new handbook** to support local development programmes aimed at improving the leadership skills of nurses working in wards irrespective of the setting. Individual ward leaders can use this handbook as part of their professional development discussions.

Stop the Pressure: updated definition and measurement framework
Following feedback from trusts, we have updated our **pressure ulcer definition and measurement recommendations**.
Directors of nursing, please share this with your tissue viability teams, safety teams and any other relevant groups to ensure they are using the latest version.

New emergency care video series
Hear about good emergency care practice in health and care teams with **our new series of videos**, which cover:

- embracing risk and enabling patient choice
- frailty
- acute assessment
- emergency department streaming
- clinical decision units
- board rounds

UPDATES FROM OTHER KEY PARTNER ORGANISATIONS:

The Homelessness Reduction Act 2017 – new duty to refer
From 1 October various bodies will need to ask any individual you think may be homeless, or threatened with homelessness, if they would like to be referred to a Local Housing Authority. The referral must include an individual's contact details, consent, and the agreed reason for the referral. Housing authorities are responsible for setting up local procedures for managing referrals, and have been asked by the Ministry of Housing, Communities and Local Government to work with their partners on the protocols and procedures that will help to make new referral arrangements effective. Local Authority partners will advise of local arrangements are in place to meet requirements **set out in this policy factsheet**.

NHS Providers/NHS Confederation
Survey into the role of non-executive directors (NEDs)
Henley Business School is conducting a survey supported by NHS Providers and NHS Confederation looking into the role of NEDs in the NHS. Both executive and non-executive board members will be able to provide invaluable insight into the challenges of being a non-executive director in the NHS today, which will help to shape the role of NEDs in the future. **Board members — complete the short survey now.**

Professional Record Standards Body (PRSB)
New training videos for completing e-discharge summaries
Ahead of the **upcoming NHS England deadline for implementing e-discharge summaries**, the PRSB has released two new educational videos for clinicians to explain how they should be completed. The videos (**an introduction** and) support plans to get trusts to start sharing discharge summaries digitally by the end of the year.

Lord Carter's report on ambulance services' operational productivity
The **report**, published last week, found if more patients are treated at the scene by paramedics, or better assessed over the phone when dialling 999 (avoiding the need for an ambulance when it is safe to do so), the NHS could treat patients closer to home and reduce unnecessary pressure on emergency departments and hospital beds. Offering safe and quicker care could save the NHS £300 million a year by 2021, with a further £200 million of savings through improvements in ambulance trusts infrastructure and staff productivity.

New Model Ambulance compartments on the Model Hospital
To help you deliver the recommendations of Lord Carter's report, we also released **Model Ambulance compartments on the Model Hospital** to help trusts identify opportunities to improve efficiency. The new version of the Model Hospital tool, now including Model Ambulance, is easier to use and has been produced in collaboration with trusts. It now features bespoke productivity opportunities, clear comprehensive metrics and new support articles, videos and tips.

ACT2improve interactive improvement tools
These new tools include digital versions of the sustainability model, process templates and stakeholder analysis – and offer a quicker, digital way to process your data. The tools are fully interactive, and you can collaborate on projects across organisations and share the results with others in your project group.

NHS England/Specialist Pharmacy Service
Doctors encouraged to use biosimilar versions of adalimumab to help save the NHS £150 million
Doctors are now **being asked to consider equally effective and safe biosimilar versions of adalimumab** (brand name Humira®) after the patent on the drug expired yesterday (Tuesday 16 October). Biosimilar versions of adalimumab are expected to be available to NHS patients from December this year and could help save the NHS at least £150 million per year by 2021. Find out how you can implement the use of biosimilars using the **implementation toolkit**.

Home Office
Plans to test EU Settlement Scheme
The Home Office last week announced plans to test the **EU Settlement Scheme** with all health and social care workers. This means EU citizens working in the health or care sector will have early access to the scheme before it is rolled out more widely in 2019. NHS Employers will be working with NHSI, the Department of Health and Social Care and the Home Office to produce and disseminate communication materials to help support colleagues who need to register for the scheme. The scheme does not open until Thursday 29 November, but it is vital to start preparing now by both identifying those staff who need to register and ensuring they are aware.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**MEDICAL DIRECTOR'S REPORT**
BOARD SPONSOR:	**MEDICAL DIRECTOR**
PAPER AUTHOR:	**MEDICAL DIRECTOR**
PURPOSE:	**DISCUSSION**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

This report encompasses the following areas:

1. **Kent and Medway Medical School**

   Professor Chris Holland, the inaugural Dean of the Kent & Medway Medical School (KMMS), attended the East Kent Medical Forum on the 16 October. He gave over 100 of the Trust's doctors an overview of the progress and future aspirations for the Medical School and a flavour for how they could become involved in the Medical School in the future.

2. **Medicines Safety**

   The Board has received regular updates concerning medicines safety through the Quality Committee. Although key aspects such as missed doses of critical medicines have significantly improved further improvement in all areas of medicines safety is required and an overarching risk will be brought through to the corporate risk register to reflect this.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	**Risks:** 1. Patient safety risks from poor safety culture (medicines safety incidents). **Actions:** 1. Continued campaigns to highlight and sustainably embed medicines safety practices across the organisation.
LINKS TO STRATEGIC OBJECTIVES:	**Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR 2 - Failure to maintain the quality and standards of patient care
RESOURCE IMPLICATIONS:	None

COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Quality Committee

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report, and to consider the merits of introduction of its own Academic Advisory Group as the Kent and Medway Medical School develops and takes shape.

1. Kent & Medway Medical School (KMMS)

   Currently KMMS remains on course to welcome the first 100 medical students in September 2020. The curriculum will follow the Brighton Medical School curriculum and will complete with the award of Bachelor of Medicine and Bachelor of Surgery degrees following a 5 year programme. There will be opportunities for students to undertake an intercalated Masters degree at year 3 and Professor Holland is exploring opportunities for quality improvement projects linked to quality improvement training (following the IHI model) in year 4. He is also exploring the possibility of an intercalated PhD programme.

   Part of the reason for making the KMMS course look as attractive as possible is that until the first students qualify the school will not be fully accredited. The other key factor is that the evidence clearly shows that Medical Schools that acknowledge and provide a research base from the outset perform better than those who either do not or who provide a research base later in their genesis.

   There is an aim to recruit students from the Kent & Medway population. KMMS are deliberating on where the bar should be set in terms of academic credentials of applicants and wish to work with further education providers to provide 'access to medicine' courses for those who might not have had the correct academic opportunities during their secondary education. For example access to GCE advanced level chemistry which is thought to be difficult in some areas of Kent.

   As the School develops KMMS will have to pass a number of General Medical Council (GMC) checks and as part of that process EKHUFT, together with all the other stakeholders, has supplied a 'capacity and services' checklist. The purpose of this is both to list what educational areas we can provide for students but also to sense check capacity in the context of both new medical students and existing medical students. A key part of the GMC assessment will be to ensure that existing medical student education is not destabilised.

   The curriculum itself introduces skills for clinical practice in the first 2 years (a major change from conventional curriculae) and patient contact through primary care and community placements is also introduced in the first 2 years together with the foundations of health and disease and the more conventional essential classroom based teaching. In years 3-5 the students come into the acute hospitals but will also retain some community and primary care experience to ensure integrated practice. During these years they will also cover the scientific basis of medicine, clinical pharmacology and therapeutics, specialist rotations, public health medicine and regional attachments. Another change from the conventional curriculae is that the students will undertake their finals before undertaking elective placements and their preparation for practice (essentially a 6+ week period of shadowing foundation doctors).

   An important hurdle for KMMS and the 2 Universities to overcome is the lack of underpinning capital or set up funding for this round of new Medical Schools which makes it essential to draw on the strengths of the 2 universities as KMMS progresses.

Whilst we as a provider of medical education have obvious advantages through the breadth of the educational opportunities we can provide, together with documented and acknowledged quality of that education, we have certain basic areas to address and improve upon such as student accommodation. There will be opportunities for our educators to join the KMMS faculty and Professor Holland envisages joint appointments in both education and research as the faculty develops. As a minimum any of our doctors becoming involved will be required to have a Certificate in Postgraduate education and for those looking to fill leadership posts in the school KMMS will be expecting a Masters in Medical Education.

Professor Holland has developed a Clinical Advisory Group which consists of Directors of Medical Education, Medical Directors and undergraduate administrators from all stakeholders. He has also established a student advisory group from the 2 universities and from Brighton and is in the process of establishing an academic advisory group drawn from the relevant faculties of the 2 local Universities.

Our responsibility, together with other providers of education in Kent & Medway, is to provide a great experience for our students to encourage them to remain local following graduation as doctors.

2. Medicines Safety

The support services risk register has consistently identified 4 issues relating to medicines safety: missed doses, inadequate systems of medicines management, staff not consistently demonstrating sufficient skills or competencies in the use of medicines which may give rise to errors, and related to this, that inpatient diabetic patients are being put at risk from insufficient knowledge and unsafe management of patients on insulin.

The Medicines Safety Group developed an action plan to mitigate the risk of missed doses of medicines following the appointment of a medicines safety officer in 2017. Since then the patient safety thermometer audits have demonstrated that missed doses of critical medicines have come down from over 20% to 7.1% and missed doses of medicines from 35% to 18.8%. Both of those need to continue to improve, for comparison national averages for missed critical doses is 6% and for missed doses 9.1%, but we should be looking to take ours well below the national average performance.

An illustration of the risks engendered by the issues identified is that in the last month there have been 125 medicines incidents reported on the Datix system. To put these in perspective 125 incidents represents 0.04% of all patient drug administrations during that time period. However, of these, 65/125 incidents involved either the wrong drug, wrong dose, wrong frequency or lack of clarity regarding dose or strength. 51 incidents were no harm, 13 low harm and 1 moderate harm. There are also themes within these 125 incidents that map to the issues above, 12 incidents involved either insulin or oral hypoglycaemic drugs and 11 incidents involved anticoagulants. This reflects national data too, figures from the National Diabetes Inpatient Audit (NaDIA) 2017 show that 40 per cent of people with Type 1 diabetes and 37 per cent of people with Type 2 diabetes treated with insulin had an insulin error while in hospital. The CQC have suggested that medicines safety is one of the canaries in the patient safety coalmine.

The issue of Medicines Safety has been highlighted to the Quality Committee and a full report detailing the actions being undertaken to mitigate the associated risks and the metrics to enable monitoring of the mitigation has been requested. An overarching risk will be escalated to the corporate risk register to reflect the concerns.

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**QUALITY COMMITTEE (QC) CHAIR REPORT**
BOARD SPONSOR:	**CHAIR OF THE QUALITY COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE QUALITY COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

The following provides feedback from the October 2018 Quality Committee meeting. The report seeks to answer the following questions in relation to the quality and safety performance:

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

MEETING HELD ON 23 OCTOBER 2018

1. The following went well over the period:

1.1 The Committee received and discussed a highlight report on the National Constitutional Standards for Emergency Departments (EDs), Referral to Treatment (RTT), Cancer and Diagnostics including an update on month 6 operational performance and activity. The Committee noted the following key areas:

1.1.1 The introduction of the new Patient Administration System (PAS) was well managed through a robust project management structure. It was acknowledged that it will take staff longer to become familiar with the new processes and information screens.

1.1.2 The Trust continues to work on implementing the ED improvement plan as well as maintaining health economy focus, and progressing the frailty pathway and upskilling staff and staff training.

1.1.3 During September performance against the A&E 4 hour target was 77.1% against the NHSI trajectory of 85.4%, which was a 3% decrease in performance compared to the previous month. There were no 12 hour trolley waits in month.

1.1.4 The Trust is focussing on patients who have a length of stay more than 21 days so that they can be discharged to their own home with the support they need.

1.1.5 Performance reported in September against the Referral to Treatment (RTT) standard of 76.27% against a trajectory of 81.32%. Improvement actions are in place as per plan.

1.1.6 Cancer performance in September reported at 77.05% against the improvement trajectory of 62.76%. We are reporting a reduction in

patients waiting greater than 104 days this month and this is now down to 8 patients.

1.1.7 In relation to the DMO1 Diagnostics standard, this was not met in month with an actual compliance of 98.53% against a trajectory of 99.1%. This was an expected result and maps to the pressures engendered by an improvement in cancer waiting list performance.

1.1.8 Actions continue to be implemented to improve the DMO1 standard, these include focussed activity to recruiting to respiratory technician posts.

1.1.9 Following the implementation of the new Care Group structure and the appointment of the leadership teams, training will be provided to ensure staff understanding of the national constitutional targets, delivery and implementation plans and escalations.

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

1.2.1 The Committee took assurance from the progress updates around mitigation of the risks. A number of risks had been updated on the same date and the Committee requested that this be looked into and a briefing provided on the reasons for this. The Committee noted:

1.2.1.1 Risk CRR16: Poor Complaints management, the residual risk score has been increased to reflect the number of long delays in complaint management and staff shortages.

1.2.1.2 Risk CRR40: Lack of robust antenatal and new-born screening programmes, the residual risk has been reduced as the likelihood has lessened and there has been no harm to date.

1.2.1.3 There have been two target scores changed. Risk CRR 41: Failure to manage patients with challenging behaviour (Dementia and other mental health challenges), has decreased from 9 (moderate) to 6 (low). Risk CRR 31: Exposure to Cyber Security Attacks, has increased from 2 (very low) to 3 (very low).

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

2. Concerns highlighted over the reporting period:

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

2.1.1 The Committee noted that there had been an infection control incident in the Neonatal Intensive Care Unit (NICU) at William Harvey Hospital (WHH) which necessitated a temporary closure of NICU earlier in the month. Immediate actions were taken and the Committee have requested a briefing report to provide further assurance from the Estates team that this risk is being dealt with appropriately around the replacement of these utility provisions.

2.1.2 The Committee noted that medicines safety remained an issue and requested a report to be presented at the next meeting on the improvement plan for missed doses. There is focussed work in place around improving the prescription and administration of insulin. A Getting it Right First Time (GIRFT) visit will take place later this month to review diabetes, which will support improvement.

2.1.3 The number of StEIS report breaches has been reduced from 21 to two, and these last two will be cleared shortly.

3. Other topics discussed:

3.1 The Committee received and discussed a Clinical Quality and Patient Safety Report, which included the patient safety metrics, and monthly complaints and compliments. The Committee noted:

3.1.1 That the number of C. Diff remains above the Department of Health trajectory. We are in receipt of an external review that was undertaken to sense check our own internal actions are sufficient to improve the trajectory and ensure these recommendations are implemented.

3.1.2 The Trust is undertaking a review of its complaints procedures in liaison with a local Acute Trust to share learning and best practice, and make step change improvements to the way we prioritise complaints and the length of time they are open.

3.1.3 The Friends and Family Test (FFT) inpatient satisfaction rate remains positive at 97%.

3.1.4 The ratio of compliments to complaints is positive.

3.1.5 There has been positive progress made in reducing the number of complaints which have been open for more than 60 working days, and the new Care Groups are on track to achieve the required reduction by mid November 2018.

3.1.6 The Patient Advice and Liaison Service (PALS) have achieved being able to take "live" PALS calls to improve patient experience and to prevent accruing delay and backlog at the beginning of the PALS process.

3.1.7 In relation to other Healthcare Associated Infection (HCAI):

3.1.7.1 E Coli bacteraemia recorded post 48 hours, remains green.

3.1.7.2 HCAI monitoring continues to be overseen by the Infection prevention and control team.

3.1.8 Grade 2 Pressure ulcers reported green and there were no grade 3 or 4 pressure ulcers reported in September.

3.1.9 There were no never events reported in month.

3.1.10 Overall Harm Free Care (HFC) related to the Harms patients are admitted with, as well as those they acquire in our care. The Safety Thermometer continues to register green for new harms in September.

3.1.11 Overall Patient Experience reported green in September reporting 90.1%, which is a recovering performance since August and is now reporting on the lower control limit.

3.1.12 In relation to mixed sex accommodation (MSA) breaches fell below control limits in September for the first time within the rolling year. The Trust continues to aim to improve patient experience of MSA by achieving 30% reduction in mixed sex breaches by March 2019; and 70% reduction by December 2019. Current performance is on track to achieve this required improvement.

3.1.13 Venous Thromboembolism (VTE) risk assessment, despite the improved position reported over the year 2017/18, Trust performance for VTE risk assessment remains red reporting 90.2 % in September (compared with 93.1% in August) against a national target of 95%. Recovery actions are in place and are being overseen by the Patient Safety Board.

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

3.2.1 The Group received and discussed the Patient involvement Action Plan, this provided reassurance that the plan is on track.

3.3 The Committee received and noted a report from The National Institute of

Clinical Excellence (NICE)/Clinical Audit and Effectiveness Committee (CAEC).

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

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

3.4.1 The Committee noted the improvement programme that has been put in place.

3.4.2 A Board workshop will be held in late November to review and discuss the improvement plan and journey around what needs to be done and embedded within the organisation to achieve getting to a rating of 'good' by the next CQC inspection. There will also be agreement regarding the assurances required to monitor improvement progress, and what metrics and areas of quality the Board needs to be sighted on and receive assurance to ensure traction and pace of improvement.

3.4.3 This report provided the Quality Committee with an update on the CQC improvement plan and associated assurance activity.

3.4.4 The Committee noted key points around the CQC improvement plan:

3.4.4.1 The Improvement Plan was submitted to the CQC on 8 October 2018.

3.4.4.2 The Trust's risk management system 4Action is being updated with all the actions, of which these will be assigned to Care Group representatives and other leads across the organisation. Action leads will be required to maintain progress against their actions, and updates will be received through the agreed governance process.

3.4.4.3 A two year improvement journey is being developed to ensure a rating of 'good' at the next inspection.

3.4.4.4 The Trust undertook a Routine Quality Review on 5 October 2018. Feedback was shared at a Trust-wide collaboration session held in the afternoon of the visit.

3.5 The Committee received and discussed an Infection Prevention and Control Quarter 2 Report. The Committee noted the key points highlighted:

3.5.1 The number of *C. difficile* cases for July to September was 11, an increase compared to Q2 the previous year of 8 cases), and is one above the Department of Health (DH) trajectory.

3.5.2 Methicillin Resistant *Staphylococcus aureus* acute Trust assigned blood stream infections remained at 2 with no further cases in Q2.

3.5.3 Methicillin Sensitive *Staphylococcus aureus* remain largely community based infections. However, in Q2 there were 3 intravenous line related cases and root cause analyses are being undertaken.

3.5.4 E. coli blood stream infections continue to increase in line with national trends, although Q2 figures for 2018/19 show a slight decrease in post 48 hour cases.

3.6 The Committee discussed and noted a report regarding Quality Impact Assessments (QIAs). These are completed for every clinical cost improvement programme (CIP) proposal submitted as a saving scheme, outlining the proposal and assesses it for risk. The Committee noted:

3.6.1 Every QIA is required to be approved by the Medical Director and Chief Nurse & Director of Quality prior to implementation. Should a scheme be turned down on quality and/or safety grounds, it will be referred back to the Head of the Programme Management Office (PMO).

3.6.2 The Committee was assured of the processes in place and that all schemes are risk assessed using a robust risk assessment tool prior to the implementation of the scheme.

3.6.3 No adverse events have been reported with any scheme that has passed the QIA process.

3.6.4 There is a rolling monitoring process of all CIPs being implemented.

3.7 The Committee received and noted an update report on the NICE and Clinical Audit and Effectiveness Committee.

3.7.1 This Committee had not met since the last Quality Committee meeting due to operational and conflicting commitments of attendees. The Committee was assured of the importance of these meetings be held and that a date was scheduled for a meeting to be held on 13 November.

3.7.2 This is a newly constituted committee and represents the amalgamation of the NICE Implementation and Clinical Audit and Effectiveness Committees. The membership, new terms of reference (ToR) and work plan had been presented for sign off but the changes to both meeting structures and the organisational structure to new Care Group has meant that the ToR require minor revisions, which will be presented to the new membership for sign off.

3.8 The Committee received and discussed a report regarding Safe Systems for Controlled Drugs (CD), and approved the Annual Assurance Report 2017/18.

3.8.1 The report provided assurance that CDs are being handled and managed safely and securely in the organisation.

3.8.2 The CD Policy has been revised as part of the Trust Medicines Policy review, which has been approved by the Drug and Therapeutics Committee and is being presented to the Policy and Procedures Group for approval.

3.8.3 The role of the Medication Safety Officer has been recruited to and the member of staff was now in post. This role is key in supporting the delivery around monitoring and improvement of CD management processes.

3.8.4 The Committee supported the Controlled Drugs Accountable Officer (CDAO) in relation to the project to pilot dedicated staffing resource for CD management, which will strengthen the support for the CDAO in delivering improvement in CD Management and surveillance systems.

3.8.5 The Committee agreed the implementation measures recommended by the CDAO to improve adherence to NICE CD Guidelines NG46.

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

RECOMMENDATIONS AND ACTION REQUIRED:

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

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**REPORT FROM THE STRATEGIC WORKFORCE COMMITTEE (SWC)**
BOARD SPONSOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE STRATEGIC WORKFORCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1 – WORKFORCE RACE EQUALITY STANDARD (WRES) ACTION PLAN** **APPENDIX 2 – OUR CARE STRATEGY**

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 August 2018 meeting.

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

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

MEETING HELD ON 9 OCTOBER 2018

1. Issues from August 2018 Integrated Performance Report (IPR) – Workforce Key Performance Indicators (KPIs) were discussed:

   1.1 The staff turnover rate in month decreased to 12.1%, and the 12 month average remains the same as the previous 12 months at 13.5%.
   1.2 The Trust remains focussed on hard to recruit roles to replace agency, as well as identifying new ways and methods of attracting to hard to recruit roles.
   1.3 Exit interviews and data continues to be constantly reviewed and analysed to highlight any areas of concern and regular reports are provided to the SWC. It was agreed that the top six reasons for leaving would be investigated further.
   1.4 There is an increase in the vacancy rate to 12.6% for the average of the last 12 months, which is higher than last year.
   1.5 The Trust is undertaking more work to target hard to fill vacancies, particularly within nursing and some medical specialties.
   1.6 The Human Resources (HR) Team is working hard with the Care Groups around the recruitment plan to ensure this process is as smooth and coherent as possible, as well as identifying new ways and methods of recruitment in a more timely way, along with exploring different workforce models.
   1.7 All HR metrics are reviewed and challenged at a Care Group level in the monthly Executive Performance Reviews (EPR).
   1.8 There has been a reduction in the sickness rate at 3.9% for the 12 month average.
   1.9 There was a slight reduction in the average percentage of employed staff vs temporary staff over the last 12 months at 88.4%, against 88.6% the previous month.
   1.10 The percentage of agency staffing of Whole Time Equivalent (WTE) remains at high levels compared to the beginning of the year, with a slight increase in the 12 months average at 6.8% of WTE, against 6.7% the previous month. Whilst current expenditure is above the

control limit, the Trust remains focussed on reducing agency costs and also focussed on recruiting substantively to reduce the use of agency. Agency costs are monitored weekly at the agency meetings and monthly at the EPRs. The Committee was assured around the recruitment of staff to posts within the wards and the Emergency Department (ED) including new wards ready for the winter.

1.11 The Clinical Strategy is being developed for East Kent which will change our on-going workforce requirements. Our workforce plan is being developed in conjunction with the Clinical Strategy to reflect emerging demands.

1.12 Compliance of staff completing statutory training has increased to 90% for the 12 month average.

1.13 There has been a reduction in the percentage rate of staff with appraisal in date to 77.9% for the 12 month average.

1.14 There has been a positive improvement in the average time taken to recruit to a new role of 14 weeks.

The Committee received the following reports and assurances:

2. Staff Turnover Report: Quarter 1
This report was received and discussed and the following noted.

2.1 The total turnover of 12.36% is lower than the 2017/18 year-end position of 12.77%.

2.2 Premature turnover of 20.8% remains equivalent to the previous year's average.

2.3 The total number of leavers per calendar month (pcm) at 55.86 is significantly less than last year's at 68.36.

2.4 This year the Trust has had more joiners than leavers to date, with a net gain of 74 WTEs.

2.5 Currently nursing turnover is 5% better than last year, at 25% for 2017/18 and 20% for 2018/19. 2.6 Turnover in nursing staff and Healthcare Assistants (HCAs) in particular is still high and plans are in place to address this.

2.7 The areas with the highest nursing turnover is in Urgent Care & Long Term Conditions (UC&LTCs) at 41%, and Surgical Services at 32%.

2.8 Surgical Services has the highest premature turnover at 28%.

2.9 Healthcare Assistants represent the largest leaver and premature leaver group.

2.10 The Committee noted the net loss of 1 WTE nurses in 2018/19 and a net gain of 58 WTE Healthcare Assistants.

2.11 The data for Q1 shows that turnover is stabilising.

2.12 It is anticipated that there will be a slight rise in staff turnover in Q2 due to the TUPE of staff to 2.13 2gether Support Solutions.

2.14 A Corporate Retention Group is proposed to be established that will consist of corporate and clinical stakeholders to address focussed work on nurse retention.

3. Clinical Excellence Awards (CEAs): Review of process and application of protected characteristics. This report was received and discussed and the following noted.

3.1 The Trust published its bonus gap for 31 April 2017 (prior to the latest round of CEAs) in line with the Equality Act 2010, as mean at 25.8% and median at 33.3%. This Act requires public sector organisations employing more than 250 people to publish on its public-facing website and report to the Government the organisation's pay gap.

3.2 The report covered the process and outcomes of the latest round of CEAs with a focus on ethnicity and gender.

3.3 The Committee noted the outcomes with regards to gender and ethnicity.

3.4 The Trust will explore why proportionally fewer female Consultants apply.

3.5 The Trust will consider ways to encourage female Consultants to apply.

3.6 The Trust will explore why proportionally fewer Consultants from BAME backgrounds apply.

3.7 The Trust will consider ways to encourage Consultants from BAME backgrounds to apply.

3.8 The Trust will carry out a comparison review of applications from Consultants from BAME backgrounds to identify the areas where they were unsuccessful.

3.9 The Trust will look at providing coaching on application completion.

3.10 All Local Award Committee (LAC) members will attend Unconscious Bias Training before sitting in assessment.

4. Tribunal Activity and Settlements Report:
   4.1 This report was received and discussed, which covered the period 1 April 2018 to 20 September 2018.
   4.2 The Trust has received 2 new tribunal claims as well as 2 potential tribunal claims.
   4.3 There has been no settlements and no redundancies.

5. Statutory and Essential Training. This report was received and discussed.

   5.1 Statutory training compliance continues to be reported monthly by the Care Groups.
   5.2 Consideration was given to amalgamating the different categories of training to encourage greater compliance. However, it was determined that the categories of statutory and essential training should be properly differentiated in order to maintain our legal responsibilities for statutory reporting.
   5.3 There has been a continuous improvement in statutory training compliance since September 2017, particularly in UC&LTCs and Surgical Services.
   5.4 In August 2018 the average statutory training compliance was at 91%, which was above the compliance target.
   5.5 The Trust was recognised nationally by the Electronic Staff Record (ESR) team as one of the top ten Trusts for e-learning completions, with 4,102 e-learning completions in Q1.
   5.6 The Trust is a 'fast follower' for the Doctors in Training (DiT) National Streamlining Project aiming to improve the experience of all junior doctors.
   5.7 There have been delays in implementing some essential training improvements, e.g. compliance reporting for resuscitation, due to increased workload within the HR Systems Team and a change of the ESR reporting tool. It is anticipated that the required changes in ESR should be complete in time for the April 2019 launch.
   5.8 A number of areas for improvement regarding statutory training were identified in the Care Quality Commission (CQC) inspection report from May 2018, which included:

      5.8.1 the Trust MUST take action to ensure all staff providing direct care and treatment to children and young people and vulnerable adults receive safeguarding level three training in line with national intercollegiate guidance and Trust policy; and
      5.8.2 the service MUST ensure doctors are up to date with mandatory training including child safeguarding training in the Emergency Department (ED).

      The Trust is currently developing additional actions to address these findings by the CQC.

6 Workforce Race Equality Standard (WRES) Action Plan. This report was received and discussed and the following noted.

   6.1 The WRES came into existence in April 2015. The NHS Standard Contract requires all NHS Provider organisations to have submitted WRES data by 10 August 2018 and publish its WRES report and action plan by 28 September.
   6.2 The 2017/18 WRES report is attached for information and noting (Appendix 1), which demonstrates that there are opportunities for the Trust to develop and improve, it is able to demonstrate some improvement over the last three years.
   6.3 The Committee noted there were nine indicators comparing BAME with White staff at the Trust:

      6.3.1 three metrics showing significant improvement;
      6.3.2 five Metrics with no significant change; and
      6.3.3 An increase in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public for both BAME and White staff.

   An action plan has been produced to address local and Trust wide issues that have been

identified by a deeper dive into the data, this is included in the WRES report.

7. Occupational Health (OH) and Wellbeing Activity Report. This report was received and discussed and the following noted.

7.1. The Committee discussed and noted the activity of the OH and Wellbeing Service in relation to KPIs regarding pre-employment screening, sickness absence referrals and other staff health metrics.

7.2 OH now had a revised role in Datix incident management enabling the reporting of key staff health and wellbeing incidents to the SWC.

7.3 Work Health Questionnaires (WHQ) screened within 2 working days at 95%, and a total of 544 WHQs were screened.

7.4 There were a total of 21 medical pre-employment appointments, which are offered when additional health checks are required to assess fitness for post.

7.5 Management Referral Forms screened within 2 working days at 95%, with a total of 405 received to date and there is a significant increase for Q1 against the same quarter for the previous year.

7.6 The highest cause of stress related referrals during Q1 related to work and work & home.

7.7 For the period April 2018 to June 2018, 7% of the workforce were referred to OH for sickness absence.

7.8 A total of 52 sharps injuries were managed by OH for the period April 2018 to June 2018.

7.9 There had been 148 Did Not Attends (DNAs) during Q1 and the approximate costs of these were £8,496.

7.10 The average waiting time for appointment has been impacted as a result of the high level of DNAs and cancellations as well as the increase in the volume of WHQ and management referrals submitted to the OH Service. The average waiting time for appointment with an OH Doctor is 10 days at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQMH), and 5 days at Kent & Canterbury Hospital (K&CH); for an OH Nurse is 20 days for all three hospitals.

7.11 The number of new staff seen for one to one stress management support during Q1 was 24, with a 3 month waiting list for this one to one support.

7.12 During Q1 there were five two day adult Mental Health First Aid courses run at K&CH, WHH and Buckland Hospital Dover, with a total of 57 staff who attended that included the Chief Nurse.

7.13 The OH Service has provided three group mindfulness training sessions at WHH, providing an opportunity for 36 Trust employees in high pressure areas to benefit from this training. The OH Service will be evaluating the impact of these sessions and if positive, aims to continue to roll this out across the Trust.

7.14 The OH Service will continue to provide the Pedometer Challenge (10,000 steps per day) that has proved to be a great successful health and wellbeing initiative, the uptake for the challenge in July was 30 teams with a total of 255 participants. The results overall were that the teams walked 74,087,703 steps equating to 31,368 miles, with an average steps per individual of 13,639. The first place team walked 28,989 steps each team member every day.

7.15 The seasonal flu planning for 2018/19 is well underway around working to achieve the Commissioning for Quality and Innovation target of 75% for clinical staff uptake, with the Communications Team taking forward and promoting the seasonal flu programme.

7.16 The Trust's Intranet provides details on a wide range of free and confidential self-referral counselling services across Kent for Trust staff.

7.17 No formal complaints were received during Q1.

8. Our Care Strategy

In August the Committee discussed and noted the Our Care Strategy for Nursing, Midwifery, Allied Health Professionals (AHP) and Care Givers 2018 to 2020. Attached (Appendix 2) for information.

The following was noted.

8.1 This Care Strategy offers the SWC with a framework for managing and providing safe staffing in a sustainable way for now and the future.

8.2 The NHS has seen a reduction of nursing registrants and the pool of overseas nurses is also reducing and changes to the way nurse training is funded is creating pressure. Our Trust has additional challenges with recruiting staff, some geographical being on a peninsula, but also due to our proximity to London. In response to this there is a robust Trust wide plan with actions in place to ensure we attract, retain, develop and create a sustainable workforce.

8.3 This Strategy outlines the Trust's approach to ensuring a sustainable workforce of the future. It describes a blended approach that is not profession dependent. This means that EKHUFT will use its workforce according to their skill set and competency, mapped to the needs of our patients.

8.4 The Trust's current challenges includes; vacancies, an ageing workforce, retention, reducing its agency spend, and the development of integrated working across the health economy.

8.5 This Strategy embraces new ways of working and the development and implementation of new roles.

8.6 This also underpins EKHUFT's ambition in its framework to deliver person-centred, safe, effective harm free care and provide a positive experience of care which exceeds expectations.

9 Integrated Education, Training and Leadership Development Board (IETLDB).

The Committee noted the report from the IETLDB along with the minutes. The forthcoming programme of Leadership Development for Clinical Directors and senior leadership teams within Care Groups was confirmed. It was agreed that the Deputy Medical Director would consider the wider clinical leadership development needs at the varying levels of the organisation.

10 Diversity and Inclusion Steering Group.

The Committee noted the report from the Steering Group and the confirmed minutes.

11 Joint Chairs of Staff Committee

The Committee noted the report from the Joint Chairs of Staff Committee.

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and accept the report from the Strategic Workforce Committee for approval.

WORKFORCE RACE EQUALITY STANDARD (WRES) AND ACTION PLAN

BACKGROUND AND EXECUTIVE SUMMARY

The WRES came into being in April 2015.

The NHS Standard Contract requires all NHS provider organisations to submit WRES data this year by 10 August, publish WRES report and action plan by 28 September.

The attached 2017/18 Report demonstrates that whilst there is room for EKHUFT to develop and improve we able to demonstrate some improvement over the last three years.

There are nine indicators comparing BAME with White Staff at EKHUFT

- 3 Metrics showing significant improvement;
- 5 Metrics with no significant change;
- Increase in Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public for both BAME and White staff.

The Trust has now produced a WRES Action Plan to address those local and trust wide issues identified by a deeper dive into the data.

Appendix A is the WRES report for EKHUFT. NHS England requires each Trust to publish a report in a specific format before the end of September 2018.

Contents

Workforce Race Equality Standard

1 Introduction

1.1 The Workforce Race Equality Standard (WRES) has been in place for three years, the main aims are:

- To improve workplace experiences and employment opportunities for Black Asian & Minority Ethnic (BAME) people in the NHS
- The WRES also applies to BAME people who want to work in the NHS. This can be achieved by taking positive action to help address race equalities in the application process.

1.2 The Equality Diversity Council (EDC NHS) prioritised the development of the WRES to tackle race equalities - the WRES was identified as the best means to achieve this by helping the NHS to improve by:

- BAME representation at Senior Management and Board level.
- To provide better working environments for the BAME workforce.

1.3 The WRES is a tool to identify gaps between BAME & White staff experiences in the workplace this is measured through a set of Metrics. Closing the gaps will achieve:

- Tangible progress in tackling discrimination
- Promoting a positive culture.
- Valuing all staff for their contribution to the NHS

1.4 This will provide an environment in the NHS whereby all staff are valued and supported across its entire diverse workforce. The result will be high quality patient care and improved health outcomes for all.

2 NHS Standard Contract

2.1 The 2018/19 NHS Standard Contract includes the WRES, which requires all NHS providers of NHS services to start to address the issue. It states at Service condition 13:

> *"The provider must implement the national Workforce Race Equality Standard and submit an annual report to the co-ordinating commissioner on its progress implementing the standard."*

2.2 The Care Quality Commission (CQC) will also consider the WRES in their assessments of how "Well Led" NHS providers are.

3 Business Benefits to the Trust

3.1 Simon Stevens said that,

> *"We want an NHS of the people, by the people, for the people. That's because care is far more likely to meet the needs of patients we are here to serve when NHS Leadership is drawn from diverse communities."*

3.2 There are numerous benefits for the Trust through the implementation of the WRES – which all make good business sense:

- Recruitment – this would open up access to a young BAME labour market.
- Would add value to the Trust as a "diverse employer", raising

awareness of different cultures, traditions and religious beliefs. Which in turn would provide greater understanding when delivering patient care, particularly in relation to dignity and respect.

- This would enhance and empower mutual respect from all staff and from our communities.
- The WRES will demonstrate our commitment as a Trust to deliver a diverse workforce, representative of the communities we serve.
- It would demonstrate to our own BAME staff the Trust commitment to ensure staff are treated equitably and appropriately free from discriminatory practices.
- The WRES will provide a transparency of what the Trust is delivering and evidence to prove progress.

4 Legal Duties

The Trust needs to fulfil legal duties regarding Protected Characteristics as detailed in the Equality Act 2010 in particular relating to the General Equality Duty as follows:

4.1 Eliminate unlawful discrimination, harassment and victimisation

The Trust has in place policies and process to eliminate discrimination and harassment of all staff and continues to take legal responsibility for all Protected Characteristics.

4.2 Advance equality of opportunity between different groups.

To mitigate risk the Trust may want to consider developing a baseline assessment of current resources and initiatives for all staff support across Protected Characteristics.

4.3 Foster good relations between different groups

- Reduce any negative impact by positive market communication. It is critical to make sure staff teams are engaged ~~and~~ understand the rationale and see the value of the work.
- Clarity about what positive action is, it's not about giving BAME staff an unfair advantage but addressing inequalities.

5 Metrics

The method of measuring progress and action plans is through nine WRES metrics which cover the following areas:

1. Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:
    i. Non-Clinical staff
    ii. Clinical staff - of which
        1. Non-Medical staff
        2. Medical and Dental staff
2. Relative likelihood of staff being appointed from shortlisting across all posts.
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.
4. Relative likelihood of staff accessing non-mandatory training and CPD.
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6. Percentage believing that trust provides equal opportunities for career progression or promotion.
7. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
8. In the last 12 months have you personally experienced discrimination at work from Manager/team leader or other colleagues
9. Percentage difference between the organisations' Board membership and its overall workforce disaggregated:
    i. By voting membership of the Board
    ii. By executive membership of the Board

6 Conclusion

East Kent Hospitals has already successfully submitted their WRES indicator data via the Strategic Data Collection Service (SDCS) system at 10:33 on 2 August 2018

Organisations should use the WRES Reporting Template to publish their annual WRES data on their websites, alongside their WRES action plans Appendix A is the EKHUFT annual WRES data formatted onto the WRES Reporting Template and Action Plan

The Clinical Commissioning Groups (CCGs) Improvement and Assessment Framework also requires CCGs to give assurance to NHS England that their providers are implementing and using the WRES. Implementing the WRES and working on its results and subsequent action plans should be a part of contract monitoring and negotiation between CCGs and their respective providers.

In addition, the completed WRES reporting template must be shared with the lead commissioner and CCGs.

7 Appendix A - Workforce Race Equality Standard Report 2018 and Action plan

1. **Name of organisation:** East Kent Hospitals University NHS Foundation Trust

2. **Date of report:** 5 September 2018

3. **Name and title of Board lead for the Workforce Race Equality Standard:**
   Sandra Le Blanc, Director Human Resources

4. **Name and contact details of lead manager compiling this report:**
   Bruce Campion-Smith, Head of Diversity and Inclusion,
   bruce.campion-smith@nhs.net
   01227 864077,
   07826890938

5. **Names of commissioners this report has been sent to:**
   Ashford CCG,
   Canterbury and Coastal CCG,
   Dartford, Gravesham And Swanley CCG,
   NHS Medway CCG,
   West Kent CCG,
   South Kent Coast CCG,
   Thanet CCG,

6. **Name and contact details of co-ordinating commissioner this report has been sent to**
   Co-ordinating Commissioner for the East Kent CCG Contract:
   Simon Perks,
   Accountable Officer
   NHS Canterbury and Coastal Clinical Commissioning Group

7. **Unique URL link on which this Report and associated Action Plan will be found:**
   http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/diversity-and-inclusion/

8. **This report has been signed off by on behalf of the Board on:**
   Sandra Le Blanc, Director of Human Resources
   24 September 2018

Background narrative:

9. **Any issues of completeness of data:**
   86.82% of our staff have declared their ethnicity compared with 85.00% last year.

10. Any matters relating to reliability of comparisons with previous years:
None

Self reporting

11. Total numbers of staff employed within this organisation at the date of the report
2017 - 7904 2018 – 7854

12. Proportion of BME staff employed within this organisation at the date of the report
2017 - 14.31% 2018 - 14.87%

13. The proportion of total staff who have self–reported their ethnicity
2017 - 85.00% 2018 - 86.82%

14. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity
Our people portal provides easier access to the Electronic Staff Record Self Service Feature. Staff are able to access and submit Protected Characteristic Data.

15. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity
None

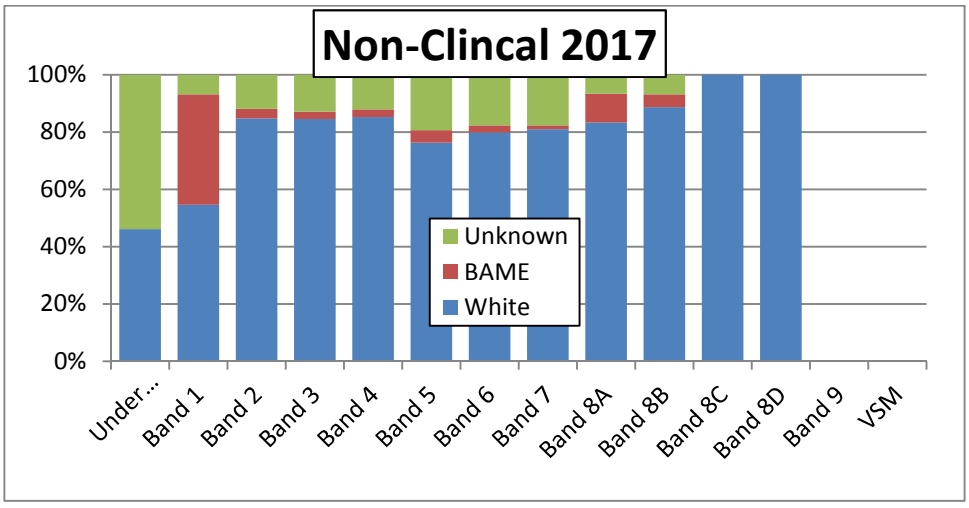
Workforce data

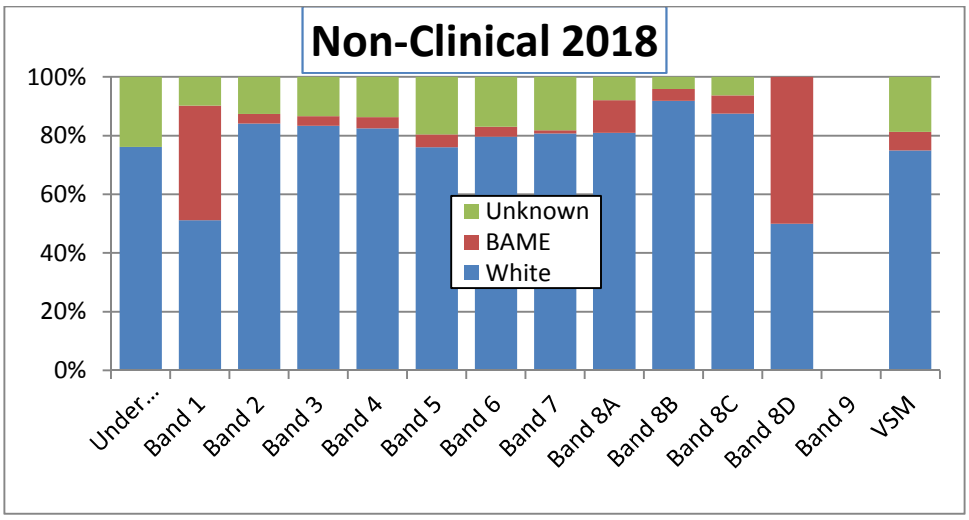
16. What period does the organisation's workforce data refer to?
01 April 2017 – 31 March 2018

17. The Workforce Race Equality Standard Indicators
WRES Indicator 1 - compare the data for white and BME staff:

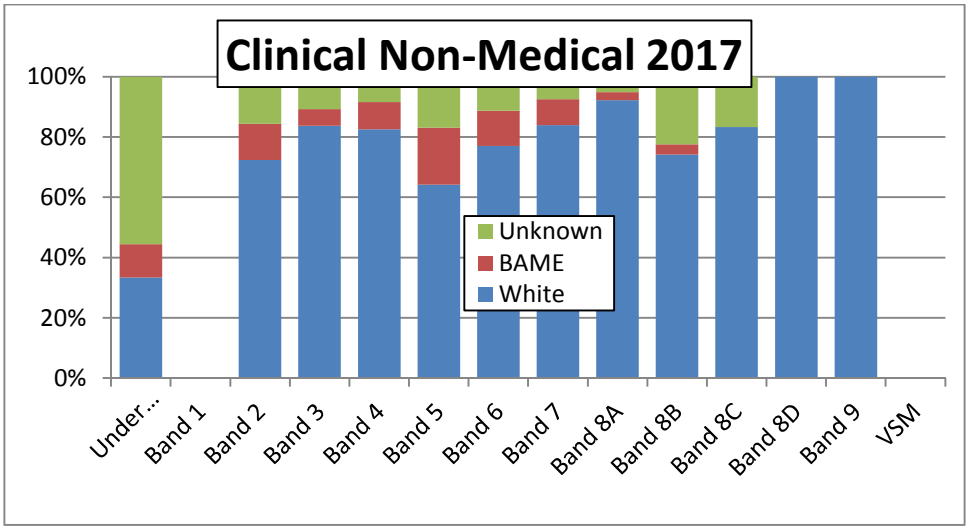
Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

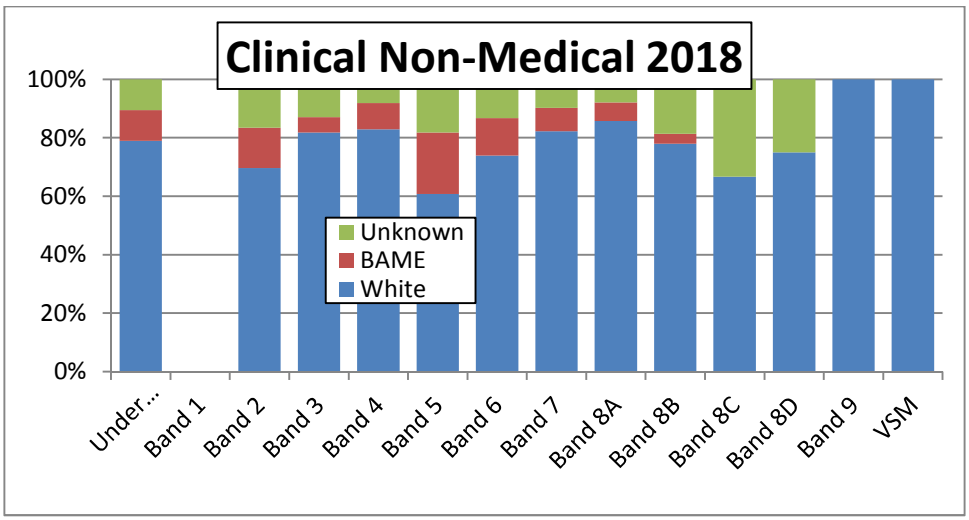
	31st MARCH 2017				31st MARCH 2018		
Non Clinical	White	BAME	Unknown		White	BAME	Unknown
Under Band 1	46.15%	0.00%	53.85%		76.19%	0.00%	23.81%
Band 1	54.55%	38.64%	6.82%		51.22%	39.02%	9.76%
Band 2	84.76%	3.33%	11.90%		84.14%	3.24%	12.62%
Band 3	84.48%	2.59%	12.93%		83.37%	3.28%	13.35%
Band 4	85.23%	2.68%	12.08%		82.47%	3.78%	13.75%
Band 5	76.24%	4.42%	19.34%		76.09%	4.35%	19.57%
Band 6	79.83%	2.52%	17.65%		79.66%	3.39%	16.95%
Band 7	81.01%	1.27%	17.72%		80.68%	1.14%	18.18%
Band 8A	83.33%	10.00%	6.67%		80.95%	11.11%	7.94%
Band 8B	88.64%	4.55%	6.82%		91.84%	4.08%	4.08%
Band 8C	100.00%	0.00%	0.00%		87.50%	6.25%	6.25%
Band 8D	100.00%	0.00%	0.00%		50.00%	50.00%	0.00%
Band 9							
VSM					75.00%	6.25%	18.75%
Total	82.77%	4.00%	13.23%		81.64%	4.61%	13.74%



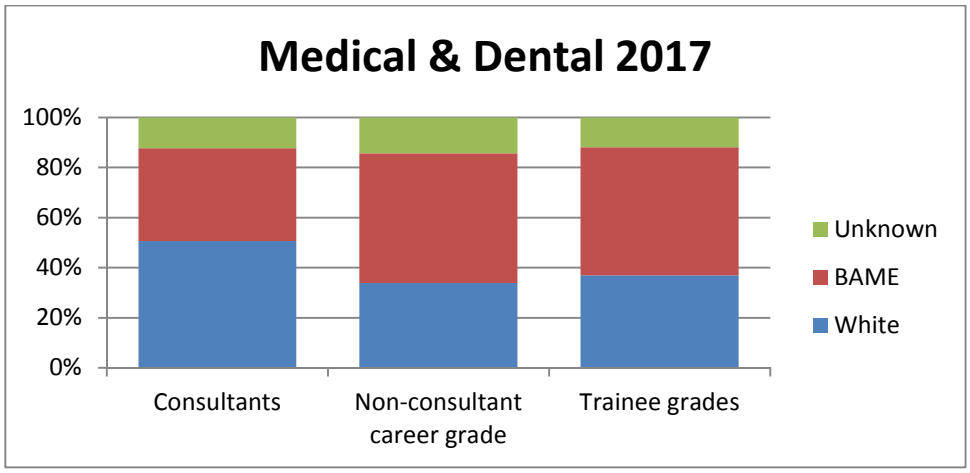


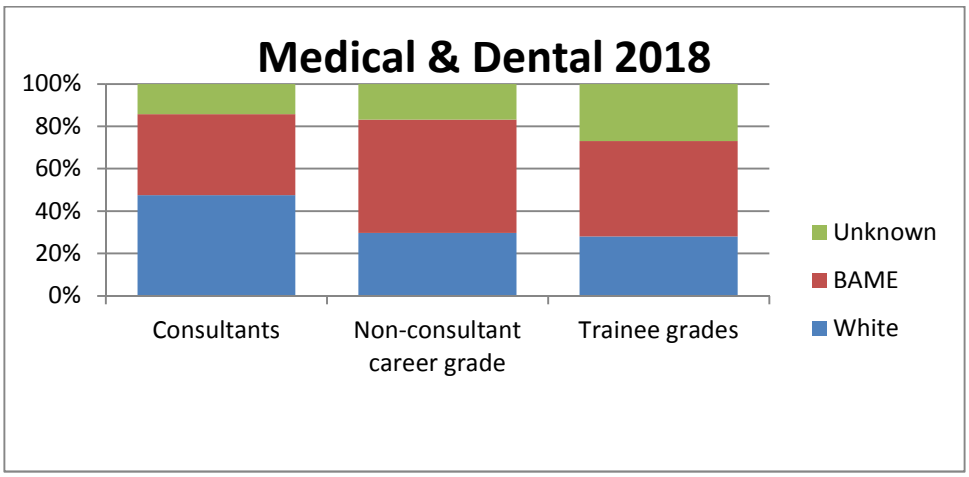
	31st MARCH 2017				31st MARCH 2018		
Clinical Non-Medical	White	BAME	Unknown		White	BAME	Unknown
Under Band 1	33.33%	11.11%	55.56%		78.95%	10.53%	10.53%
Band 1							
Band 2	72.36%	12.03%	15.61%		69.69%	13.79%	16.52%
Band 3	83.74%	5.54%	10.73%		81.79%	5.30%	12.91%
Band 4	82.59%	8.96%	8.46%		82.91%	8.97%	8.12%
Band 5	64.17%	18.96%	16.88%		60.78%	21.04%	18.18%
Band 6	77.03%	11.67%	11.30%		73.94%	12.75%	13.30%
Band 7	83.97%	8.57%	7.46%		82.23%	7.98%	9.79%
Band 8A	92.24%	2.59%	5.17%		85.71%	6.35%	7.94%
Band 8B	74.14%	3.45%	22.41%		77.97%	3.39%	18.64%
Band 8C	83.33%	0.00%	16.67%		66.67%	0.00%	33.33%
Band 8D	100.00%	0.00%	0.00%		75.00%	0.00%	25.00%
Band 9	100.00%	0.00%	0.00%		100.00%	0.00%	0.00%
VSM					100.00%	0.00%	0.00%
Total	74.04%	12.65%	13.30%		71.84%	13.61%	14.56%



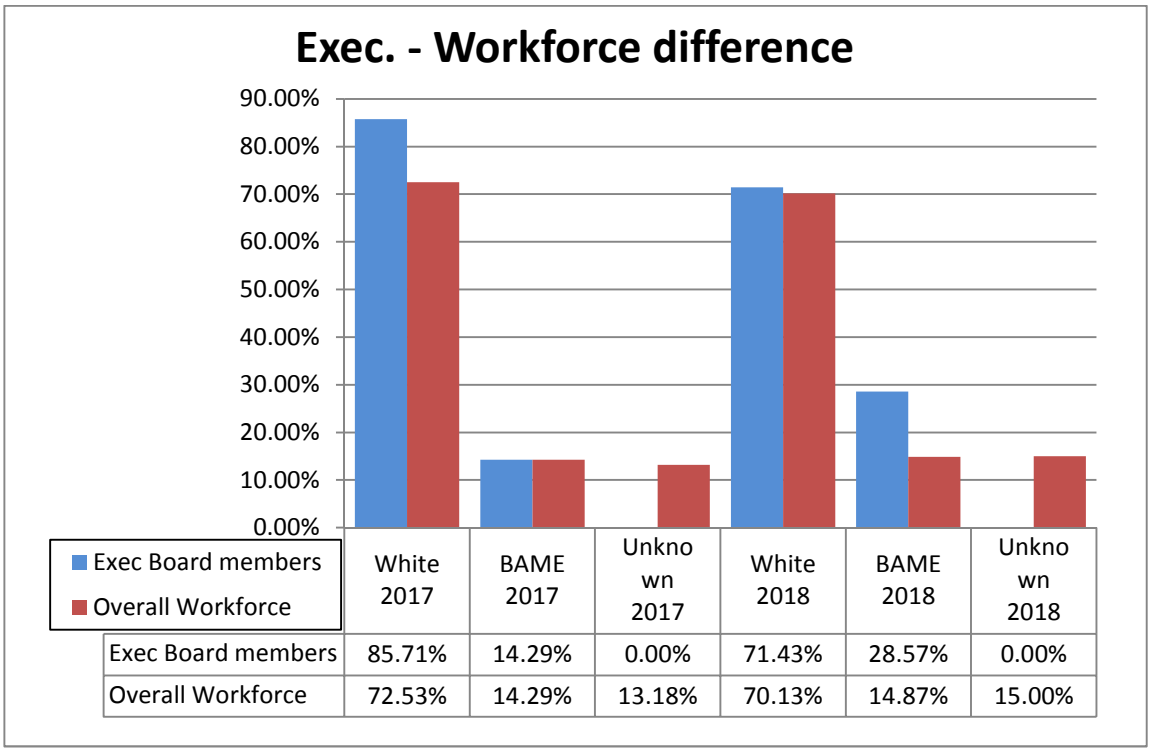


Medical & Dental	31st MARCH 2017				31st MARCH 2018		
	White	BAME	Unknown		White	BAME	Unknown
Consultants	50.66%	37.01%	12.34%		47.57%	38.11%	14.32%
Non-consultant career grade	33.90%	51.69%	14.41%		29.77%	53.44%	16.79%
Trainee grades	36.92%	51.10%	11.98%		27.99%	45.04%	26.97%
Total	42.29%	45.26%	12.44%		36.86%	43.16%	19.98%
Overall Workforce	72.53%	14.29%	13.18%		70.13%	14.87%	15.00%





	31st MARCH 2017				31st MARCH 2018		
	White	BAME	Unknown		White	BAME	Unknown
Exec Board	85.71%	14.29%	0.00%		71.43%	28.57%	0.00%
Overall Workforce	72.53%	14.29%	13.18%		70.13%	14.87%	15.00%
Difference	13.18%	0.00%	-13.18%		1.30%	1.80%	-15.00%



WRES Indicators 2-9

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

East Kent Hospitals WRES Action Plan August 2018.

1. Data Analysis 2018

Our metrics shows developments over the last three years. In 2018, three metrics demonstrate significant improvement with five indicating no significant change.

The areas identified for action in 2018 are:

1.1 The percentage of staff that personally experienced discrimination at work from Manager/team leader or other colleague

White 8.56%

BAME 17.31%

The proportion of BAME staff reporting having experienced discrimination is more than twice that of white staff. 114 BAME staff answered the question “On what grounds have you experienced discrimination?”

90 (78.9%) responded “ethnic background”

1.2 The percentage staff believing that the trust provides equal opportunities for career progression or promotion

White 83.36%

BAME 74.15%

Tables showing EKHUFT Staff Survey 2017 data for Questions 16 and 17

The following tables show the Divisional/Departmental scores for BAME staff for questions 16 and 17. Measured against column one which measures the Trust Average for all staff.

Q16. Percentage believing that trust provides equal opportunities for career progression or promotion •

Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? (b) Manager/team leader or other colleagues

Q	Description	Trust Average	Clinical Support Services Division	Corporate Division	Specialist Services Division	Strategic Development & Capital Planning Division	Surgical Services Division	Urgent Care & Long Term Conditions Division
16+	Organisation acts fairly: career progression	82	76	*	80	76	62	81
17b	Not experienced discrimination from manager/team leader or other colleagues	90	82	69	87	92	76	87

Q	Description	Trust Average	K&C Hospital	QEQM Hospital	William Harvey Hospital
16+	Organisation acts fairly: career progression	82	73	74	77
17b	Not experienced discrimination from manager/team leader or other colleagues	90	81	83	84

Q	Description	Trust Average	Accident & Emergency	Acute Medicine	Anaesthetics	Child Health	Facilities	General Surgery
16+	Organisation acts fairly: career progression	82	*	81	54	82	*	85
17b	Not experienced discrimination from manager/team leader or other colleagues	90	92	89	69	88	100	90
Q	Description	Trust Average	HCOOP	Head & Neck	Outpatient Services	Pathology EKHUFT	Pharmacy	Radiological Sciences
16+	Organisation acts fairly: career progression	82	84	67	*	*	*	*
17b	Not experienced discrimination from manager/team leader or other colleagues	90	88	88	69	77	100	83
Q	Description	Trust Average	Renal Directorate	Specialty Medicine	Therapies	Trauma & Orthopaedics	Womens Health	
16+	Organisation acts fairly: career progression	82	83	73	75	55	69	
17b	Not experienced discrimination from manager/team leader or other colleagues	90	84	76	87	67	84	

Trust wide WRES Action Plan 2018

- Recruiting Managers training continues to include bias/prejudice
- Cultural Change programme will continue to address bullying and harassment but will include additional attention to bullying and harassment from patients, relatives and the public.
- Junior managers training will include fairness and bias inputs
- Leadership training will include raising awareness of bias/prejudice
- Diversity and Inclusion Steering Group will direct and review WRES Action Plans & report progress to Strategic Workforce Committee
- Diversity & Inclusion Team will provide targeted Unconscious Bias Training
- Engage with Divisional/Departmental Leads and BAME Staff.
- The 'Respecting each other' programme
    - Tackle behaviour - we are setting out what is and is not acceptable behaviour ~~and~~ we are also training managers in putting good working practices in place and tackling the bad
    - Review progress - every six months we will ask all staff about bullying and harassment in the Staff Friends & Family Test so we can make sure it is getting better, everywhere.

Surgical Services Division: WRES Action Plan (August 2018)

Issue	Target Completion Date	By Whom	RAG Rating	Action Taken to Date	Key Measures
SAS Doctors: Bullying & Harassment					
Raised from SAS Doctors report. Link to Staff Engagement Action Plan – engaging Managers & Leaders, Integrity, Employee Voice, Great Place to Work, Respect Campaign	Ongoing	L&OD		Listed in the Staff Engagement Action plan 2018 – supported by the Leadership and OD Programme Manager	Improvements in the relevant areas of the staff survey
Autonomous Working for SAS Doctors	Ongoing	KM/AS/ RS		Agreed in October 2017 that SAS Doctors wanted independent practice, and the Consultant was happy this could be implemented. The Deputy Head of Employee Relations to discuss including this at future SAS Doctor Medical Education Day, or picked up as part of CPD programme.	SAS Doctors being aware of this programme and feel it is beneficial.
Wellbeing, Support and Mentoring					
Awareness of counselling	Ongoing	Comms		Staff Zone has pages dedicated to staff wellbeing and counselling. The Medical Education Centres have posters regarding wellbeing on the back of the toilet doors and around the Medical Education areas advertising local Mental Health First Aiders. Details on wellbeing	Survey results indicate awareness of support and options available for assistance

				support are advertised on rotation on the television screens in the Medical Education Centres. Requires advertisement of the support on offer.	
Awareness of mentoring	Ongoing	SR/AS		SAS Doctors' Framework for Continuing Professional Development is in draft format and outlines support and development for SAS Doctors.	Survey results indicate SAS Doctors feel that they are supported in their development.
Awareness of Freedom to Speak Up Guardian	Ongoing	Comms		In June 2018 the Freedom to Speak up Guardians advertisement was shown on the rotating front window of Staff Zone.	Survey results indicate SAS Doctors aware of option for reporting issues.
Respect & Resilience Workshops – teams understand what bullying and harassment is, and how to report it. Includes section on improving resilience.	Ongoing	KW		Respect & Resilience Workshops are being held across the Division, including in T&O and Anaesthetics on all sites. These include both clinical and non-clinical teams.	Improvement in staff survey results.
Stress Management Workshops – including resilience and how to report stress at work, or feeling under pressure from colleagues and/or managers.	Ongoing	Occ Health		Stress Management Workshops were offered to all Surgical Divisional Staff during Winter 2018. This will be repeated again during Autumn 2018 and Winter 2019.	Improvement in staff survey results.
Bullying & Harassment (Anaesthetics/T&O)					
Staff Forums – Nursing/Medical/A&C – issues of racism from patients identified	Ongoing	KW/BC-S		Zero Tolerance posters aimed at patients given to ward manager	Improvement in staff survey

on T&O wards, particularly at WHH (Kings D).				to put around ward. Medical teams supporting ward manager by speaking with patients. HRBP and Head of Diversity & Inclusion meeting with ward manager (29/08/18) to discuss interventions and options.	results, and improved feedback from staff at forums.
Staff Forums – Nursing – issues raised by some staff saying they feel bullied by some overseas nurses because of issues with their sexuality.	Ongoing	KW/ Matron		Matron met with all ward managers across Kings floor and Rotary to highlight the issue. This message was communicated to all staff. Mini-Respect Workshops to be conducted in Autumn 2018 to include the protected characteristics and zero tolerance of discrimination.	Improvement in staff survey results, and improved feedback from staff forums.
Discrimination: Career Progression					
SAS Doctors issues – supported by SAS Doctors Action Plan mentioned above	Ongoing	L&OD		As SAS Doctor Action Plan	Improvement in staff survey results
Staff Forums – 3 x staff forums planned for anaesthetics during Autumn 2018 Audit Days	Ongoing	KW		Discuss career progression, claims, concerns & issues session. Are any issues re: career progression raised at these forums?	Improvement in staff survey results
Investigation into career progression – particularly for senior roles (Clinical Leads, Matrons, Ward Managers, General Managers).	October 2018	KW/Div Dir/Div Med Dir/ Div Head Nursing		Investigate how advertised, communicated, who applied, who was appointed and if there is any other way of improving opportunities.	Improvement in staff survey results.

Clinical Support Services Division- Outpateints: WRES Action Plan (September 2018)

Issue	Target Completion Date	By Whom	RAG Rating	Action Taken to Date	Key Measures
Bullying & Harassment					
Raised from Staff Survey. Link to Staff Engagement Action Plan – engaging Managers & Leaders, Integrity, Employee Voice, Great Place to Work, Respect Campaign	Ongoing	ALL		Listed in the Staff Engagement Action plan 2018 – supported by the Leadership and OD Programme Manager	Improvements in the relevant areas of the staff survey
Wellbeing, Support and Mentoring					
Awareness of counselling	Ongoing	Comms		Staff Zone has pages dedicated to staff wellbeing and counselling..	Survey results
Awareness of Freedom to Speak Up Guardian	Ongoing	Comms		In June 2018 the Freedom to Speak up Guardians was on the rotating front window of Staff Zone.	Survey results.
Respect & Resilience Workshops – teams understand what bullying and harassment is, and how to report it. Includes section on improving resilience.	Ongoing	JT		Respect & Resilience Workshops are being held across the sites.	Improvement in staff survey results.
Stress Management Workshops – including resilience and how to report stress at work, or feeling under pressure from colleagues and/or managers.	Ongoing	Occ Health		Stress Management Workshops were offered to all staff during Winter 2018. This will be repeated again during Autumn 2018 and Winter 2019.	Improvement in staff survey results.
Communication					
Team Brief	On-going	Ops Manager		Month	Improvement in staff survey results.
Career Progression					
Rising Stars programme which is part of the GPTW programme offered to all staff		PB/JT		In house training to gain awareness of others roles and understand the structure of the organisation and patient flow/ pathways.	Improvement in staff survey results.

Training programmes for Band 4,5 and 6	December 2018	PB/JT/EH/ EB		In-house and trust work based training to improve skills and knowledge.	Improvement in staff survey results.
Investigation into career progression – particularly for senior roles Band 7 and 8,	October 2018	HRBP		Encourage participating in leadership and management programs	Improvement in staff survey results.
Appreciation					
Awards programme to be set up		JT/EB		To be nominated by managers for: Most patients focused. Going the extra mile Inspiring Team Award	Improvement in staff survey results.

East Kent Hospitals University NHS
NHS Foundation Trust

Our Care Strategy

for Nursing, Midwifery, AHP and Care Givers

2018 – 2020



We care

Contents

East Kent Hospitals University NHS Foundation Trust

We care

Introduction

Welcome to the East Kent Hospitals University NHS Foundation Trust Nursing, Midwifery, & AHP Care Strategy. We are just commencing our new Quality Strategy and this professional view of the way we deliver our care and practise in a highly professional way complements the Quality Strategy.

The NHS and wider political environment has undergone a period of unprecedented change and indeed has our Trust and our workforce ambition and the way we practise. Despite this – this strategy's Vision Statement and Themes remain relevant - living the our professional codes in practice, keeping our patients safe, delivering an outstanding patient experience and leading the way in nursing, midwifery & AHP research and education.

Professionals have a long tradition in leading change across the health service; this leadership is vibrant at EKHUFT, where the voice of nursing, midwifery & AHPs is strong and respected across our hospitals and community sites. I draw your attention to our Chief Nursing Officer's 'Leading Change Adding Value' programme – which directly links to the aims of our strategy whilst focusing on nurses, midwives and AHPs leading the drive to reduce variation and standardise care.

This strategy offers a blended model of care delivery by our workforce to ensure sustainability for the future and highly professional,

Quality and safe person centred care.

What we are committed to delivering:

- Person-centred, safe effective harm free care and providing a positive experience of care which exceeds expectations
- Through innovation and a blended model deliver the Trust Quality ambition (described EKHUFT strategy 2018 – 21)

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The Challenge

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The Changing Environment

- Changing political health and social care landscapes
- Changing demographic and growing care needs
- A changing world of innovation and technology
- Changing expectations and knowledge
- Embracing diversity
- Generational differences across the workforce
- Making the NHS a more inclusive “family friendly” employer
- Competitive recruitment market – gap between availability and demand
- Opportunity for innovative future fit blended workforce model

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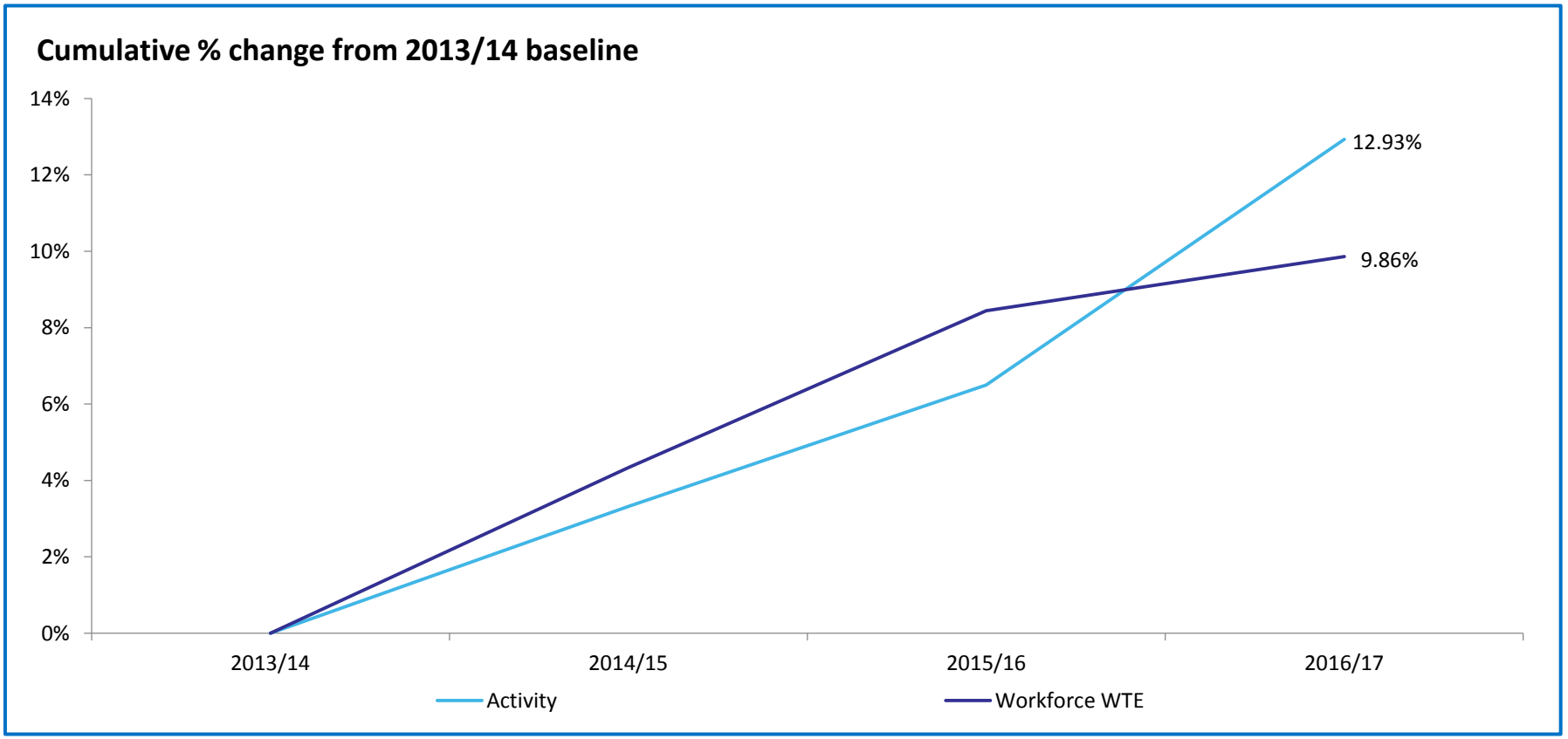
NHS Workforce Profile – Workforce Productivity



Since 2013/14, NHS providers have experienced year on year growth in terms of total activity and WTE workforce. In recent years, the rate of workforce growth has slowed to the point of no longer keeping pace with the growth in activity which suggests a productivity gain across NHS providers.

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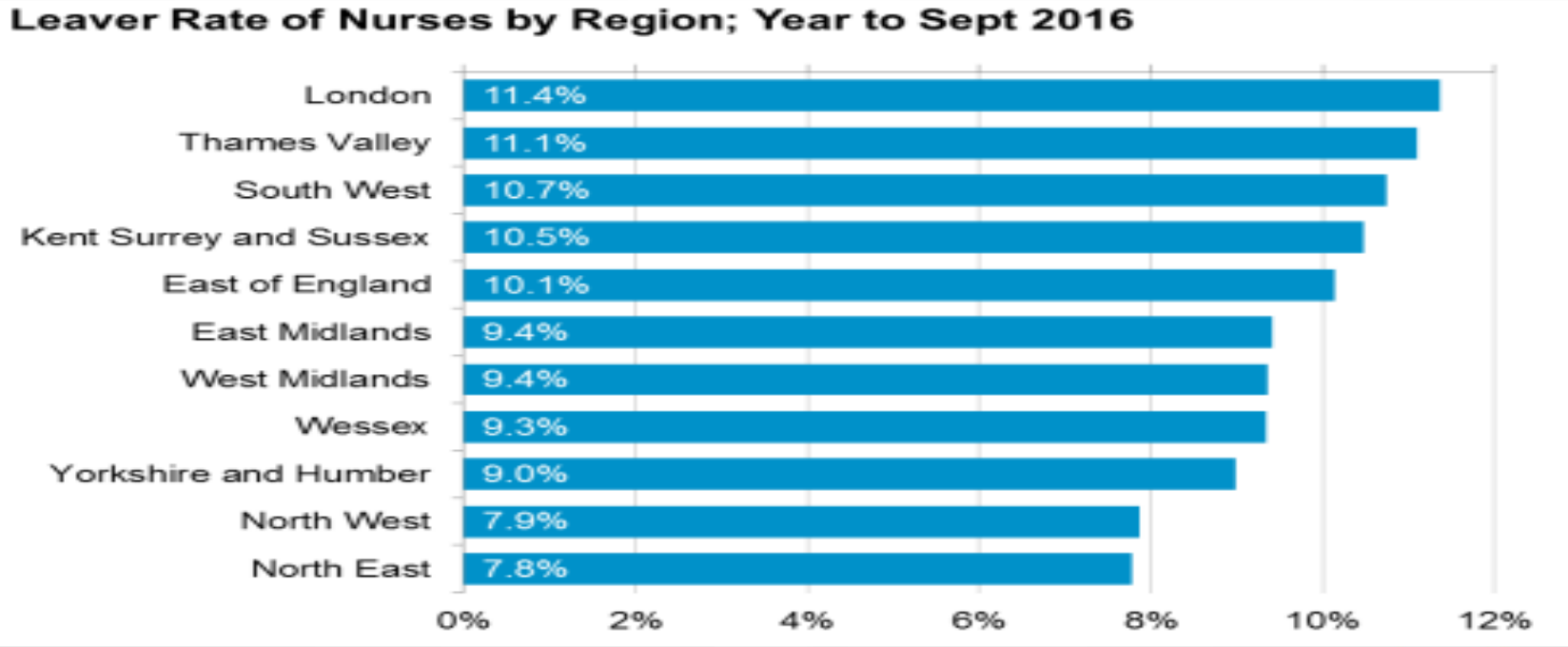
The National Recruitment and retention challenge



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Addressing the challenges of:

- Vacancies
- Ageing workforce
- Deficit in availability of some traditional roles – prompting blended future model
- Retention
- Agency spend
- Development of integrated working across the health economy

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We recognise the following influences

- ‘Leading change and adding value; a framework for nursing midwifery and care staff’, May 2016
- AHPs into Action. Using Allied Health Professions to transform health, care and wellbeing 2016 / 17 – 2020/21 (2017) Chief Allied Health Professions Officer – NHS England
- Next steps ‘NHS 5 year forward view’, March 2017
- ‘Raising the bar shape of caring – review of future education and training of registered nurses and care assistants’, HEE 2015
- Advanced clinical practice defining the future forward role, HEE 2016
- Right person right time right place right skills, National Quality Board 2014

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Leading Change

- Health and wellbeing
- Care and quality
- Funding and efficiency

UNWARRANTED VARIATION

Adding Value

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Our Organisational Framework

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Our vision

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Our vision: Great healthcare from great people

Our mission: Improving health and wellbeing

The **six key priorities** we are focussed on delivering by **2020/21**:

- **Getting to Good**, and then Outstanding, in our CQC rating.
- Delivering **Higher Standards for Patients,** for example by improving access to emergency and planned care, and cancer treatment.
- Having **Healthy Finances** by providing better, more effective patient care that makes resources go further.
- Making the Trust a **Great Place to Work**, for our current and future workforce.
- **Delivering our future,** by transforming the way we provide services.
- And developing teams, so they have 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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Our values

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People feel **cared** for as individuals

People feel **safe**, reassured and involved

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

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

We care

Shared Purpose Framework

East Kent Hospitals University NHS Foundation Trust

Person-centred Care (Caring)

- Improving Patient Experience
- People feeling cared for
- People feel teamwork, trust and **respect** sit at the heart of everything we do

Safe Care (Safe)

- Improving safety
- Reducing harm
- People feel safe, reassured and involved

Effective Care (Effective & Responsive)

- Improving clinical effectiveness
- Improving reliability of care
- People feel confident we are making a difference

Effective workplace cultures (Well led)

- Support delivery of the People Strategy
- Sustain quality Improvement
- Enabler for quality improvement

The Improvement Journey – Getting to Good

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Our Vision

Providing a sustainable workforce for the future

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Shared Principles

- Delivering and sustaining person centred, safe and effective care in partnership with patients and service users
- Secure the supply of staff by enabling a flexible and adaptable workforce through our investment in educating (learning and development) and training new and current staff
- Provide broad pathways for careers in the NHS ensuring the system is underpinned by evidence based best practice
- Widen participation in NHS jobs so that people from all diverse backgrounds have the opportunity to contribute and benefit from public investment in our healthcare
- Workforce innovation integrates service, financial, workforce planning, and is tested a refined
- Deliver a competence based workforce model that integrates the skills and expertise of a diverse interdisciplinary team
- To implement new roles, empowering our people to deliver an increasingly blended workforce model which is accountable and owned.

How we will deliver

We will ensure a safe, fit for purpose model by mapping Tiers of Care and competency for each role

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Competences

- Single career and competence framework for the client group service
- Outcome model of competences
- Underpinned by knowledge, understanding and know how
- Aligned with the evidence base
- The patient pathway across the health economy is central to the competency framework
- Performance indicators linked to lowest level in NHS Career framework

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Key Elements of the Career Framework

Skills for Health

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9 Career Framework Level 9
People working at level 9 require knowledge at the most advanced frontier of the field of work and at the interface between fields. They will have responsibility for the development and delivery of a service to a population, at the highest level of the organisation. **Indicative or Reference title: Director**

8 Career Framework Level 8
People at level 8 of the career framework require highly specialised knowledge, some of which is at the forefront of knowledge in a field of work, which they use as the basis for original thinking and/or research. They are leaders with considerable responsibility, and the ability to research and analyse complex processes. They have responsibility for service improvement or development. They may have considerable clinical and/or management responsibilities, be accountable for service delivery or have a leading education or commissioning role.
Indicative or Reference title: Consultant

7 Career Framework Level 7
People at level 7 of the career framework have a critical awareness of knowledge issues in the field and at the interface between different fields. They are innovative, and have a responsibility for developing and changing practice and/or services in a complex and unpredictable environment. **Indicative or Reference title: Advanced Practitioner**

6 Career Framework Level 6
People at level 6 require a critical understanding of detailed theoretical and practical knowledge, are specialist and / or have management and leadership responsibilities. They demonstrate initiative and are creative in finding solutions to problems. They have some responsibility for team performance and service development and they consistently undertake self development. **Indicative or Reference title: Specialist/Senior Practitioner**

5 Career Framework Level 5
People at level 5 will have a comprehensive, specialised, factual and theoretical knowledge within a field of work and an awareness of the boundaries of that knowledge. They are able to use knowledge to solve problems creatively, make judgements which require analysis and interpretation, and actively contribute to service and self development. They may have responsibility for supervision of staff or training. **Indicative or Reference title: Practitioner**

4 Career Framework Level 4
People at level 4 require factual and theoretical knowledge in broad contexts within a field of work. Work is guided by standard operating procedures, protocols or systems of work, but the worker makes judgements, plans activities, contributes to service development and demonstrates self development. They may have responsibility for supervision of some staff. **Indicative or Reference title: Assistant/Associate Practitioner**

3 Career Framework Level 3
People at level 3 require knowledge of facts, principles, processes and general concepts in a field of work. They may carry out a wider range of duties than the person working at level 2, and will have more responsibility, with guidance and supervision available when needed. They will contribute to service development, and are responsible for self development. **Indicative or Reference title: Senior Healthcare Assistants/Technicians**

2 Career Framework Level 2
People at level 2 require basic factual knowledge of a field of work. They may carry out clinical, technical, scientific or administrative duties according to established protocols or procedures, or systems of work.
Indicative or Reference title: Support Worker

1 Career Framework Level 1
People at level 1 are at entry level, and require basic general knowledge. They undertake a limited number of straightforward tasks under direct supervision. They could be any new starter to work in the Health sector, and progress rapidly to Level 2. **Indicative or Reference title: Cadet**

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Growing our workforce

- Workforce growth comes from;
  - new graduates
  - work experience
  - return to practice
  - recruitment from outside the NHS
  - retention of current staff
  - extending the traditional roles of our Allied Health Professionals and wider support staff (porters; housekeepers; administrators)
- Education will deliver undergraduate places and other priorities
- New roles will play a major part of growth and increasing skill mix and skill set
- Using the workplace as the main resource for learning, developing and improving our workforce and growing workplace facilitators
- Implement retention strategies to retain existing staff to secure immediate impact
- To become a world class employer, recognised for excellence and integrated learning, development and improvement approach

NHS
East Kent Hospitals University NHS Foundation Trust

Growing our workforce (2)

- Using the opportunities that Tiers of Care provide to support:
  - Clear career pathways matched to the needs of service users
  - Develop flexible routes into and across nursing, midwifery and allied health professionals through apprenticeships
  - Supporting the up skilling of the wider workforce to deliver advanced practice and clinical system leadership
  - Build on talent management and succession planning
- Identify a reward and recognition scheme
- To develop a workforce for today and tomorrow align initiatives to the ethics and needs of different generations of our workforce e.g. provide flexible working, respond to wish for a change in career direction while remaining within the NHS

We care

This Care Strategy will be supported by the Trust Quality Strategy, reflecting our commitment to build Academic Potential to sustain person centred safe and effective care:

East Kent Hospitals University NHS Foundation Trust

Aim

Deliver care, treatment and support that achieves good outcomes and is based on best available evidence

By 2021 we will have improved our potential as a University Trust. To achieve this we will:

- Position the Trust as a **centre of excellence** for research and innovation through growing our research champions;
- Increase our **partnerships** at every level;
- Building on a renowned track record of **practice development** achievement with the **England Centre of Practice Development**;
- Establish the **evidence base** through undertaking research across our organisation and health economy;
- Increase flexible opportunities to **support staff** to use the workplace as the main resource for **inquiry, innovation and research**;
- Enable and encourage staff to participate in research and undertake **higher research qualifications** including PHD by publication, providing academic opportunities including posts e.g. Darzi fellow posts;
- Work with partners to establish the **Medical School** in Kent.

We care

The Care Strategy is further supported by our commitment to develop effective workplace cultures:

East Kent Hospitals University NHS Foundation Trust

Aim

Deliver care, treatment and support that achieves good outcomes and is based on best available evidence

By 2021 we will have a workforce that demonstrates an inter relationship between holistic safety, being person centred and team effectiveness and that we live and breath this culture everyday. To achieve this we will have:

- Continue to embed a **caring compassionate person centred approach**
- Growing quality clinical leaders who are transformational and who can **embed transformational leadership behaviours**
- **Work together to implement 'Learning from Excellence'**
- **Strengthen our safety culture** through improving support to front line teams

We care

New ways of working – developing new roles

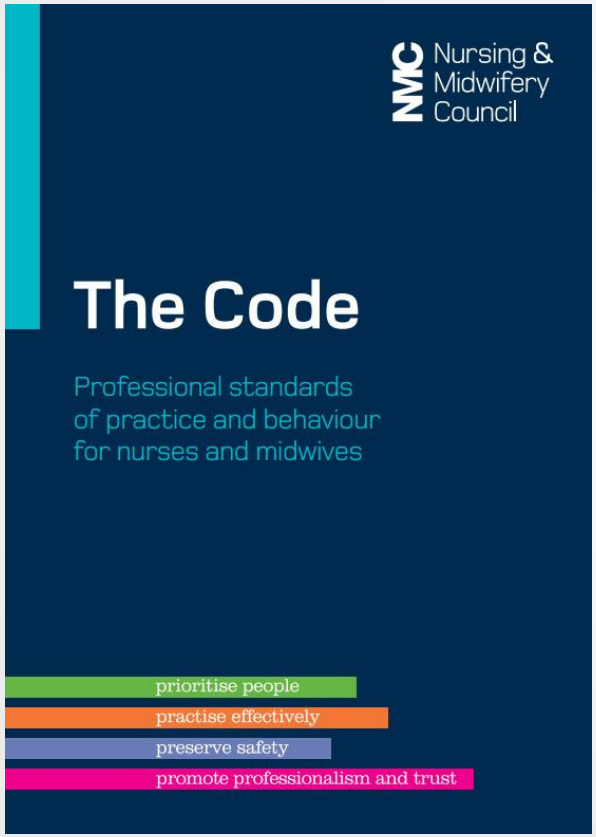
East Kent Hospitals University NHS Foundation Trust

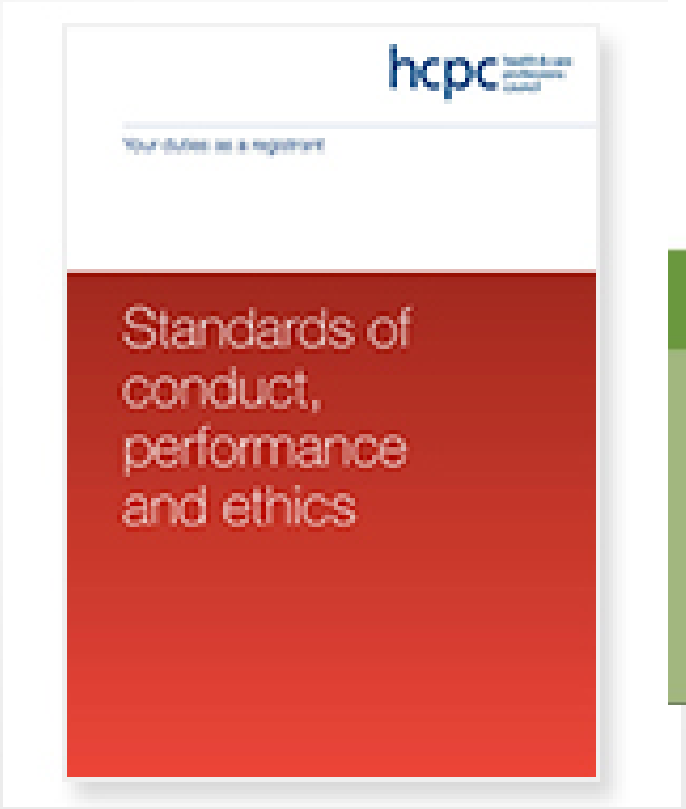
- Consultant Practitioners
- Advanced practice level Clinical Practitioners
  - MSc Education & Royal College Curriculums
  - Educational & Clinical Supervision
- Advanced Clinical Practitioners
- Associate Practitioners and Apprentice schemes
- Nursing Associates
- Surgical Care Practitioners
- Extended allied health professional roles, including but not limited to physiotherapists and pharmacists
- Extended roles for support staff (porters; administrators; housekeepers)
- Flexible medical roles such as frailty specialists working at the front door.

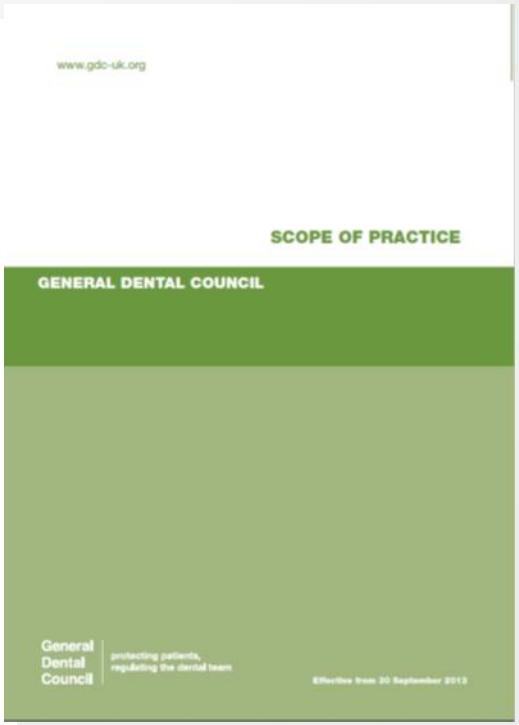
We care

How we will ensure that we deliver high quality, safe care: Codes of Practice

NHS
East Kent Hospitals University
NHS Foundation Trust







We care

Delivering high quality, safe care:

- Use workforce tools (tiers of care and related competences)
- Use the Safe Care Tool and systematic acuity and dependency audit
- Review Health Roster to oversee / assure skill mix
- Undertake peer review to provide the basis for improvement and learning and celebrate achievement

The Governance Umbrella

East Kent Hospitals University NHS Foundation Trust

- Roles are developed through identifying what **competences** are needed to support the required role
- New roles are tested against **regulator requirements (NMC etc)** and relevant **legislation** (e.g. medicines act); and **NHSLA** indemnity requirements
- A prescribed job role template is used to describe all roles to **assure clarity regarding essential criteria** i.e. scope and governance / clear description of competency requirement including development plan
- For developmental posts, the review process that the post holder will need to undertake to progress will be clearly described before the post is agreed
- Role **evaluation** against the criteria of person centeredness, safety and effectiveness, (including assessment of productivity and resource utilisation) will be built into the implementation of all new roles from the outset
- **Evaluation of the role and outcomes will be reported to the Chief Nurse / Care Group lead** at prescribed points across the implementation process with overarching progress of all new roles reporting to the strategic workforce committee annually.
- All new roles will require **initial sign off by the Chief Nurse/ Care Group lead before recruitment**

We care

References

- East Kent Hospitals University Foundation Trust People Strategy (2017)
- East Kent Hospitals University Foundation Quality Strategy (2018-21)
- Leading change and adding value a framework for nursing midwifery and care staff (May 2016)
- Facing the Facts, Shaping the Future (HEE 2017)
- Next steps NHS 5 year forward view (March 2017)
- Raising the bar shape of caring – review of future education and training of registered nurses and care assistants (HEE 2015)
- Advanced clinical practice defining the future forward role (HEE 2016)
- Right person right time right place right skills (National Quality Board 2014)

REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE **BoD 88/18**

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**REPORT FROM THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)**
BOARD SPONSOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE INTEGRATED AUDIT AND GOVERNANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**NONE**

BACKGROUND AND EXECUTIVE SUMMARY

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

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

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

MEETING HELD ON 16 OCTOBER 2018

Positive assurance was received in relation to:

1. The Committee received and discussed a report on the principal corporate and strategic risks, noting the changes that had been made to the risk register. The Committee took assurance from the progress updates provided in relation to the management of the risks, noting the following.

1.1 There were no risks proposed for closure;
1.2 There was one new risk added to the corporate risk register. Risk CRR51 - Patient safety may be compromised as a result of the move of acute medicine, acute geriatric medicine and Stroke from the Kent & Canterbury Hospital (K&CH) site. This had been agreed for closure in August but in view of the relocation of elective orthopaedic surgery from the William Harvey Hospital (WHH) to the K&CH site, this risk is being re-instated.

2. The Committee received and discussed a Cost Improvement Programme (CIP) deep dive report regarding the Maternity Safety Strategy Clinical Negligence Scheme for Trusts (CNST) Discount.

2.1 The Committee received assurance around the processes and controls in place around the governance of schemes within the CIP plan.
2.2 Robust key project management functions are in place to facilitate the delivery of

and quality assurance around the CIP schemes, providing project updates, monitoring of risks and mitigations, and milestones and finances.

The following reports were also discussed:

3 The Committee received and discussed a quarterly Freedom to Speak Up Guardian (FTSUG) report providing an update on the activity of the FTSUGs in Q2. The following was noted.

3.1 There have been no cases referred during the quarter.
3.2 The Guardians had recently attended a Regional meeting.
3.3 The Board undertook a workshop at the beginning of October around their responsibilities and completed the NHS Improvement (NHSI) self-assessment.

4 The Committee received and approved a report on losses and special payments summarising the losses and special payments made from 1 April 2018 to 30 September 2018. The Committee noted the level to date was more than the previous year, which was mainly due to overseas visitors and accommodation arrears.

5 The Committee received and approved a report on Single Tender Waivers (STWs). The Committee noted the number of STWs approved during the period reported in comparison against the period in the previous year. The following was noted.

5.1 The value of STWs has exceeded the total value of 2017/18 and is 27% higher.
5.2 The Procurement Services Department manages the process for STW approval and documents all instances.
5.3 The Trust is committed to reducing the number and value of retrospective STWs, and continues to focus on-going monitoring of STWs. Budget holders are reminded of their requirement to competitively tender requirements in line with Standing Financial Instructions (SFIs) and EU Procurement Legislation.

6 The Committee received and approved a report on the Data Security and Protection Toolkit and noted the following.

6.1 The Committee noted the submission status in relation to the Information Governance Toolkit (IGT).
6.2 The IGT has been replaced and the replacement toolkit has been changed significantly, with a strong focus on security.
6.3 The IGT is due to be submitted on 31 October 2018.
6.4 The Committee agreed the appropriate timing for baseline assessment reporting as well as a way forward for future internal audit.
6.5 The new toolkit is still being developed.

7 The Committee received and discussed a progress update from External Audit regarding the work undertaken during the quarter reported.

8 The Committee received and discussed the Internal Audit progress report. Three internal audit reports had been completed and were reported to the Committee, these were regarding Consultant Job Planning, Care Groups Risk Management, and the pre-implementation review of the Patient Administration System. The Committee highlighted its disappointment with regards to the number of follow ups of audit actions.

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

9.1 One case has been submitted to the Crown Prosecution Service;

9.2 On-line training has been provided to all Finance Directorate;
9.3 The Counter Fraud pages on the Trust's Internet and Intranet have been updated;
9.4 Work has commenced on the National Fraud Initiative (NFI) process to inform staff of data usage and data uploading to the Cabinet Office;
9.5 A number of fraud alerts have been issued that included mandate fraud.

RECOMMENDATIONS AND ACTION REQUIRED:

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

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**FINANCE AND PERFORMANCE COMMITTEE (FPC) CHAIR REPORT**
BOARD SPONSOR:	**SUNNY ADEUSI, CHAIR FINANCE AND PERFORMANCE COMMITTEE**
PAPER AUTHOR:	**CHAIR OF THE FINANCE AND PERFORMANCE COMMITTEE**
PURPOSE:	**APPROVAL**
APPENDICES:	**APPENDIX 1: MONTH 6 FINANCE REPORT**

BACKGROUND AND EXECUTIVE SUMMARY:

The purpose of the Committee is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the Trust. This will include:-

- Overseeing the development and maintenance of the Trust's Financial Recovery Plan (FRP), delivery of any financial undertakings to NHS Improvement (NHSI) in place, and medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance overseeing financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and the 2018/19 capital plan.
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The Committee also has a role in monitoring the performance and activity of the Trust.

23 October 2018 Meeting

The Committee reviewed the following matters:

Financial Special Measures (FSM) Update:

1. The Committee received an update report on FSM:

    1.1. This was around the Trust's proposals for the delivery of the financial plan in 2018/19, as well as 2019/20 and beyond. The key areas of focus for the Trust include:

        1.1.1 Sustaining effective confirm and challenge meetings with Clinical Care Groups;
        1.1.2 Sustaining prospecting for financial improvement opportunities;
        1.1.3 Strengthening the Programme Management Office (PMO);
        1.1.4 Sustaining Grip and Control Actions;
        1.1.5 Sustaining Board and Executive Level focus on financial improvement;

1.1.6 Governance.

1.2. The implementation of the new Care Group structure around the organisation being clinically led will ensure the closer alignment of the Cost Improvement Programmes (CIPs), quality, productivity, and transformation as well as the clinical voice being present in all decisions.

1.3. The Trust's proposals to ensure sustained delivery of its financial plans will be around continuing the work on the positive governance already put in place with the support of the current Financial Improvement Director:

1.3.1 Continuation of the monthly confirm and challenge meetings with Care Groups, to be attended by Executive Directors, the Deputy Medical Director, PMO representation, Care Group Clinical Directors and Heads of Nursing as well as the Finance Lead, and the Operations Director. These sessions will include specific focussed discussion on the quality impacts of past and future decisions.

1.3.2 These monthly meetings will also be strengthened with a mid-month confirm and challenge session attended by the Care Group Clinical Director, Heads of Nursing, Operations Directors and Finance Lead, PMO and representation from one of the Executive Directors. These sessions will not be held where Care Groups are delivering their recurrent CIPs in year.

1.3.3 If a Care Group is not meeting its CIP targets or milestones, bi-weekly confirm and challenge sessions will be held until the position improves.

1.3.4 When the current Financial Improvement Director finishes, a part-time Financial Improvement Director will be appointed who will work five days per quarter to provide 'external' challenge around its CIP plans.

1.3.5 The role of the Head of PMO will have a focus around providing more support of the planning and execution oversight of the CIP plan. The PMO structure is also being strengthened by the recruitment of permanent staff.

1.3.6 In addition to the confirm and challenge sessions the Trust will utilise tools focussing on productivity, variation and innovation in relation to ensuring its CIP plans are achieved. This will be around reviewing the Model Hospital, continued use of the Service Line Reporting (SLR) and patient level costing, continuing to follow NHSI best practice guidance, ensure the completion of the Getting it Right First Time (GIFRT) reports and that the actions from these are acted upon. The Trust is fully engaged with the County wide Sustainability and Transformation Partnership (STP) projects and shared learning across the Region. Linking with the local Clinical Commissioning Groups around alignment across the health economy and reviewing the Right Care Outputs. The Transformation and Improvement Group (TIG) will be the forum leading finance and quality improvements to ensure the Trust builds sustained improvement and addresses any areas where things are not working.

1.3.7 The Trust has control actions in place around the continued monitoring of agency spend, vacancies, and e-rostering systems.

1.3.8 The Trust will continue to maintain financial control through its governance structure and internal meetings.

1.4. EKHUFT is meeting with a local Trust who recently exited FSM to understand their exit process. FSM undertakings are currently being

actioned.

1.5. An Integrated Business Plan/Long-Term (three year) Financial Plan will be developed.

CIPs Update

2. The Committee received and discussed an update against CIPs:

2.1. In Month 6 £1.6m CIPs had been achieved against the plan of £1.3m against the 2018/19 CIP target to deliver £30m.
2.2. The Year to Date (YTD) delivery of CIPs is £12m and is £0.6m ahead of plan. This has been driven by the over-delivery of the Clinical Negligence Scheme for Trusts (CNST) rebate scheme, less underperformances in Procurement, Spencer Hospital and 2gether Support Solutions (2SS); the latter is related to timing.
2.3. Currently £26m (87%) CIP schemes are RAG rated green, and the remaining red/amber schemes are being re-assessed. Additional schemes are being scoped around achievement of the £30m target.
2.4. The Committee noted the importance of delivering the CIPs plan.
2.5. The current identified CIPs pipeline for 2019/20 is c£12m, and the Trust aims to identify at least £20m green RAG rated by 31 December 2018.
2.6. The Committee requested that the CIP forecast be reassessed and revalidated following the implementation of the new Care Groups, and a report will be presented to the next Committee meeting on the required CIP target following the revalidation.

Month 6 Finance Report:

3. The Committee received the Month 6 finance report (attached Appendix 1).

3.1. The following points were noted in relation to the Trust's financial position in Month 6:

3.1.1. The Trust's consolidated deficit in month is £1.8m and the YTD deficit is £17.4m, which is £1.2m behind plan.
3.1.2. There was a reduction in month 6 of clinical income as a result of the go live of the new Patient Administration System (PAS). This would have meant the Trust being £1.1m under plan, if it were not for the release of £1.7m of the previous year's expert determination reserve that the CCGs have now settled.
3.1.3. As the Trust is in FSM it is measured against its performance excluding technical adjustments. After the removal of these the Trust's YTD Income & Expenditure (I&E) deficit to Month 6 is £17.1m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £15.7m, and is £1.4m below the plan.
3.1.4. The Trust's cash balance as at the end of September is £5.1m and this is on plan. The Trust's total cash borrowing is now £60.7m.
3.1.5. Risks remain around achieving the year-end position in relation to expert determination and challenges on income, CIP delivery and activity related costs. The Trust continues to mitigate these risks throughout the year.

Financial and Operational Risks Review

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

4.1. The principal financial risk to the Trust remains as SRR5 – Failure to achieve financial plans as agreed by NHSI under the FSM regime.
4.2. During the period reviewed, the FPC noted:
4.2.1 There have been no changes to the residual risk scores.
4.2.2 There were no financial risks for closure.
4.2.3 There were no new financial risks to be added to the register.

Month 6 Operational Performance and Activity/Highlight Report on the National Constitutional Standards

5. The FPC received a highlight report on the National Constitutional Standards. The following key areas were discussed and noted in relation to the Trust's operational performance and activity:

5.1. The introduction of the new PAS was well managed through a robust project management structure. It was acknowledged that it will take staff longer to become familiar with the new processes and information screens. During downtime, paper based systems were used. The paper based systems did not slow down the Emergency Department (ED) during downtime, but directly following implementation processes slowed as staff became familiar with the new software.
5.2. The Trust continues to work on implementing the ED improvement plan as well as maintaining health economy focus. Along with progressing the frailty pathway and up skilling staff and staff training.
5.3. During September performance against the A&E 4 hour target was 77.1% against the NHSI trajectory of 85.4%, which was a 3% decrease in performance compared to the previous month. There were no 12 hour trolley waits in month. The number of patients who left ED without being seen remained compliant and significantly decreased to 0.5%. Unplanned re-attendances improved but still remained non-compliant at 8.6%.
5.4. The importance of system wide management of patients whose length of stay of seven days or more (stranded patients) and patients whose length of stay of over 21 days (super stranded patients) to ensure the provision of appropriate care to meet the needs of these patients.
5.5. Performance reported in September against the Referral to Treatment (RTT) standard of 76.27% against a trajectory of 81.32%. The total waiting list reported of 55,800 against the trajectory of 50,857, a shortfall of 4,943. In relation to 52 week patients, 129 were reported against a trajectory of 175. Production plans are in place. A backlog of validation is required following the implementation of PAS.
5.6. Actions continue to improve RTT performance including:

5.5.1 Review of the production plans around maximising capacity.
5.5.2 Review of 6-4-2 theatre booking.
5.5.3 Review of each 52 week wait patients with an agreed appointment/admission date.
5.5.4 Continuing to work with CCGs and GPs to embed electronic referral management.
5.5.5 Validation of the waiting lists following go live of PAS.
5.5.6 Review performance plans.

5.7. Cancer performance in September reported at 77.05% against the improvement trajectory of 62.76%. The total number of patients on an active cancer pathway in month is 2,995 of which 15 were waiting 104 days or more for treatment or potential diagnosis, this is a marked reduction from the 31 patients the previous month. Improvements are showing following the significant improvement plans in place on the cancer pathways and initiatives. The demand and capacity regarding the 2 week waits (WW) continues to be reviewed daily. The number of treatments and capacity has increased following the redesign and improvement in cancer access. There will be further work on timed pathways that will assist with maintaining progress on improvements.

5.8. In relation to the DMO1 Diagnostics standard, this was not met in month with a compliance of 98.53%. 187 patients had waited over 6 weeks for their diagnostic procedure. Demand for Sleep Studies continues and a robust plan has been developed in response to the increased demand and to achieve sustainability. There has been an increase in demand for cardiac CT.

5.9. Actions continue to be implemented to improve the DMO1 standard and these include:

5.9.1 Recruiting to respiratory technician posts.

5.9.2 Liaising with GPs and the CCGs requesting that patients are booked within 6 weeks on the e-referral system.

5.9.3 The provision of additional capacity through outsourcing and internal additional lists for cardiac CT.

5.10. Following the implementation of the new Care Group structure and the appointment of the leadership teams, training will be provided to ensure staff understand the national constitutional targets, delivery and implementation plans and escalations.

Winter Capacity Plan

6. The FPC received and discussed a report on the Trust's Winter Capacity Plan, noting the following key areas:

6.1 A winter task force meeting has been formed to ensure the implementation of the internal winter plan, which meets on a weekly basis. Project Leads provide an update against the project plan at each meeting.

6.2 A comprehensive Winter Task Force project plan is in place.

6.3 This plan will be supported by the approved business cases in relation to staffing the observation and winter wards, and the orthopaedic plan.

6.4 Recruitment plans are underway and are being progressed.

6.5 Building works have already commenced with the provision of the orthopaedic theatres at Kent and Canterbury Hospital (K&CH) and the observation wards at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM).

6.6 A health economy Winter Plan has been submitted to NHSI and NHS England (NHSE) with feedback provided, which will be reviewed by the East Kent Chief Operating Officers.

6.7 In relation to System Risks, reassurance is being sought on the Kent Social Services Investment Plan for services and whether this will provide additional capacity.

Energy Performance Contract

7. The FPC noted an Energy Performance Contract Report, which provided an update on the Trust's work with Breathe Energy. This is around the Trust reducing its energy consumption and carbon emissions, along with securing funding for any capital investments required to achieve this.

    7.1 The Trust will be taking forward the recommended scheme from Breathe, following the investigative work (called an Investment Grade Proposal (IGP)), which will be based on a staged approach:

        7.1.1 Phase 1 Audit – will focus on the Energy Quick Wins (EQW) that are low cost and interventions that are relatively easy to implement.
        7.1.2 Phase 2 Audit – (called the Energy Reduction Programme (ERP)) will focus on the more material energy cost reduction measures that generally require more engineering and are more complex to implement.
        7.1.3 Phase 3 Audit – (called the EPR 2) will now commence that will focus on the more material energy cost reduction measures, which will payback over a longer period of time and focus on renewable energy sources such as solar PV and further light upgrades across all sites.

    7.2 It is anticipated that the result of the IGP will achieve savings of c£1.2m per annum over 15 years.

Capital Report 2018/19 Quarter 2

8. The FPC received and noted a quarter 2 capital report 2018/19 summarising the current and forecast position for capital expenditure for the YTD. Expenditure to the end of Q2 is 17% below the NHSI plan, this is an improvement from the 21% below plan the previous month.

Business Planning Update Report 2019/20 to 2021/22

9. The FPC received and discussed an update report regarding business planning 2019/20 to 2021/22, outlining the proposed annual business planning process to ensure the Trust has plans in place to deliver its strategy, good quality care and achieve a sustainable financial position acceptable to regulators. The FPC approved the 2019/20 business plan high level assumptions and noted the key areas as below:

    9.1 The high level timetable with key planning milestones.
    9.2 Construction of the Trust's business plan.
    9.3 Key principles.
    9.4 Corporate support.
    9.5 High level planning assumptions.
    9.6 Key outputs of the business planning process.
    9.7 Trust Committee timetable.
    9.8 Emerging financial risks for 2019/20.
    9.9 The formal NHSI business plan submission timetable is yet to be released and is expected to be in November. The Trust has agreed a target deadline of all 2019/20 contracts signed and final operational plans to be completed by the end of March 2019.
    9.10 The Trust will be developing its business plan to be presented for approval at the March 2019 Board meeting.

9.11 The FPC will receive regular progress updates.

Strategic Investment Group (SIG)

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

RECOMMENDATIONS AND ACTION REQUIRED:

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

East Kent Hospitals University NHS Foundation Trust

Finance Performance Report 2018/19

September 2018

Director of Finance and Performance Management
Philip Cave

We care

Contents and Appendices

Month 06 (September) 2018/19

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Executive Summary
Month 06 (September) 2018/19

Executive Summary

The Trust has generated a consolidated deficit in month of £1.8m and a year to date (YTD) deficit of £17.4m which is £1.2m behind plan. YTD position includes some significant variances the drivers for which remain similar to last month.
However in month 6 clinical income has suffered as a result of PAS go live and would be £1.1m under plan if it were not for the release of £1.7m of prior year expert determination reserve which CCGS have now settled. In addition the Trust operational and information teams are reviewing the activity recording for September to confirm the estimates which have had to be included in this months income position due to some missing data. In previous months over performance in income has offset the pay overspends, unfortunately this month due to the above reasons this has not happened. The plan assumes increased elective activity over the coming six months which, if not delivered, will lead to failure to deliver the financial plan.
As the Trust is in FSM it is measured against its performance excluding technical adjustments. After these are removed the Trust's YTD I&E deficit to Month 6 (September) was £17.1m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £15.7m, £1.4m worse than plan. A reconciliation of the various adjustments is presented below.

	This Month			Year to Date		
£'000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EKHUFT Income (inc PSF)	49,891	50,469	577	290,600	298,955	8,355
EKHUFT Pay	(30,363)	(31,952)	(1,589)	(182,599)	(190,826)	(8,226)
EKHUFT Non-Pay	(20,334)	(20,588)	(254)	(124,244)	(126,039)	(1,795)
EKHUFT Financial Position (inc PSF)	**(806)**	**(2,071)**	**(1,265)**	**(16,242)**	**(17,909)**	**(1,667)**
Subsidiaries Financial Position	10	229	219	57	483	425
Consolidated I&E Position (inc PSF)	**(796)**	**(1,842)**	**(1,046)**	**(16,185)**	**(17,427)**	**(1,242)**
Impairments Adjustment	85	88	3	511	368	(142)
PSF Funding	0	0	0	0	0	0
Consolidated I&E Position (excl PSF)	**(711)**	**(1,754)**	**(1,043)**	**(15,675)**	**(17,059)**	**(1,384)**

Trust unconsolidated pay costs in the month of £32m are £0.5m less than August. However the prior month included a net £1m of pay areas and once this is taken into account the net position is an increase of £0.5m in month. After removing the pay award adjustments, substantive staff costs were £0.2m more than last month due to increasing permanent staff numbers. Temporary staffing costs have also increased in month with Bank costs increasing £0.3m (driven by medical and nursing increases) and Agency spend increasing £0.1m driven by medical staffing. Agency costs are now £11.5m more than plan YTD driven by operational pressures. Permanent staff costs (including Overtime and waiting list work) are £2.7m less than plan YTD driven by all staff groups other than HCA's. U&LTC have managed to reduce agency in month by initiatives such as removal of TFS.
Clinical income was ahead of plan by £0.6m in month (£0.2m once the impact of central pay award funding is removed). The net YTD position is now £2.7m ahead of plan. The key drivers to this remain over performance of non-electives, A&E and ITU offset by under performance in elective and Outpatient activity. In month clinical income has over performed slightly mainly due to a favourable resolution of 2017/18 disputes with commissioners and high NEL and A&E performance however this is offset by underperformance in Elective and Outpatient work driven by a PAS go live and an increasing plan. Other income is on plan in month and above plan YTD driven mainly by the SERCO termination payment.
CIPS: Against the full year £30m target, including income, £12m has been reported YTD against a target of £11.4m, £0.6m ahead of plan. CIPs achieved in M06 were £1.6m against a plan of £1.3m. Medicines Value and Divisions over performed in month and YTD. Agency is above plan in month, but adverse YTD, whilst Procurement is below plan in month and YTD. CIPs in September amounted to £1.5m recurrent and £0.1m on a non-recurrent basis. The YTD position is recurrent £6.8m and non-recurrent £5.2m.
Cash: The Trusts cash balance as at the end of September was £5.1m, which is on plan. The Trust's total cash borrowing is now £60.7m.
Risk: The Trust carries and estimated £7.3m of risk to the year end position in relation to expert determination and challenges on income, CIP delivery and activity related costs. The Trust will seek to mitigate these risks as we move through the year.

Income and Expenditure A

Income has performed over plan in September, due largely to recognition of prior year settlements £1.65m and £0.4m unplanned income to fund Agenda for Change pay awards. Non-Electives, A&E and Other NHS Areas also over performed in month. Non-Electives are over plan by £0.6m in September, largely due to Obstetrics, Healthcare of the Elderly and Stroke Medicine activity. Other non clinical income is on plan.
Pay performance is adverse to plan in September by £1.6m and by £8.2m ytd (4.5%). Pay CIPs are adverse to plan in month by £0.5m and by £2.0m ytd. The YTD variance is driven principally by additional Agency costs associated with UC&LTC and Surgery medical and nursing staffing . Interventions in U&LTC are beginning to show signs of reducing agency spend e.g. the removal of TFS but pressures remain in Surgery and pay CIPS are under delivering.
Non pay is overspent by £0.5m in September mainly as a result of phasing on unrealised planned CIPs from 2gether Support Solutions, an adverse performance on clinical supplies and higher than planned referrals to the independent sector totalling £1.2m. This is offset by a favourable performance on drugs and receipt of CNST maternity incentive scheme rebate totalling £0.9m.

Cash G

The Trust's cash balance at the end of June was £5.1m which on plan. The main drivers for the YTD position are as follows:-

- CCG payments are net £7.1m below plan due to the lowering of the contract value and no cash settlement for 2017/18 being received yet.
- HMRC VAT returns are £1.3m above plan
- Other Income is £6.1m above plan; £2.2m from Serco on other income, STF funding of £1.4m and £2.5m of AfC funding from the DoH
- Loans from DHSC are £8.5m above plan
- Cash payments including agency and capital are £12m above plan net.
- Payroll costs are £3.2m lower than planned.

The Trust borrowed £5m in month bringing total borrowings to £60.7m. The total expected borrowing by the end of the year will be £89.8m. The increase in expected borrowings from plan is due to adoption of a cautious view on cash receipts from the CCG contract.

Capital Programme A

The Trust has spent £5m on capital to September which is £1m behind plan. The majority of the underspend is driven by slippage on the Dementia Village project and some PEIC and IT programmes due to long lead times ordering IT goods. The capital plan is currently being reviewed in order that developments such as the pilot elective orthopaedic centre can be reflected. The Capital plan for the year remains at £16m.

Cost Improvement Programme G

Net CIPs in month were £0.3m ahead of plan bringing the YTD position to £0.6m ahead of plan at £12m of savings YTD. The main variances in month relate to over delivery of agency reduction and Divisional efficiencies whilst procurement schemes under delivered. YTD 43% of all CIPs are non-recurrent .Risks to the full year plan remain. A review of plans has identified planned schemes which are unlikely to deliver in 2018/19. Care groups are currently in the process of assessing options for the delivery in the remainder of the year.

Income and Expenditure Summary
Month 06 (September) 2018/19

Unconsolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Electives	10,423	8,198	(2,225)	50,880	47,196	(3,684)	103,209
Non-Electives	13,242	13,755	514	81,562	84,630	3,069	161,862
Accident and Emergency	2,162	2,473	311	13,325	14,805	1,480	26,226
Outpatients	6,507	6,302	(205)	40,066	38,920	(1,146)	81,011
High Cost Drugs	4,575	4,389	(186)	27,906	26,910	(996)	55,662
Private Patients	21	8	(13)	126	155	29	248
Other NHS Clinical Income	9,142	11,493	2,352	53,961	60,356	6,396	109,496
Other Clinical Income	154	198	44	921	916	(5)	1,845
Total Clinical Income	**46,224**	**46,818**	**594**	**268,746**	**273,889**	**5,143**	**539,558**
Non Clinical Income	3,667	3,651	(16)	21,854	25,065	3,211	44,059
Total Income	**49,891**	**50,469**	**577**	**290,600**	**298,955**	**8,355**	**583,617**
Expenditure							
Substantive Staff	(27,904)	(27,497)	407	(166,899)	(164,157)	2,742	(326,479)
Bank	(1,111)	(1,472)	(361)	(6,744)	(7,423)	(678)	(19,900)
Agency	(1,348)	(2,983)	(1,635)	(8,956)	(19,246)	(10,290)	(19,431)
Total Pay	**(30,363)**	**(31,952)**	**(1,589)**	**(182,599)**	**(190,826)**	**(8,226)**	**(365,810)**
Non Pay	(18,119)	(18,659)	(540)	(110,998)	(113,291)	(2,293)	(222,146)
Total Expenditure	**(48,482)**	**(50,611)**	**(2,129)**	**(293,597)**	**(304,116)**	**(10,519)**	**(587,956)**
Non-Operating Expenses	(2,215)	(1,929)	286	(13,246)	(12,748)	498	(26,648)
Income and Expenditure Surplus/(Deficit)	**(806)**	**(2,071)**	**(1,265)**	**(16,242)**	**(17,909)**	**(1,667)**	**(30,987)**

Consolidated	This Month			Year to Date			Annual
£000	Plan	Actual	Var.	Plan	Actual	Var.	Plan
Income							
Clinical Income	46,915	47,609	694	272,892	279,020	6,128	547,857
Non Clinical Income	3,552	3,691	139	21,164	24,669	3,505	42,682
Total Income	**50,467**	**51,300**	**833**	**294,056**	**303,689**	**9,633**	**590,539**
Expenditure						-	
Pay	(30,717)	(33,635)	(2,918)	(184,723)	(195,703)	(10,980)	(370,054)
Non Pay	(18,308)	(17,558)	750	(112,132)	(112,564)	(432)	(224,416)
Total Expenditure	**(49,025)**	**(51,193)**	**(2,168)**	**(296,855)**	**(308,267)**	**(11,412)**	**(594,470)**
Non-Operating Expenses	(2,238)	(1,949)	289	(13,386)	(12,849)	537	(26,924)
Income and Expenditure Surplus/(Deficit)	**(796)**	**(1,842)**	**(1,046)**	**(16,185)**	**(17,427)**	**(1,242)**	**(30,855)**

Clinical Income

Income from Commissioners in month was ahead plan. Non elective income remains higher than planned, while elective income is showing a large, one off, negative variance due to a phased increase in plan and lower than normal run rates recorded due to the impact of the PAS implementation. The majority of the adverse variances are contained within Electives, Outpatients and Non-PbR The reduction in outpatient attendances was put in place in order to ensure the smooth implementation of the PAS system. The largest increase in income is £1.65m relating to settlement of previous years contract valued with the local Commissioners, as well as £0.4m funding received in month to cover the pay awards which is included under "Other NHS Clinical Income" and for which there is no clinical income plan.

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

NHSE Contracts are behind plan in month by £902k. Rechargeable expenditure such as high cost drugs, devices and haemophilia blood products over performed by £167k in month across all contracts. The Trust contract with NHSE includes £4.1m of QIPP expectation with the Trust agreeing to work with NHSE to implement cost savings where possible, however, the risk against non achievement sits with the commissioner.

Non Clinical Income and Expenditure

Non clinical income is on plan in September and favourable to plan ytd by £3.2m. In month, unplanned income relating to services provided and recharges to 2gether Support Solutions of lest than £0.1m is offset by adverse performances against plan on donated asset and education and training income totalling £0.1m. YTD variances are as previously reported.

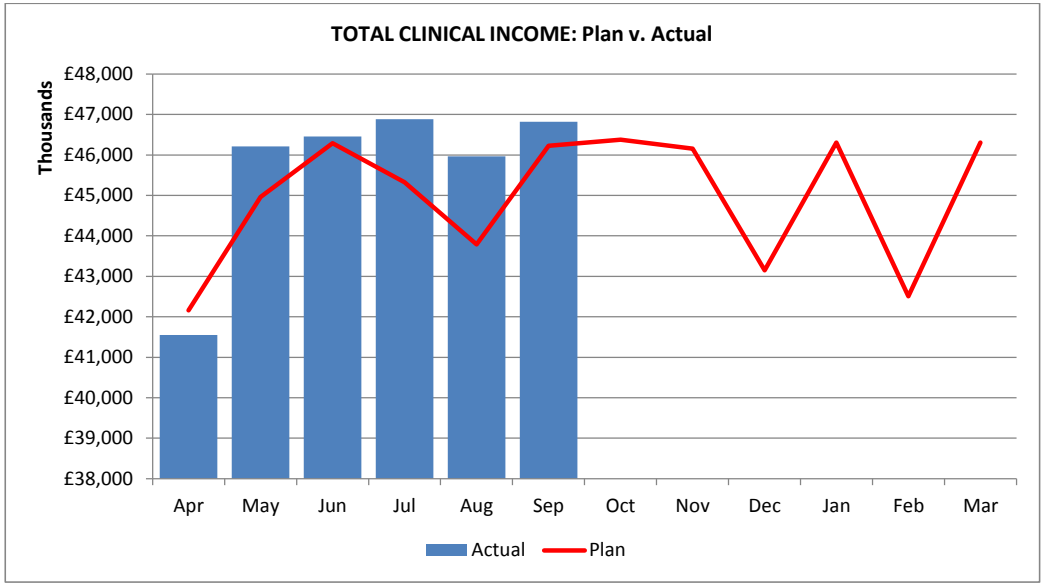
Total expenditure is adverse to plan by £2.1m in September and £10.5m ytd. In month, pay is overspent by £1.6m again mainly driven by agency and direct engagement spend, predominantly medical and nursing staff, which is £1.6m adverse to plan. Non pay is overspent by £0.5m in September mainly as a result of phasing on unrealised planned CIPs from 2gether Support Solutions, an adverse performance on clinical supplies and higher than planned referrals to the independent sector totalling £1.2m. This is offset by a favourable performance on drugs and receipt of CNST maternity incentive scheme rebate totalling £0.9m.

The expenditure run rate has reduced by £1.3m in September when compared to August, with pay spend reducing by £0.5m (August included net additional costs of £1.0m re pay award adjustments) and non pay spend reducing by £0.8m. The CNST maternity incentive scheme rebate mentioned above accounts for £0.5m of the non pay reduction and drug spend reduced by £0.2m.

Key Highlights
Month 06 (September) 2018/19

CLINICAL INCOME

Clinical income is over plan in September by £0.6m. The main reason for this is £1.65m of over performance which is due to recognition of previous year settlements. Non-Elective income is ahead of plan (£0.5m), while Elective income is under planned levels by £2.2m due to a one off increase in phased budget. Outpatients are under performing by 0.2m. Non-Elective income remains high due to continued richer than planned casemix as activity is below plan in month but income is greater. The Trust services are treating patients with more complex needs than planned. A&E Income is also ahead of plan in month by 14.4% driven largely by activity, which includes an estimate to catch up for activity issues during the PAS switch over. Elective CIPs are held centrally and services are finding it difficult to meet these income targets in month. Higher than planned levels of regular day attenders continue which is generating a lower case mix variance resulting in lower average tariffs within Electives.



ACTIVITY

A&E demand is ahead of plan by 2.7% this month. This over performance follows on from August and continues to improve against recent trends which was driven by the temporary transfer of some ED specialties from KCH to WHH and QEQM. Non-elective activity has performed below plan in month, however richer casemix has meant that income is 3.9% above plan. The commissioners have increased the provision of care packages with a view to returning patients home more quickly and as part of their QIPP schemes are investing in preventing patients with Pneumonia from coming to the hospital where they can be treated at home. Outpatient activity is behind plan in month and YTD. Elective activity is 12.9% behind plan in month, however, the phased plan adjustment made for higher elective income was not applied to activity so this measure is not reflected here.

COMMISSIONER ANALYSIS

Activity plans reflected CCG QIPP schemes to the value of £2.1m YTD. Any new commissioner QIPP schemes will be added to the contracts via a contract variation once the Trust is satisfied that the schemes are achievable in the timeframes set out. GP referrals were 8.4% behind plan in September. Many of our outpatient services are now listing at 13 weeks and beyond, but continued focus on reducing 52 week waiters is producing positive results.

The Trust has agreed an April and May closedown position with East Kent CCGs and both parties have committed to a financial reconciliation and closedown of Q1 by the 1st October 2018. However, EK CCGs have subsequently challenged the Q1 outturn and it has not yet been possible to enact the closedown. Negotiations are ongoing. The Trust does not foresee any risk to our reported position.

Key Highlights
Month 06 (September) 2018/19

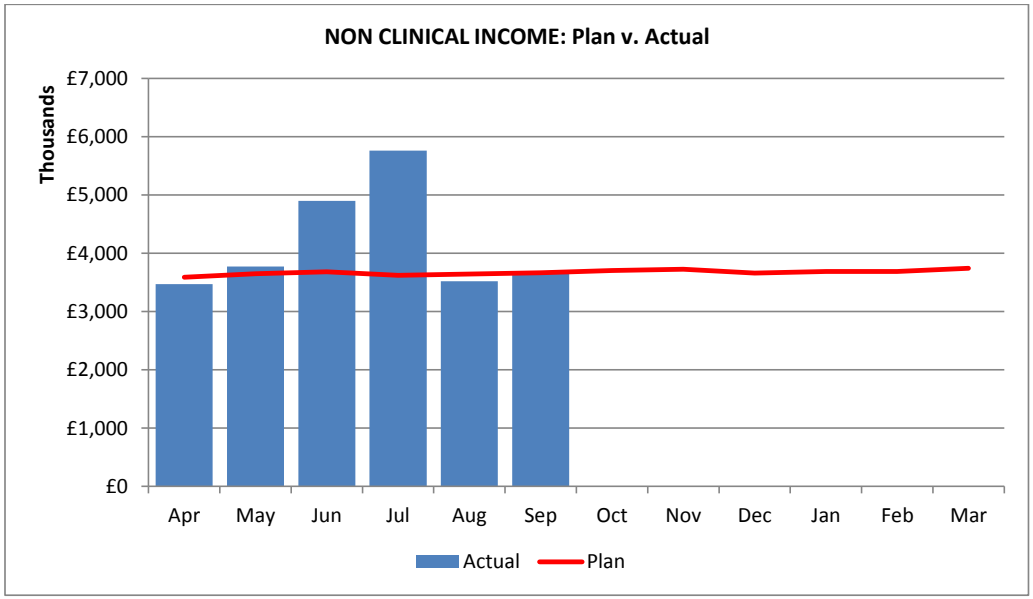
NON CLINICAL INCOME
Non clinical income is on plan in September and favourable to plan ytd by £3.2m.

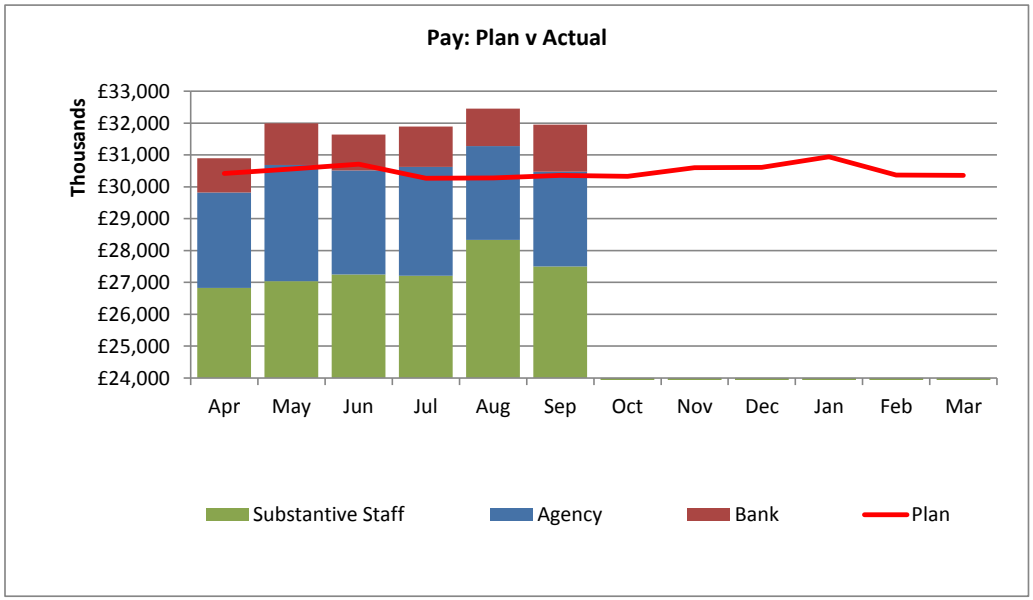
In month, unplanned income relating to services provided and recharges to 2gether Support Solutions of £0.1m is offset by adverse performances against plan on donated asset and education and training income totalling £0.1m.

PAY
Pay performance is adverse to plan in September by £1.6m and by £8.2m ytd (4.5%). Pay CIPs are adverse to plan in month by £0.5m and by £2.0m ytd.

Total expenditure on pay in September was £32.0m, £0.5m lower than in August. However, August spend included a net cost of £1.0m relating to non medical pay award arrears offset by the release of medical pay award accruals. Expenditure on temporary staffing, medical locum sessions and waiting list payments increased in total by £0.2m when compared to spend in August.

The overspend in month is again driven by the usage of agency and directly engaged staff which are overspent by a total of £1.6m. Pressures remain in UC&LTC where nursing agency usage is adverse to plan in month by £0.9m and in Surgical Services where medical agency usage is adverse to plan by £0.4m. Premium rate spend on TFS agency HCAs within UC&LTC ceased in September which is evidenced by the breakeven position on Other staff agency.





Key Highlights
Month 06 (September) 2018/19

NON-PAY
Non Pay expenditure is adverse to plan in September by £0.5m and by £2.3m ytd.

The main drivers for the overspend in September are an adverse performance on CIP schemes, predominantly Clinical Supplies and 2gether Support Solutions totalling £0.7m and referrals to the independent sector which are £0.2m adverse to plan. These overspends are offset by receipt of the maternity incentive scheme rebate from CNST of £1.0m, £0.5m of which was accounted for in September and allocated to CIPs.

Non pay actual expenditure in September reduced by £0.8m when compared to August, mainly relating to the CNST maternity incentive scheme rebate detailed above and a reduction in drug spend of £0.2m.

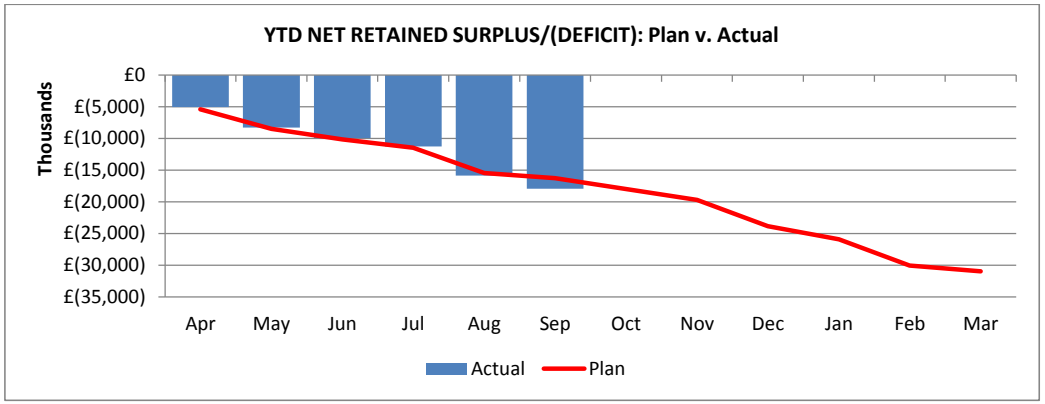
DEBT
Total invoiced debtors have decreased from the opening position of £28.5m by £8.9m to £19.6m. The largest debtors at 30th September were East Kent CCGs £6.8m and East Kent Medical Services £1.9m.

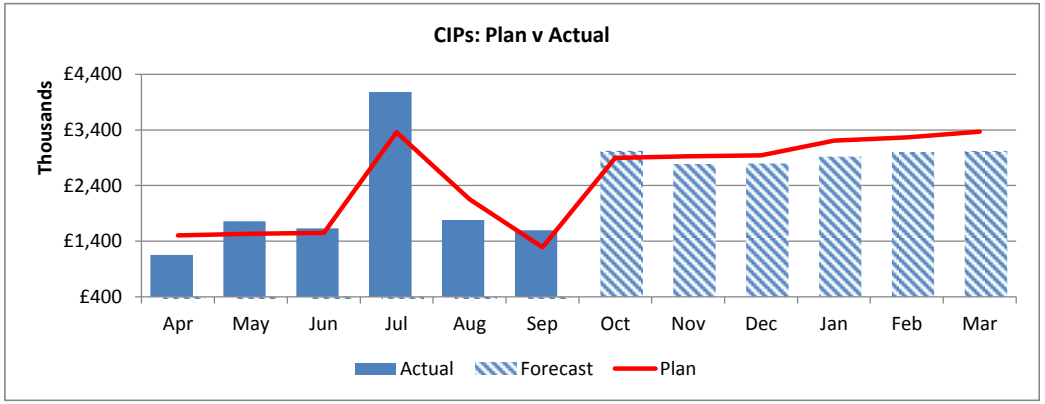
CAPITAL
Total YTD expenditure for Mth 6 2018/19 is £1.0m below the NHSI plan

EBITDA
The Trust is reporting a year to date deficit EBITDA of £5.1m

CASH
The closing cash balance for the Trust as at 30th September was £5.1m.

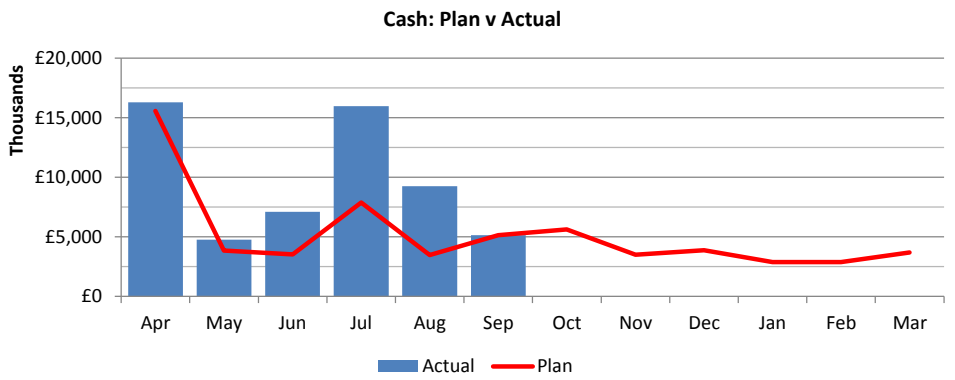
FINANCING
£931k of interest was incurred in respect of the drawings against working capital facilities to 31st March 2018 (£46.2m) and April 2018 (£2.2m), July 2018 (£3.4m), August (£3.7m) and September (£5.1m)





CIPS
The target for the year is £30m. The NHSI Improvement Director is maintaining confirm and challenge meetings. As at the time of reporting, c.89% of schemes were 'green' rated . The major focus is on delivering 18/19 schemes and progressing 'red' and 'amber' schemes to 'green'. Divisions , supported by the PMO, are being asked to work up schemes to close out 2018/19 and deliver 2019/20.

Cash Flow
Month 06 (September) 2018/19



Unconsolidated Cash balance was £5.1m at the end of September 2018, £0.02m above plan.

Total receipts in September 2018 were £3.7m below plan

- Receipts from East Kent CCGs were £0.9m below plan for Main Contract and £6.5m below plan for 1718 overperformance
- Receipt from NHSE for 1718 overperformance £1.4m below plan
- Loans from DHSC £5.1m over plan
- Total Payments in September 2018 were £2.0m over plan
- Monthly payroll was £0.4m above plan
- Creditor payments inc Capital were £1.7m above plan

YTD cash receipts are £8.8m above plan

- East Kent CCGs are net £7.1m below plan. Payments against contract are £5.9m below plan due to the reduction of their contract value. Payments for 17/18 overperformance are £1.2m below plan
- Receipt of £2.5m AfC funding from DoH
- HMRC VAT returns are £1.3m above plan
- STF receipt was £1.4m above plan
- Loans from DHSC £8.5m above plan
- Other receipts are £2.2m above plan; £2.5m received from Serco offset by other receipts £0.3m below plan
- YTD cash payments are £8.9m above plan
- Payroll is £3.2m below plan
- Creditor Payments including Capital are £12.1m above plan

2018/19 Forecast

- The forecast includes restrictions on creditor payment runs throughout the year to ensure that a positive cash balance is maintained
- The impact of 2gether Support Solutions operating fully has been reflected in the Payroll and Creditors payments forecast. Additional changes to the forecast may still be made once the full effects are known.

Provider Sustainability Funding (Formerly Sustainability and Transformation Funding)

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

Working Capital Facility

Loan Schedule	Loan Value £'000	Facility Type	Repayment date	Interest rate	Total Interest if full term £'000
2016/17 Received	22,736	ISRWF	17/05/2021	3.5%	3,688
2017/18 Received	23,492	ISUCL	2020/21	3.5%	2,485
Apr' 2018 (Received)	2,234	ISUCL	2021/22	3.5%	323
July' 2018 (Received)	3,410	ISUCL	2021/22	3.5%	359
Aug' 2018 (Received)	3,708	ISUCL	2021/22	3.5%	391
Sept' 2018 (Received)	5,103	ISUCL	2021/22	3.5%	538
Nov' 2018 (Forecast)	6,032	ISUCL	TBA	TBA	TBA
Dec' 2018 (Forecast)	7,988	ISUCL	TBA	TBA	TBA
Jan' 2018 (Forecast)	3,746	ISUCL	TBA	TBA	TBA
Feb' 2018 (Forecast)	3,532	ISUCL	TBA	TBA	TBA
March' 2018 (Forecast)	7,856	ISUCL	TBA	TBA	TBA

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

Creditor Management

- Creditor management continued to be applied throughout September 18. The Trust is close to the limit in restricting creditor payments and still being able to receive essential goods and services. At the end of September 2018 the Trust was recording 67 creditor days (Calculated as invoiced creditors at 30th September/ Forecast non pay expenditure x 365)
- The Trust has been flagged in the national press as one of the slowest paying Trusts in the country.

Facility Type Key

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

Income and Expenditure Forecast
Month 06 (September) 2018/19

Unconsolidated	Annual			Forecast	Normalised [D.12]	
£000	Plan	Forecast	Var.	Adjustment	Forecast	Var.
Income						
Electives	100,573	-	-	-	-	-
Non-Electives	161,862	-	-	-	-	-
Accident and Emergency	26,226	-	-	-	-	-
Outpatients	81,677	-	-	-	-	-
High Cost Drugs	55,662	-	-	-	-	-
Private Patients	248	-	-	-	-	-
Other	113,310	-	-	-	-	-
Total Clinical Income	**539,558**	**559,883**	**20,325**	**-**	**559,883**	**(20,325)**
Non Clinical Income	44,059	46,775	2,716	(500)	46,275	(2,216)
Total Income	**583,617**	**606,658**	**23,041**	**(500)**	**606,158**	**(22,541)**
Expenditure	-	-	-	-	-	
Substantive Staff	(332,710)	(330,529)	2,181	-	(330,529)	(2,181)
Bank	(13,411)	(14,148)	(737)	-	(14,148)	737
Agency	(19,431)	(39,081)	(19,650)	-	(39,081)	19,650
Total Pay	**(365,552)**	**(383,758)**	**(18,206)**	**-**	**(383,758)**	**18,206**
Non Pay	(222,404)	(231,997)	(9,593)	-	(231,997)	9,593
Total Expenditure	**(587,956)**	**(615,755)**	**(27,799)**	**-**	**(615,755)**	**27,799**
Non-Operating Expenses	(26,648)	(47,948)	(21,300)	26,025	(21,923)	(4,725)
Income and Expenditure Surplus/(Deficit)	**(30,987)**	**(57,045)**	**(26,058)**	**25,525**	**(31,520)**	**533**

Consolidated	Annual			Forecast	Normalised [D.12]	
£000	Plan	Forecast	Var.	Adjustment	Forecast	Var.
Income						
Clinical Income	547,857	568,182	20,325	-	568,182	20,325
Non Clinical Income	42,682	47,731	5,049	(500)	47,231	4,549
Total Income	**590,539**	**615,913**	**25,374**	**(500)**	**615,413**	**24,874**
Expenditure						
Pay	(370,054)	(388,260)	(18,206)	-	(388,260)	(18,206)
Non Pay	(224,416)	(234,494)	(10,078)	-	(234,494)	(10,078)
Total Expenditure	**(594,470)**	**(622,754)**	**(28,284)**	**-**	**(622,754)**	**(28,284)**
Non-Operating Expenses	(26,924)	(48,690)	(21,766)	26,025	(22,665)	4,259
Income and Expenditure Surplus/(Deficit)	**(30,855)**	**(55,531)**	**(24,676)**	**25,525**	**(30,006)**	**849**

The Trust's consolidated year end forecast has been amended to £29.9m deficit, having been modelled against assumptions under a 'best case' scenario. When compared against a deficit control total equivalent (no STF assumed) of £29.8m, this is £0.1m adverse to plan.

CIPS of £30.5m have been assumed to support the delivery of this forecast.

The unconsolidated forecast for non-operating expenses worsens considerably because of an estimated £25.0m of impairments triggered by the transfer of assets to 2SS. However, after NHSi technical adjustments this impact is removed as referenced in the normalised forecast.

The Trust's income year end forecast is based on Month 5 actuals, adjusted for a number of assumptions including Elective and Day Case activity meeting planned levels by year end, two additional wards opening in emergency care over the winter at WHH and QEQM and 2 additional ITU beds. Over performance in other NHS Clinical Income includes £5m unplanned funding for pay awards, £3m over performance for ITU and better than CQUIN achievement . Q1 achieved at 100%.

Expenditure includes an estimated additional £7m of cost for business cases approved to support the Winter plan

Work will continue to evaluate the forecast in 'best', 'likely' and 'worst' case scenarios considering current trends, progress against approved investments and identified risks

Risks and Opportunities
Month 06 (September) 2018/19

Risk/Opp	Area	Description	Narrative	Full Year (Risk)/Opp £000	Probability	Impact £,000
RISK	Clinical Income	Expert Determination and Challenges	The full impact of the Expert Determination findings is currently being worked through with commissioners. There is some risk that the actual impact of the determination is higher than assumed in our 18-19 plan and further challenges exist.	(3,580)	55%	(2,000)
Risk	CIP Delivery	Failure to deliver Planned activity	Organisation is running well behind planned activity levels which are required to meet the financial targets	(10,000)	14%	(1,400)
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)
Risk	Pay and Non Pay	Costs of Additional Activity	The costs of additional activity may exceed the marginal costs for this activity and additional spend may be required to cover winter activity and address elective backlogs.	(5,857)	43%	(2,543)
			Total Risk			(7,343)
			Total Opportunity			
			NET (RISK)/OPPORTUNITY			(7,343)

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

Clinical Income

Month 06 (September) 2018/19

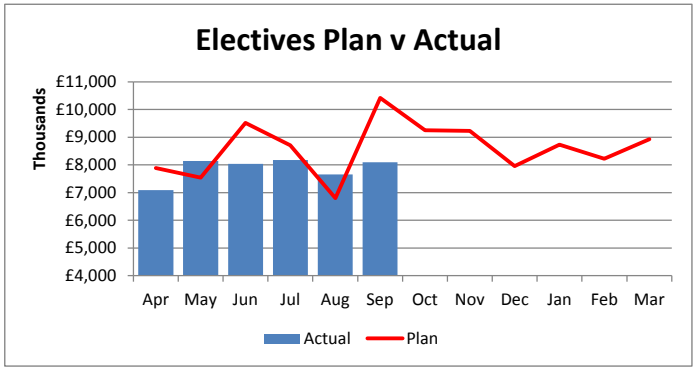
	This Month				Year to Date				Annual
£000	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	10,423	8,095	(2,327)	(22.3%)	50,880	47,196	(3,684)	(7.2%)	103,209
Non-Electives	13,242	13,833	592	4.5%	81,562	84,630	3,069	3.8%	161,862
Accident and Emergency	2,162	2,472	310	14.3%	13,325	14,805	1,480	11.1%	26,226
Outpatients	6,506	6,101	(406)	(6.2%)	40,066	38,920	(1,146)	(2.9%)	81,011
High Cost Drugs	4,575	4,748	173	3.8%	27,906	26,910	(996)	(3.6%)	55,662
Private Patients	21	8	(13)	(59.5%)	126	155	29	23.1%	248
Other NHS Clinical	9,142	11,330	2,189	23.9%	53,961	60,358	6,397	11.9%	109,496
Other Clinical	153	198	44	28.9%	921	916	(5)	(0.5%)	1,845
Prior Month Adjustment		33	33	0.0%				0.0%	
Total	**46,224**	**46,819**	**595**	1.3%	**268,746**	**273,891**	**5,145**	1.9%	**539,558**
			Favourable				Favourable		

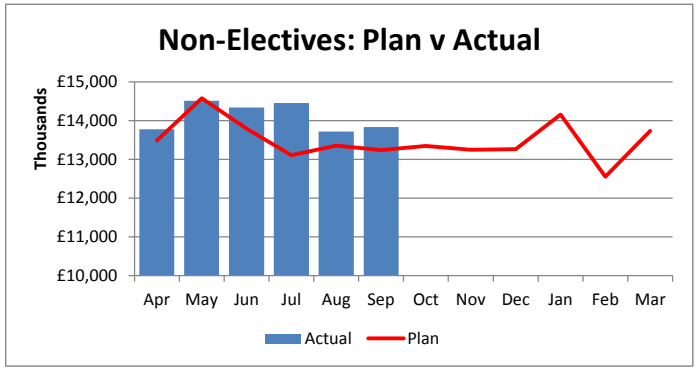
Income has performed over plan in September, due largely to recognition of prior year settlements £1.65m and £0.4m unplanned income to fund Agenda for Change pay awards. Non-Electives, A&E and Other NHS Areas also over performed in month. Non-Electives are over plan by £0.6m in September, largely due to Obstetrics, Healthcare of the Elderly and Stroke Medicine activity.

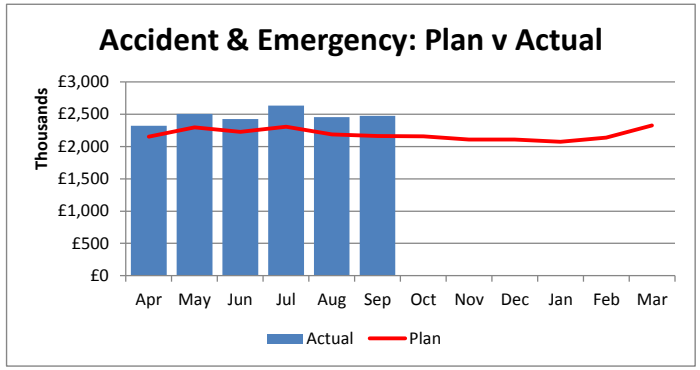
Elective inpatients and Day cases under performed in month as the Elective plan phasing was increased above run-rate. The main areas behind plan were T&O, General Surgery, Ophthalmology, Pain Management, Dermatology & Gynaecology. To mitigate the risk of non achievement, plans for using Independent Sector organisations for the rest of the year are as follows: 18 Week Support in Gastroenterology, Chaucer, One Ashford, SHS and Spencer wing for Trauma & Orthopaedics, DMC to continue to deliver Dermatology activity, Insourcing for Ear, Nose & Throat patients, HBS and Spencer Wing for Ophthalmology outpatient activity and Spencer Wing to help waiting times for Rheumatology Outpatient first attendances.

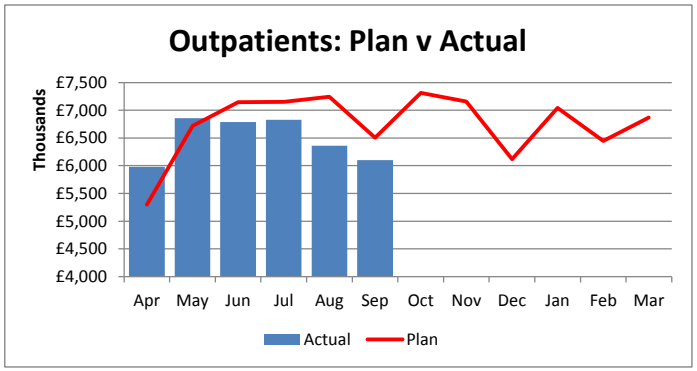
Other NHS Clinical activity is also ahead of plan due to an amount received to cover the increased pay award costs (£0.4m) along with a reduction in the risks position and recognition of prior year settlements with the East Kent CCG's (£1.65m)

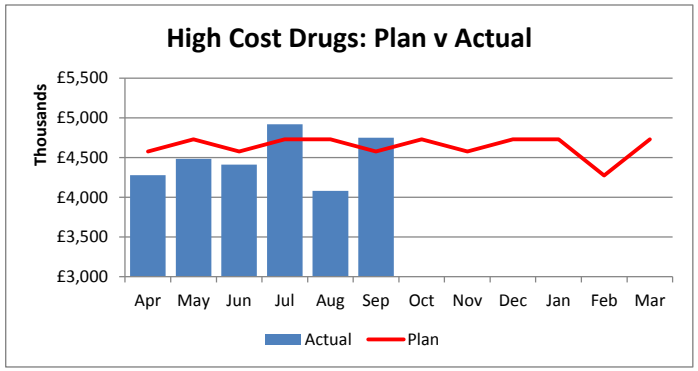
Rechargeable income is over plan in month with Drugs and Devices £167k above plan. This does not impact the bottom line as there is a corresponding increase in expenditure.

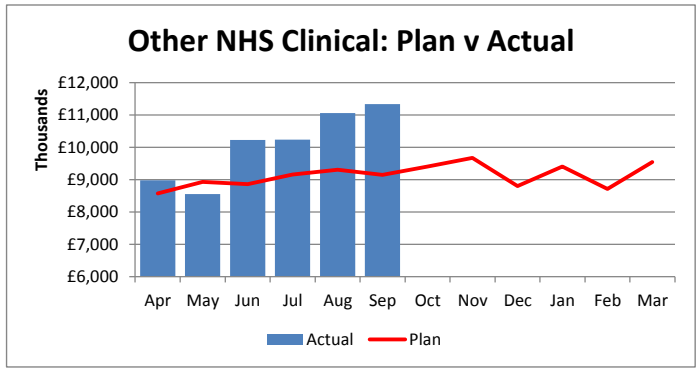












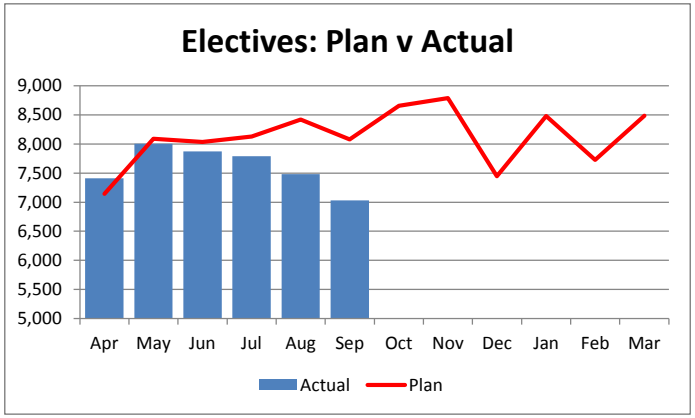
Clinical Activity

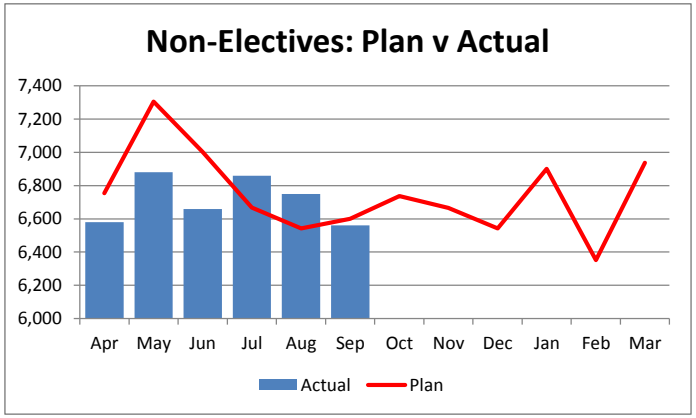
Month 06 (September) 2018/19

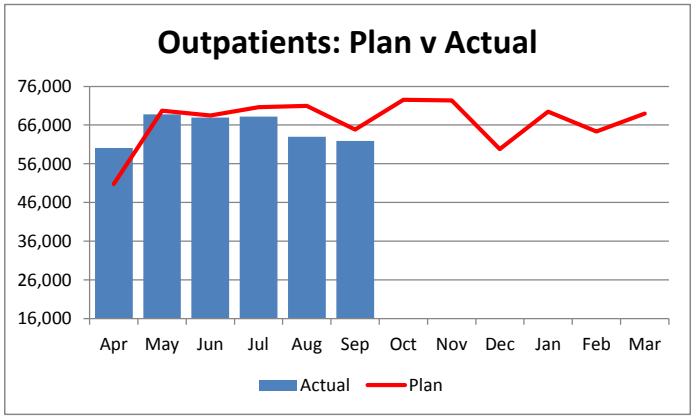
	This Month				Year to Date				Annual
Activity Units	Plan	Actual	Variance		Plan	Actual	Variance		Plan
Electives	8,077	7,033	(1,044)	(12.9%)	47,891	45,594	(2,297)	(4.8%)	97,481
Non-Electives	6,601	6,561	(40)	(0.6%)	40,875	40,287	(588)	(1.4%)	81,010
Accident & Emergency	17,387	17,849	462	2.7%	107,265	110,668	3,403	3.2%	211,076
Outpatients	64,863	61,879	(2,984)	(4.6%)	395,498	389,780	(5,718)	(1.4%)	802,956
Other NHS Clinical	454,456	448,352	(6,104)	(1.3%)	2,723,461	2,828,484	105,023	3.9%	5,397,116
Total	**96,928**	**93,322**	**(3,606)**	(3.7%)	**591,529**	**586,329**	**(5,200)**	(0.9%)	**1,192,523**
				Adverse				Adverse	

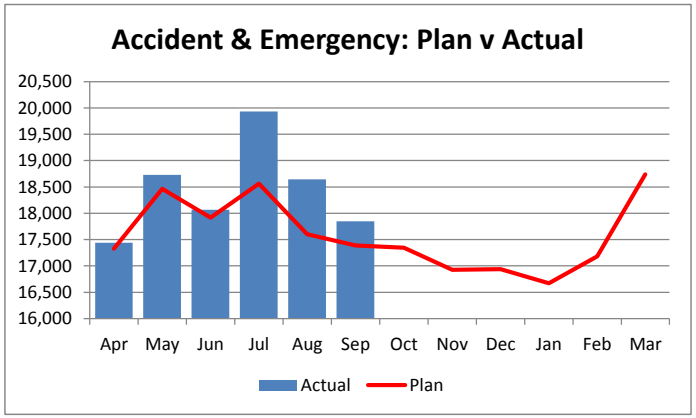
Within Elective activity (overall 12.9% under), Inpatient activity was 15.3% over plan largely due to Cancer activity (by 179) and General Medicine (by 72), and Day case activity was 19.1% under plan (Dermatology 258, T&O 219, Ophthalmology 114, Pain Management 269 and General Medicine 171). There has been an error relating to Regular Day Attender activity being classified as Electives & Daycases in the 2 weeks immediately after new PAS go live. This has since been corrected and activity levels will be in line with trend going forward. This has no financial implications.

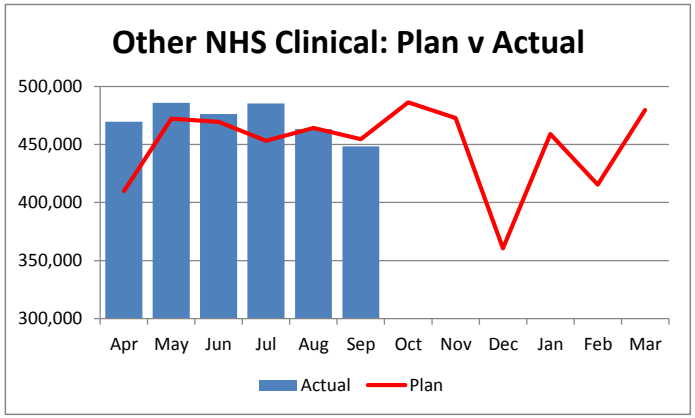
Outpatient activity under performed in month by 4.6% across new and follow up attendances, many areas were behind plan such as: Urology, Oral Surgery, T&O, Pain Management, General Medicine, Gynaecology, Respiratory Medicine, Rheumatology, Paediatrics and Physiotherapy, while the only notable over performing specialties were Cardiology and Ophthalmology. Most specialties reduced activity in September in order to ensure the smooth implementation of PAS system. Divisions have signed off their demand and capacity plans and have been funded to resource each speciality to a level that will allow the to meet their plans. Achievement of this will depend upon the ability to recruit to key positions in hard to recruit to areas and an increased use of the independent sector.







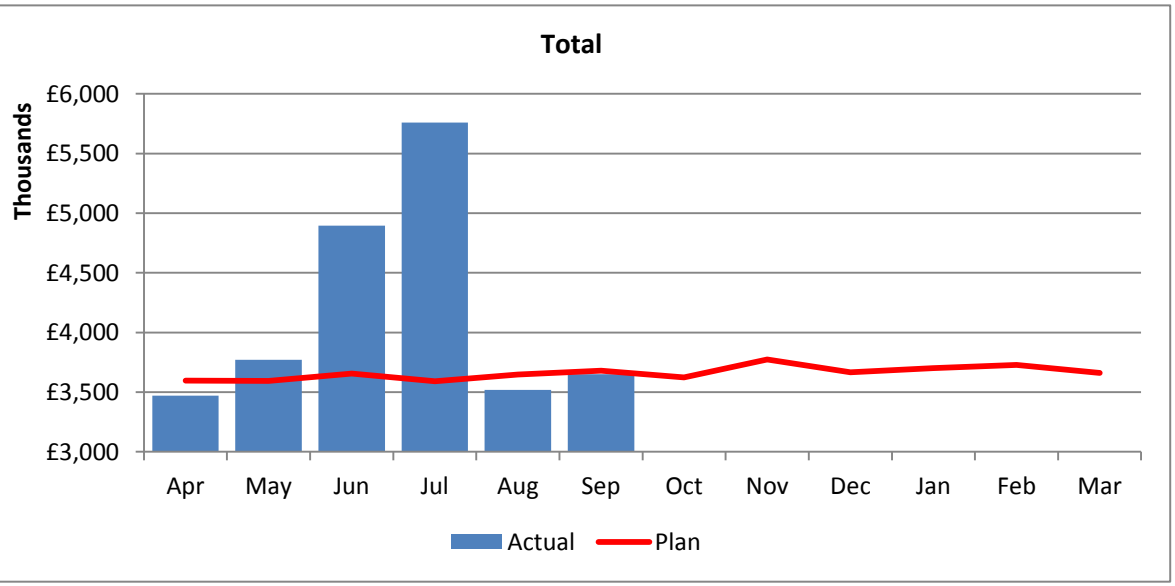




Non Clinical Income

Month 06 (September) 2018/19

Income - Other	This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Non-patient care services	1,429	1,398	(31)	8,576	9,355	779	17,150
Research and development	223	224	1	1,338	1,351	13	2,673
Education and Training	1,269	1,206	(63)	7,614	7,534	(80)	15,233
Car Parking income	383	408	25	2,278	2,446	168	4,766
Staff accommodation rental	217	228	11	1,174	1,106	(68)	2,494
Property rental (not lease income)	1	1	()	7	6	(1)	13
Cash donations / grants for the purchase of capital assets	42		(42)	252	160	(92)	500
Charitable and other contributions to expenditure	12	12	()	72	72	()	145
Other	91	174	84	543	3,036	2,493	1,085
Total	**3,667**	**3,651**	**(16)**	**21,854**	**25,065**	**3,211**	**44,059**
			-0.44%			14.69%	
			Adverse			Favourable	



Non clinical income is on plan in September and favourable to plan ytd by £3.2m.

In month, unplanned income relating to services provided and recharges to 2gether Support Solutions of £0.1m is offset by adverse performances against plan on donated asset and education and training income totalling £0.1m.

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

Pay
Month 06 (September) 2018/19

Pay Expenditure	WTE This Month			This Month			Year to Date			Annual
£000	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Permanent Staff										
Medical and Dental	1,101	1,021	80	(8,173)	(8,032)	141	(48,887)	(47,743)	1,143	(97,532)
Nurses and Midwives	2,429	2,031	398	(7,731)	(7,624)	107	(46,238)	(45,514)	724	(92,248)
Scientific, Therapeutic and Technical	1,414	1,362	51	(4,556)	(4,383)	174	(27,251)	(26,047)	1,204	(54,367)
Admin and Clerical	1,464	1,282	182	(2,889)	(2,730)	159	(17,280)	(16,445)	835	(34,474)
Other Pay	1,593	1,488	105	(4,011)	(4,340)	(329)	(23,992)	(25,367)	(1,375)	(47,859)
Permanent Staff Total	**8,002**	**7,185**	**817**	**(27,360)**	**(27,109)**	**251**	**(163,647)**	**(161,116)**	**2,531**	**(326,479)**
Waiting List Payments										
Medical and Dental	0	0	0	(228)	(187)	41	(1,365)	(1,487)	(122)	(2,723)
Waiting List Payments Total	**0**	**0**	**0**	**(228)**	**(187)**	**41**	**(1,365)**	**(1,487)**	**(122)**	**(2,723)**
Medical Locums/Short Sessions										
Medical and Dental	1	0	1	(316)	(201)	115	(1,888)	(1,554)	333	(3,766)
Medical Locums/Short Sessions Total	**1**	**0**	**1**	**(316)**	**(201)**	**115**	**(1,888)**	**(1,554)**	**333**	**(3,766)**
Substantive	**8,002**	**7,185**	**818**	**(27,904)**	**(27,497)**	**407**	**(166,899)**	**(164,157)**	**2,742**	**(332,968)**
Bank										
Medical and Dental	0	23	(23)	(468)	(279)	189	(2,843)	(1,866)	977	(5,654)
Nurses and Midwives	0	96	(96)	(248)	(392)	(144)	(1,504)	(1,991)	(487)	(2,990)
Scientific, Therapeutic and Technical	1	5	(4)	(12)	(27)	(14)	(74)	(130)	(56)	(147)
Admin and Clerical	0	80	(80)	(94)	(230)	(136)	(570)	(922)	(352)	(1,133)
Other Pay	0	210	(210)	(289)	(544)	(255)	(1,753)	(2,513)	(760)	(3,487)
Bank Total	**1**	**414**	**(413)**	**(1,111)**	**(1,472)**	**(361)**	**(6,744)**	**(7,423)**	**(678)**	**(13,411)**
Agency										
Medical and Dental	38	142	(104)	(618)	(1,741)	(1,123)	(4,105)	(10,084)	(5,979)	(8,906)
Nurses and Midwives	0	134	(134)	(396)	(951)	(555)	(2,629)	(6,170)	(3,541)	(5,704)
Scientific, Therapeutic and Technical	0	27	(27)	(45)	(168)	(123)	(300)	(1,496)	(1,196)	(650)
Admin and Clerical	0	(3)	3	(5)	7	12	(34)	(115)	(82)	(73)
Other Pay	0	7	(7)	(38)	(29)	9	(254)	(981)	(727)	(550)
Agency Total	**38**	**307**	**(269)**	**(1,102)**	**(2,883)**	**(1,781)**	**(7,321)**	**(18,846)**	**(11,525)**	**(15,883)**
Direct Engagement - Agency										
Medical and Dental	0	7	(7)	(246)	(100)	146	(1,635)	(400)	1,236	(3,548)
Direct Engagement - Agency Total	**0**	**7**	**(7)**	**(246)**	**(100)**	**146**	**(1,635)**	**(400)**	**1,236**	**(3,548)**
Agency	**38**	**313**	**(275)**	**(1,348)**	**(2,983)**	**(1,635)**	**(8,956)**	**(19,246)**	**(10,290)**	**(19,431)**
Total	**8,041**	**7,912**	**129**	**(30,363)**	**(31,952)**	**(1,589)**	**(182,599)**	**(190,826)**	**(8,226)**	**(365,810)**
						-5.23%			-4.51%	
						Adverse			Adverse	

Pay performance is adverse to plan in September by £1.6m and by £8.2m ytd (4.5%). Pay CIPs are adverse to plan in month by £0.5m and by £2.0m ytd.

Total expenditure on pay in September was £32.0m, £0.5m lower than in August. However, August spend included a net cost of £1.0m relating to non medical pay award arrears offset by the release of medical pay award accruals. Expenditure on temporary staffing, medical locum sessions and waiting list payments increased in total by £0.2m when compared to spend in August.

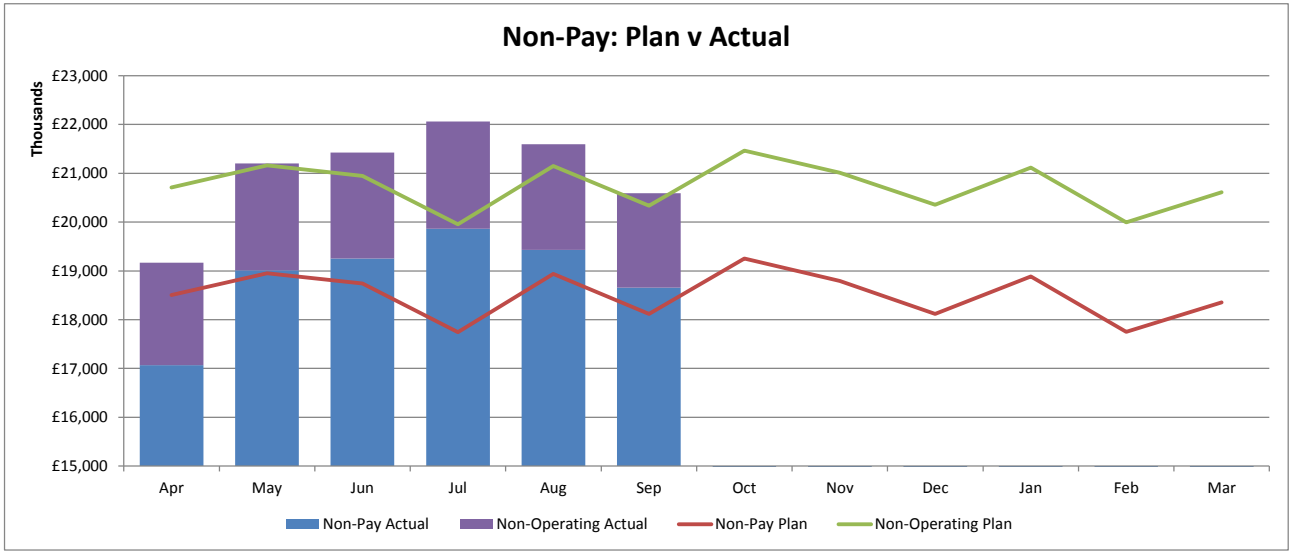
Substantive staff expenditure is favourable to plan by £0.3m in September and favourable to plan by £2.5m ytd. All substantive pay groups are underspent against plan in month and ytd except Other staff which are overspent by £0.3m in month and £1.4m ytd. This overspend relates predominantly to HCAs which are adverse to plan in month by £0.2m and by £0.9m ytd. CIP schemes for Other staff account for the remainder of the variance.

Bank staff are adverse to plan £0.4m in month and by £0.7m ytd with underspends on medical staff offsetting overspends on all other staffing groups.

Agency and Direct Engagement performance is again adverse to plan with an overspend in month of £1.6m and ytd of £10.3m. September has seen a marginal reduction in actual spend when compared to August and A&C and Other staff are marginally favourable to plan in month. TFS agency usage of HCAs at premium rates in UC&LTC ceased in September and staff are now being sourced via NHSP which is reflected in the breakeven position against plan. Adverse variances remain in the usage of all other staffing groups, particularly medical and nursing.

Non-Pay
Month 06 (September) 2018/19

	This Month			Year to Date			Annual
£000	**Plan**	**Actual**	**Var.**	**Plan**	**Actual**	**Var.**	**Plan**
Drugs	(5,568)	(5,157)	411	(34,054)	(31,971)	2,083	(67,802)
Clinical Supplies and Services	(5,271)	(5,895)	(624)	(33,566)	(34,809)	(1,243)	(66,208)
Non-Clinical Supplies and Services	(1,702)	(2,227)	(525)	(9,622)	(11,843)	(2,221)	(22,245)
Purchase of Healthcare	(762)	(976)	(214)	(4,572)	(5,035)	(463)	(9,138)
Education & Training	(246)	(328)	(82)	(1,476)	(1,147)	329	(2,951)
Consultancy	(72)	(68)	4	(432)	(386)	46	(861)
Premises	(1,731)	(1,679)	52	(10,387)	(11,594)	(1,207)	(20,552)
Clinical Negligence	(1,859)	(1,367)	492	(11,154)	(10,630)	524	(21,336)
Transport	(323)	(319)	4	(1,938)	(1,871)	67	(3,877)
Establishment	(274)	(270)	4	(1,658)	(1,885)	(227)	(3,296)
Misc Other Operating Expenses	(311)	(374)	(63)	(2,139)	(2,120)	19	(3,880)
Total Non-Pay Expenditure	**(18,119)**	**(18,659)**	**(540)**	**(110,998)**	**(113,291)**	**(2,293)**	**(222,146)**
Depreciation & Amortisation-Owned Assets	(1,517)	(1,598)	(81)	(9,101)	(9,261)	(160)	(18,201)
Impairment Losses	(42)		42	(250)		250	(500)
Profit/Loss on Asset Disposals	(10)		10	(60)	1	61	(120)
PDC Dividend	(501)	(162)	340	(3,007)	(2,667)	340	(6,013)
Interest Receivable	9	29	20	55	110	55	110
Interest Payable	(154)	(198)	(44)	(880)	(931)	(51)	(1,917)
Other Non-Operating Expenses	(1)		1	(4)		4	(7)
Total Non-Operating Expenditure	**(2,215)**	**(1,929)**	**286**	**(13,246)**	**(12,748)**	**498**	**(26,648)**
Total Expenditure	**(20,334)**	**(20,588)**	**(254)**	**(124,244)**	**(126,039)**	**(1,795)**	**(248,794)**



Non Pay expenditure is adverse to plan in September by £0.5m and by £2.3m (2.1%) ytd.

Drug expenditure is favourable to plan by £0.4m in month and by £2.1m ytd. Pass-through drugs are favourable to plan in month by £0.2m and by £1.0m ytd, offset by an adverse position on clinical income. All other drugs are favourable to plan in month by £0.2m and by £1.1m ytd. CIP schemes account for £0.1m of the favourable variance on non pass-through drugs in month and £0.2m of the variance ytd.

Clinical supplies and services are adverse plan in month by £0.6m and adverse to plan ytd by £1.2m. The adverse performance continues to be driven by underperformance on CIP schemes which are adverse to plan in September by £0.3m and by £1.5m ytd. Diagnostic scanning and reporting services (mainly MRI) are adverse to plan in month by £0.2m.

Expenditure on non clinical supplies and services is adverse to plan in September by £0.5m and by £2.2m ytd. The in month variance again relates predominantly to an adverse performance on CIP schemes of £0.5m, mainly due to slippage on the start date of the 2gether Support Solutions subsidiary. As previously reported the remainder of the ytd variance is driven by the planned benefit of the Serco contract exit fee being realised in non clinical income.

The adverse trend on expenditure on the purchase of healthcare from external sources continues and is adverse to plan in September by £0.2m and by £0.4m ytd.

Non pay actual expenditure in September reduced by £0.8m when compared to August, mainly relating to the CNST maternity incentive scheme rebate totalling £1.0m, received following the Trust's full compliance with safety requirements. Half of the rebate was accounted for in September and allocated to CIPs which also explains the favourable performance against the CNST plan of £0.5m. Drug spend reduced by £0.2m in September.

Non Operating Expenditure YTD is £0.5m below plan. The Trust has incurred £931k interest charges in respect of the facility utilised in 2016/17 and 2017/18. in 2018/19 £2.2m was drawn in April 2018, £3.4m in July, £3.7m in August and £5.1m in September.

Cost Improvement Summary

Month 06 (September) 2018/19

Delivery Summary	This Month			Year to Date			Forecast	
Programme Themes £000	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Outturn**	**Variance**
Patient Flow/LOS	-	-	-	-	-	-	1,000	-
Agency	(132)	206	337	3,342	2,420	(921)	5,321	(2,147)
Workforce *	20	44	24	50	192	142	402	233
Procurement	206	52	(153)	739	350	(389)	1,213	(770)
Medicines Value	68	161	93	312	784	472	1,457	586
Division Schemes **	948	1,234	286	5,262	6,357	1,095	15,939	405
Sub-total	**1,110**	**1,698**	**588**	**9,705**	**10,103**	**398**	**25,332**	**(1,693)**
Central	179	(100)	(279)	1,684	1,900	216	3,924	949
Grand Total	**1,289**	**1,598**	**309**	**11,389**	**12,003**	**614**	**29,255**	**(745)**

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

Delivered £000

Month	Target	Actual
April	1,502	1,155
May	1,533	1,758
June	1,552	1,629
July	3,357	4,081
August	2,156	1,783
September	1,289	1,598
October	2,895	
November	2,927	
December	2,944	
January	3,208	
February	3,267	
March	3,370	
	30,000	**12,003**
		40.0%

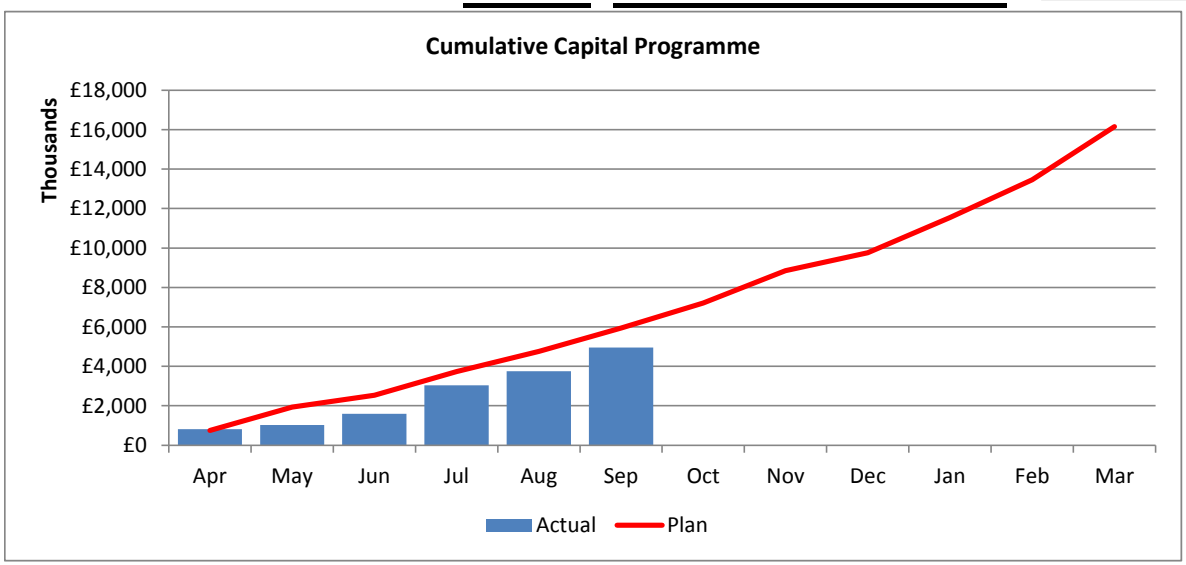
CIPs

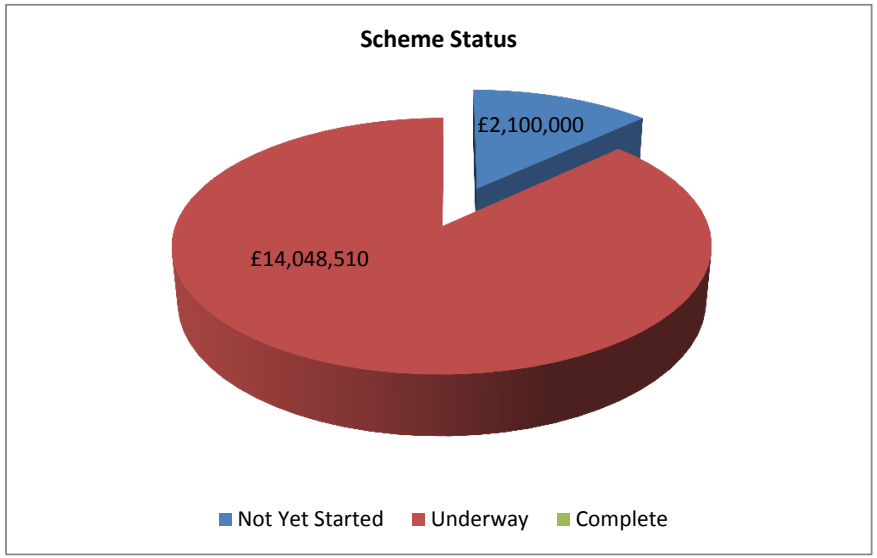
The CIPs Plan of £30.0m is net of the cost of delivery. CIPs achieved in M06 were £1.6m against a plan of £1.3m. Medicines Value and Divisions over performed in month and YTD. Agency is above plan in month, but adverse YTD, whilst Procurement is below plan in month and YTD. CIPs in September amounted to £1.5m recurrent and £0.1m on a non-recurrent basis. The YTD position is recurrent £6.8m and non-recurrent £5.2m.

Capital Expenditure
Month 06 (September) 2018/19

Capital Programme	Annual	To Date		
£000	Plan	Plan	Actual	Variance
Dementia Village	1,065	1,065	43	1,022
A&E Observation Area			995	(995)
Clinical Strategy Plans	200	150	108	42
Orthopaedic Modular Theatres			54	(54)
CT/CT SPECT Replacement	2,921	50	30	20
Invest To Save Schemes	150	50		50
Medical Devices Group	3,082	870	968	(98)
Patent Environment Investment Committ	2,200	1,273	754	519
Information Development Group	2,000	1,250	1,213	37
Other Equipment Schemes				
Other IT Schemes	2,281	1,564	1,295	269
All Other Schemes	150	(323)	(166)	(157)
VAT Reclaim			(343)	343
Unallocated Capital Funds	2,100			
Total	16,149	5,949	4,951	998

- Total expenditure at Mth 6 2018/19 is 17% below the NHSI plan. NHSI have notified the Trust that they will require a detailed full-year capital forecast in Q3. This forecast is in the process of being prepared and will form the basis of the Trust re-prioritised capital plan.
- The capital forecast outturn position for 2018/19 is to meet plan. The capital plan has been re-prioritised to recognise forecast slippage on the CT SPECT replacement scheme and to accommodate internal funding for the transfer of Elective Orthopaedics activity to K&C as part of the Trust's winter plan. The updated plan will be reflected in the Month 7 capital position onwards.
- The capital underspend YTD is predominantly driven by slippage on the Dementia Village scheme, slippage on PEIC schemes whilst a prioritisation process has been undertaken and the level of VAT reclaim being higher than planned. This position will recover by the end of the financial year.





Statement of Financial Position

Month 06 (September) 2018/19

£000	Opening	To Date	Movement	
Non-Current Assets	**270,767**	**266,998**	**(3,769)**	▼
Current Assets				
Inventories	8,949	9,112	164	▲
Trade and Other Receivables	39,034	41,465	2,432	▲
Assets Held For Sale			-	
Cash and Cash Equivalents	7,157	5,128	(2,029)	▼
Total Current Assets	**55,139**	**55,706**	**566**	▲
Current Liabilities				
Payables	(39,536)	(40,935)	(1,398)	▲
Accruals and Deferred Income	(26,013)	(25,240)	773	▼
Provisions	(884)	(582)	301	▼
Net Current Assets	**(11,294)**	**(11,051)**	**242**	▲
Non Current Liabilities				
Provisions	(3,203)	(3,131)	72	▼
Long Term Debt	(46,228)	(60,683)	(14,455)	▲
Total Assets Employed	**210,042**	**192,133**	**(17,909)**	▼
Financed by Taxpayers Equity				
Public Dividend Capital	191,687	191,687	-	
Retained Earnings	(41,167)	(59,077)	(17,909)	▼
Revaluation Reserve	59,523	59,523	-	
Total Taxpayers' Equity	**210,042**	**192,133**	**(17,909)**	▼

Non Current asset values reflect in year additions of £5.2m (including donated assets) less depreciation charges of £9.1m. The balance of movements relates to fluctuations in the level of RTA income recognised for new claims

Trust closing cash balances for September was in line with revised plan at £5.1m. See cash report for further details.

Trade and other receivables have increased from the 2018/19 opening position by £2.4m. Invoiced debtors have decreased from the opening position of £28.5m by £8.9m to £19.6m at the end of September.

Accruals and Deferred Income have decreased by 0.8m since the opening position. Of the £25.2m balance, £19.1m relates to Accruals and £6.1m is Deferred Income.

The long term debt entry reflects drawings against working capital facilities. The Trust drew £22.7m in 16/17, £23.5m in 17/18, £2.2m in April, £3.4m in July, £3.7m in August and £5.1m in September.

Retained earnings reflects the year to date deficit.

Working Capital
Month 06 (September) 2018/19

Creditors

Invoiced creditors have increased by £0.8m from the opening position to £34.4m. 55% relates to current invoices with 8% or £2.8m over 90 days.

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

YTD the Trust has paid 65.8% of NHS and 47.1% of non NHS invoices by value to 30 days. The average payment terms are now 45 days.

Debtors

Total invoiced debtors have decreased from the opening position of £28.5m by £8.9m to £19.6m.
At 30th September there were 5 debtors owing over £1m.

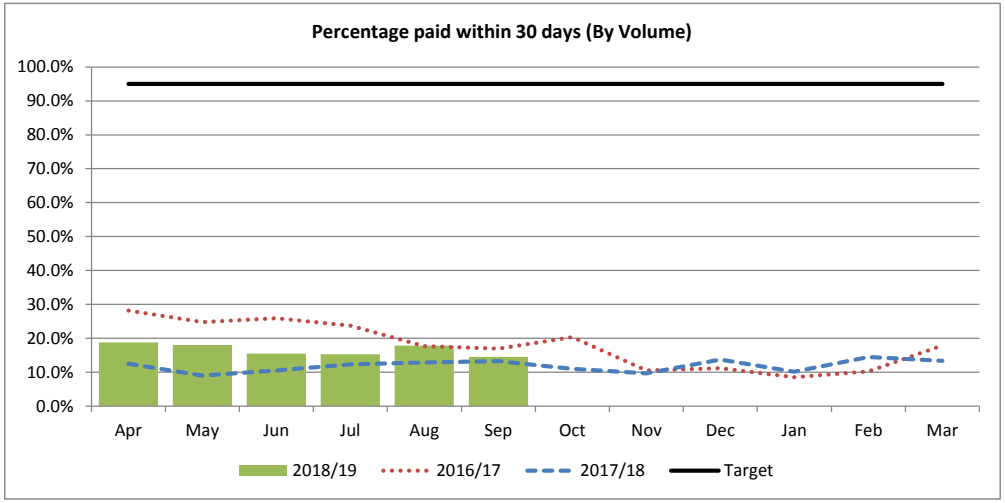
- East Kent CCGs owing: South Kent Coast CCG £1.6m, Canterbury & Coastal CCG £1.8m, Ashford CCG £1.3m and Thanet CCG £2.1m. (outstanding invoices for 1718 overperformance offset by unallocated cash payments on their accounts)
- East Kent Medical Services £1.9m

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

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

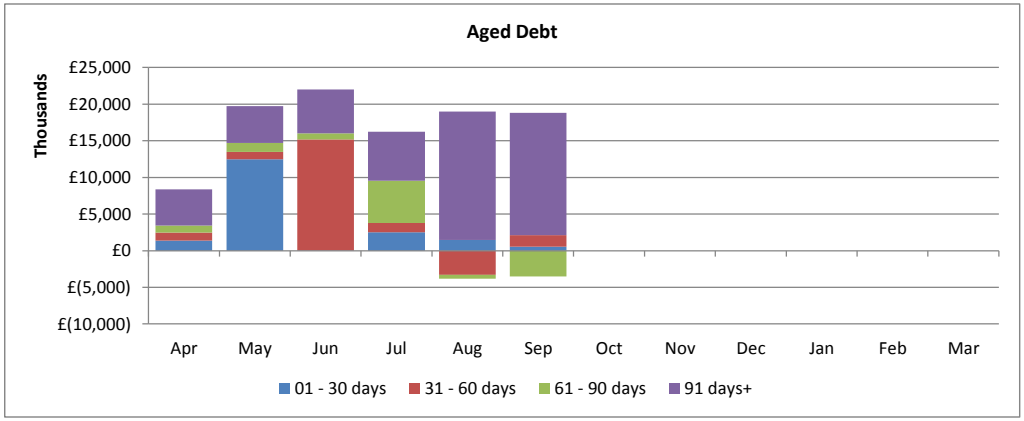
Better Payment Practice Code

	Year to Date		This Month	
	Non NHS Creditor Invoices	NHS Creditor Invoices	Non NHS Creditor Invoices	NHS Creditor Invoices
By Value £000				
0 - 30 days	(87,140)	(14,136)	(15,041)	(2,343)
30+ days	(97,889)	(7,349)	(14,541)	(1,593)
By Volume				
0 - 30 days	8,810	141	1,116	30
30+ days	43,188	1,345	6,494	271
% by Value £	47.1%	65.8%	50.8%	59.5%
% by Volume	16.9%	9.5%	14.7%	10.0%
Target	95.0%	95.0%	95.0%	95.0%



Aged Debt

£000	Current	01 - 30 days	31 - 60 days	61 - 90 days	91 days+	Total
Apr	12,651	1,397	1,073	974	4,911	8,354
May	925	12,478	1,013	1,216	5,018	19,725
Jun	527	39	15,136	845	5,989	22,009
Jul	2,660	2,515	1,255	5,771	6,687	16,228
Aug	1,382	1,455	(3,278)	(530)	17,545	15,192
Sep	4,338	556	1,550	(3,524)	16,703	15,285
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
		4%	10%	-23%	109%	



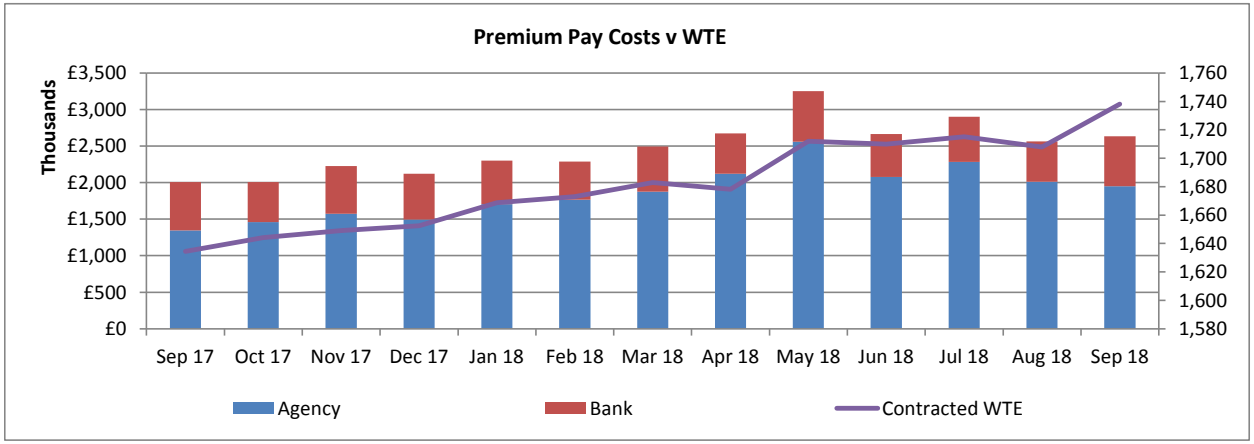
Divisional Performance
Month 06 (September) 2018/19

Year to Date Actual £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
Urgent Care and Long Term Conditions	10,869	47,381	14,555	10,411	2,423	44	7,503	389	(56,305)	(15,285)	21,985
Surgical Services	28,605	20,286	0	16,178	3,296	57	8,640	1,019	(49,904)	(21,047)	7,131
Clinical Support Services	261	16	0	2,207	7,718	32	17,568	2,968	(30,800)	(22,640)	(22,670)
Specialist Services	6,774	16,877	0	10,125	13,312	21	23,637	971	(34,302)	(18,591)	18,824
Clinical Divisions Total	**46,509**	**84,560**	**14,555**	**38,920**	**26,750**	**154**	**57,349**	**5,346**	**(171,310)**	**(77,563)**	**25,270**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	5,977	(6,692)	(20,633)	(21,348)
Corporate	0	0	0	0	0	0	0	8,747	(11,562)	(15,421)	(18,236)
Divisional Total	**46,509**	**84,560**	**14,555**	**38,920**	**26,750**	**154**	**57,349**	**20,070**	**(189,564)**	**(113,617)**	**(14,314)**
Central	687	70	250	0	161	1	3,925	4,995	(1,261)	326	9,153
							EBITDA				**(5,160)**
							Capital Charges and Interest			(12,748)	(12,748)
							Income and Expenditure Surplus/(Deficit)				(17,908)

Year to Date Variance to Plan £000	Electives	Non-Electives	Accident & Emergency	Outpatients	High Cost Drugs	Private Patients	Other Clinical	All Other Income	Pay	Non Pay	Net Position
Urgent Care and Long Term Conditions	(99)	2,563	1,200	(407)	(231)		(98)	30	(3,124)	(775)	(941)
Surgical Services	(3,606)	805	0	(865)	(489)	42	1,643	(2)	(2,967)	(588)	(6,027)
Clinical Support Services	(78)	7	0	115	(22)	(13)	328	176	(808)	(718)	(1,013)
Specialist Services	(411)	(409)	0	72	(176)		(429)	(47)	(1,351)	27	(2,723)
Clinical Divisions Total	**(4,194)**	**2,966**	**1,200**	**(1,085)**	**(918)**	**30**	**1,444**	**157**	**(8,249)**	**(2,054)**	**(10,705)**
Strategic Development and Capital Planning	0	0	0	0	0	0	0	401	328	(434)	295
Corporate	0	0	0	0	0	0	0		303	(84)	219
Divisional Total	**(4,194)**	**2,966**	**1,200**	**(1,085)**	**(918)**	**30**	**1,444**	**558**	**(7,619)**	**(2,572)**	**(10,191)**
Central	510	103	281	(61)	(78)	(1)	4,948	2,654	(607)	279	8,028
							EBITDA				**(2,163)**
							Capital Charges and Interest			498	498
							Income and Expenditure Surplus/(Deficit)				(1,666)

Urgent Care and Long Term Conditions
Month 06 (September) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,970	1,736	(234)	10,968	10,869	(99)
Non-Electives	7,213	7,316	103	44,817	47,381	2,563
Accident & Emergency	2,167	2,222	55	13,356	14,555	1,200
Outpatients	1,716	1,726	10	10,818	10,411	(407)
High Cost Drugs	442	388	(55)	2,654	2,423	(231)
Private Patients	7	2	(5)	44	44	
Other NHS Clinical	1,195	1,077	(118)	6,846	6,729	(116)
Other Clinical	126	179	53	755	774	18
Prior Month Adjustment	0	212	212	0	0	0
Total Clinical Income	**14,836**	**14,857**	**21**	**90,258**	**93,186**	**2,928**
Non Clinical Income	58	46	(12)	359	389	30
Total Income	**14,894**	**14,903**	**9**	**90,617**	**93,575**	**2,958**
Expenditure						
Substantive Staff	(7,159)	(6,654)	505	(43,448)	(39,614)	3,834
Bank	(651)	(686)	(36)	(3,533)	(3,685)	(151)
Agency	(1,075)	(1,949)	(874)	(6,200)	(13,006)	(6,806)
Total Pay	**(8,884)**	**(9,289)**	**(405)**	**(53,181)**	**(56,305)**	**(3,124)**
Non Pay	(2,423)	(2,422)	2	(14,511)	(15,285)	(775)
Total Expenditure	**(11,307)**	**(11,710)**	**(403)**	**(67,692)**	**(71,590)**	**(3,898)**
Contribution	**3,587**	**3,192**	**(395)**	**22,925**	**21,985**	**(941)**



The Division is £0.4m adverse in September and £0.9m adverse YTD.

Income delivered on plan overall in September compared to £2.9m over-performance for Q1; A&E and NEL were ahead of plan but below the previous trend, the former due to diagnostics that had not been coded but will be updated prior to closedown. Electives were significantly behind plan whilst the impact of activity recording for the new PAS is still under investigation in this area. Outpatients were ahead of plan particularly in Neurology where 4 new Consultants have joined.

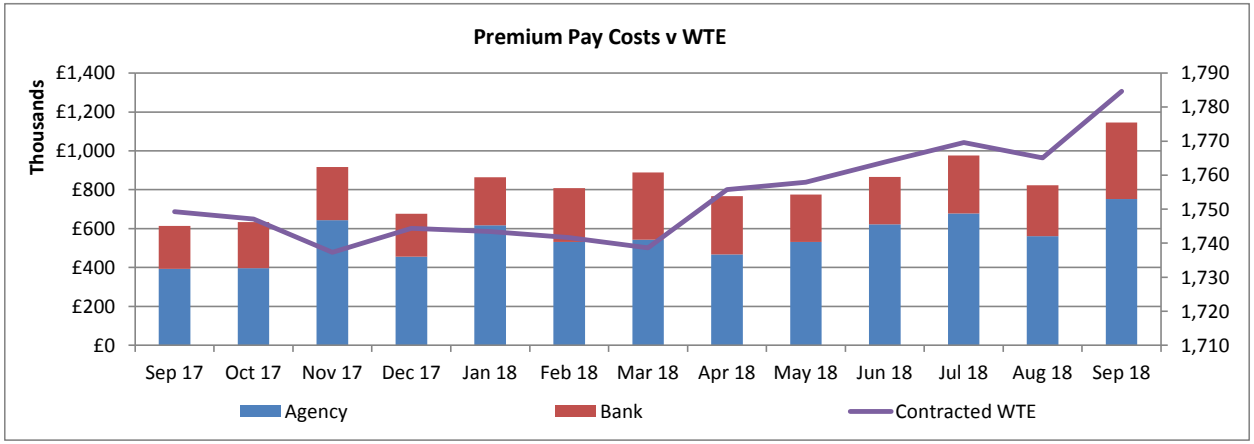
Pay overspent by £0.4m in September, consistent with August, a sustained improvement compared to previous months (£3.1m adverse ytd). Agency spend decreased by £0.1m to £1.9m notably due to the removal of HCA Agency through TFS wef 1st September; this reduction was offset by increased HCA Bank and growth in substantive wte but the overall usage of HCA fell slightly. All other Agency usage in Nursing and Medical remained broadly consistent with August.

The non pay run rate fell by £0.1m compared to August relating to rechargeable drugs and devices, other clinical consumables and recruitment fees.

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

Surgical Services
Month 06 (September) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	5,321	4,514	(807)	32,212	28,605	(3,606)
Non-Electives	3,094	3,400	306	19,482	20,286	805
Accident & Emergency	0	0	0	0	0	0
Outpatients	2,758	2,428	(330)	17,043	16,178	(865)
High Cost Drugs	631	528	(103)	3,785	3,296	(489)
Private Patients	3		(2)	15	57	42
Other NHS Clinical	1,312	1,444	132	6,925	8,568	1,643
Other Clinical	12	14	2	73	73	
Prior Month Adjustment	0	10	10	0	0	0
Total Clinical Income	**13,130**	**12,339**	**(791)**	**79,534**	**77,064**	**(2,470)**
Non Clinical Income	188	178	(11)	1,021	1,019	(2)
Total Income	**13,318**	**12,517**	**(802)**	**80,555**	**78,082**	**(2,472)**
Expenditure						
Substantive Staff	(7,180)	(7,377)	(197)	(43,146)	(44,550)	(1,404)
Bank	(257)	(392)	(136)	(1,366)	(1,743)	(377)
Agency	(404)	(753)	(349)	(2,425)	(3,611)	(1,186)
Total Pay	**(7,841)**	**(8,522)**	**(681)**	**(46,938)**	**(49,904)**	**(2,967)**
Non Pay	(3,369)	(3,627)	(258)	(20,458)	(21,047)	(588)
Total Expenditure	**(11,210)**	**(12,150)**	**(939)**	**(67,396)**	**(70,951)**	**(3,555)**
Contribution	**2,108**	**367**	**(1,741)**	**13,159**	**7,131**	**(6,027)**



The division is £1.7m adverse to plan in month and £6.0m adverse YTD.

Below plan elective income (£3.6m) is mostly due to underperformance in Orthopaedics (£1.5m), and unachieved CIPs (£0.9m). Orthopaedic activity has been significantly impacted by reduced capacity issues, i.e. beds and Independent sector. However with the set up of the new Elective Orthopaedic Centre in November, the production plan forecasts that the Orthopaedic elective plan will be achieved by year end. Although Elective CIP plans were not achieved, this was offset from savings realised by ITU and Non Elective overperformances.

Non-Elective income is above plan (£805k) with high levels of General Surgery & Maxillo Facial activity.

Outpatient performance is adverse (£865k), with significant underperformance across all specialties in September, in part due to the PAS migration. Orthopaedics (£418k) is the largest YTD which is mostly due to the greater than anticipated impact of the Virtual Fracture Clinics. Forecast production plans for all other specialties indicate monthly overperformances which will deliver the year end plan.

High Cost Drugs under performance (£489k) is solely in relation to Ophthalmology AMD patients, and is offset with an underspend in expenditure.

Other NHS Clinical Income is favourable mostly due to ITU (£1.5m).

Pay is adverse with the continuation of high medical agency costs for middle grade vacancies in General Surgery, Urology, Vascular and also additional support for the ED's. Interviews and appointments have been made, and the delays on VISAs for foreign nationals is slowly unblocking. Nursing agency is still high at WHH for ITU and bedding of patients overnight in the Day Surgery Unit. These have contributed to an unmet CIP Pay target (£859k), which has instead been met through Income. Business cases for ITU, SEAU and Hospital at Home services are awaiting review and approval of funding.

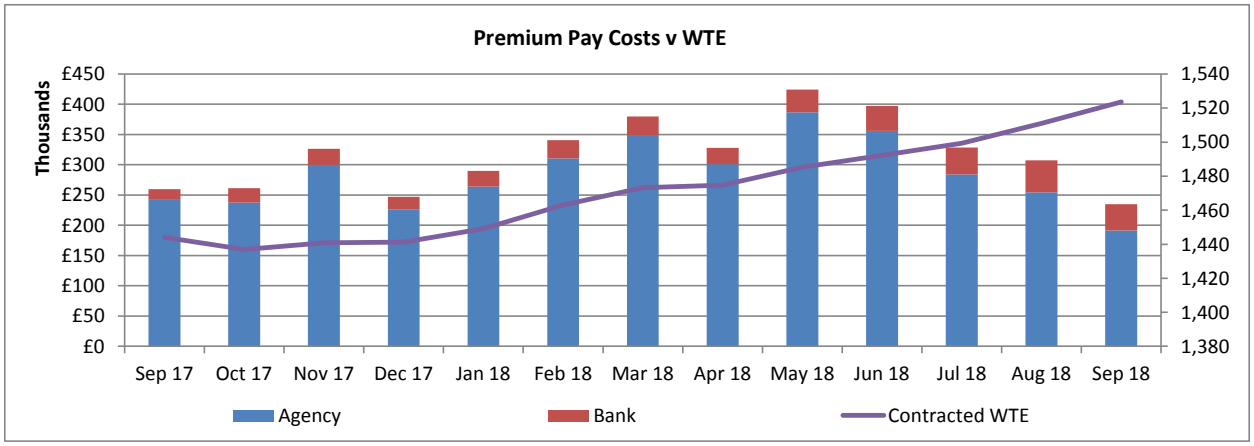
Non Pay is adverse (£588k) YTD with underspends on Drugs (£267k) and Independent Sector usage (£70k) for Orthopaedic services, more than offset by Clinical Supplies overspend (£352k) and CIP underachievement (£513k). However this CIP underachievement has been partially met through Income.

Included in the above expenditure is approximately £730k for medical patient outliers with no additional income. This has equated to the loss on average of 24 Surgical beds per day. Also incurred is £554k supporting the Winter/ED plan.

CIPs YTD target of £2.6m is underachieved by £363k .

Clinical Support
Month 06 (September) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	55	37	(18)	339	261	(78)
Non-Electives	1	2		9	16	7
Accident & Emergency	0	0	0	0	0	0
Outpatients	363	324	(39)	2,092	2,207	115
High Cost Drugs	1,290	1,707	417	7,740	7,718	(22)
Private Patients	8	4	(3)	45	32	(13)
Other NHS Clinical	2,868	2,871	3	17,240	17,568	328
Other Clinical	0			0		
Prior Month Adjustment	0	(401)	(401)	0	0	0
Total Clinical Income	**4,585**	**4,544**	**(42)**	**27,465**	**27,802**	**337**
Non Clinical Income	465	498	33	2,792	2,968	176
Total Income	**5,051**	**5,042**	**(9)**	**30,257**	**30,770**	**513**
Expenditure						
Substantive Staff	(4,674)	(4,887)	(214)	(28,648)	(28,778)	(131)
Bank	(26)	(43)	(17)	(144)	(247)	(104)
Agency	(254)	(192)	63	(1,200)	(1,774)	(573)
Total Pay	**(4,954)**	**(5,122)**	**(168)**	**(29,992)**	**(30,800)**	**(808)**
Non Pay	(3,680)	(3,900)	(220)	(21,921)	(22,640)	(718)
Total Expenditure	**(8,635)**	**(9,022)**	**(388)**	**(51,913)**	**(53,439)**	**(1,526)**
Contribution	**(3,584)**	**(3,981)**	**(397)**	**(21,656)**	**(22,670)**	**(1,013)**



The position worsened by £0.4m in September. This was largely due to continued pressures within the expenditure budgets including an increased CIP target. Main SLA income and activity was below plan, impacted by the implementation process of the new PAS system.

Radiology income was favourable to plan this month, with both CT & MRI unbundled outpatient imaging above plan. Interventional Radiology was also above plan on Elective inpatients. Pathology was overall below plan, particularly in Cytology driven by capacity issues and also an adjustment to the GUM estimated value for August. Physiotherapy and Occupational Therapy first outpatient attendances were below plan in September. Referrals appear to be low and the impact of the PAS system implementation means that template utilisation has deteriorated. Work is planned to correct this.

Homecare drugs income is on plan in month with the backlog for August now caught up.

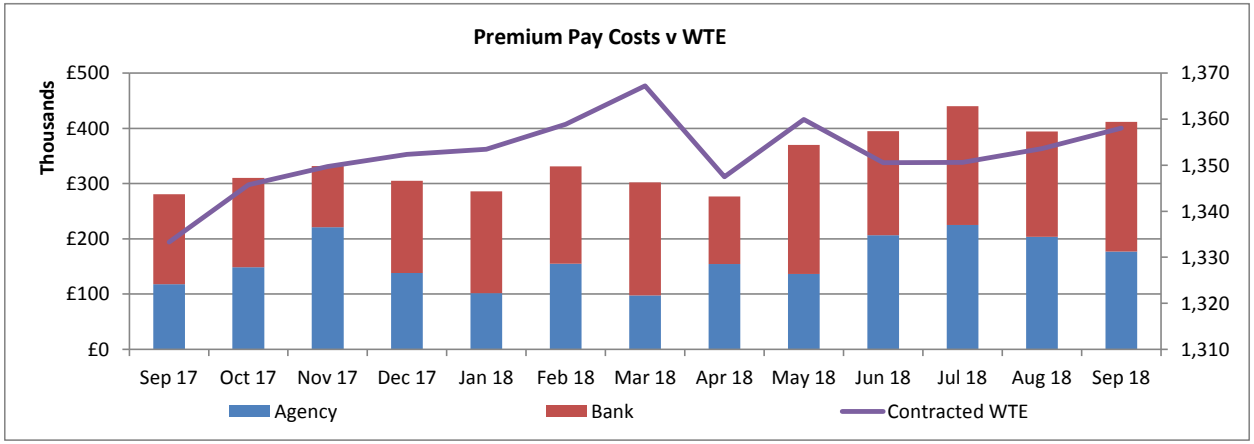
Pay was overspent in the month, continuing the trend. The run rate was on par with last month's costs. However there was a further reduction in agency costs, particularly with respect to radiographers. There was an increase in contracted WTE in Radiology of 12 WTE compared to August. Other areas of pay cost pressures include Outpatients where costs are being incurred above plan for the implementation of the Electronic referral system and PAS.

Non-pay was overspent in 3 of the 5 departments, with the most significant area being Radiology where the impact of substantially increased demand for MRI is driving high outsourcing costs, both scanning and reporting. Medical gases was overspent again this month, a review of the areas from where this cost is driven will be reported next month.

£0.35m CIPs were delivered in month 6, £2.47m year to date. This is above plan £0.1m year to date.

Specialist Services
Month 06 (September) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	1,178	1,122	(56)	7,185	6,774	(411)
Non-Electives	2,939	3,046	107	17,286	16,877	(409)
Accident & Emergency	0	0	0	0	0	0
Outpatients	1,660	1,622	(38)	10,053	10,125	72
High Cost Drugs	2,248	2,103	(145)	13,488	13,312	(176)
Private Patients	3	2	(1)	20	21	
Other NHS Clinical	3,934	3,736	(198)	23,956	23,591	(365)
Other Clinical	18	5	(13)	111	46	(64)
Prior Month Adjustment	0	94	94	0	0	0
Total Clinical Income	**11,981**	**11,730**	**(251)**	**72,099**	**70,746**	**(1,352)**
Non Clinical Income	175	152	(22)	1,017	971	(47)
Total Income	**12,156**	**11,883**	**(273)**	**73,116**	**71,717**	**(1,399)**
Expenditure						
Substantive Staff	(5,228)	(5,380)	(153)	(31,332)	(32,014)	(682)
Bank	(176)	(234)	(58)	(968)	(1,184)	(216)
Agency	(111)	(177)	(66)	(650)	(1,104)	(454)
Total Pay	**(5,515)**	**(5,792)**	**(277)**	**(32,950)**	**(34,302)**	**(1,351)**
Non Pay	(2,814)	(2,552)	262	(18,618)	(18,591)	27
Total Expenditure	**(8,329)**	**(8,344)**	**(14)**	**(51,568)**	**(52,893)**	**(1,324)**
Contribution	**3,827**	**3,539**	**(288)**	**21,547**	**18,824**	**(2,723)**



Elective income is significantly adverse to plan in month. This is predominantly driven by gynaecology and dermatology underperformance. Up until this month Dermatology's adverse variance has been offset by over performance in outpatients and the release of a risk provision (related to the outcome of the expert determination negotiation). Investigations are underway to determine if the PAS upgrade has contributed to the deteriorating position and whether all activity is accounted for. Work is being prioritised to address efficiency and capacity problems affecting Gynaecology. There has been some success in reducing waiting time breaches and there are early signs that activity levels are beginning to recover.

Non-elective income has improved significantly in month due to higher births than planned and an increase in paediatric admissions. Year to date activity variances are relatively small but, due to high value tariffs in the shortfall areas, the effect on income is significant. Underperformance is spread across a number of specialties-Obstetrics, Paediatrics, Renal and Clinical Haematology. A change in guidance linked to Sepsis related activity and a small fall in high value (tariff) activity in renal have been identified. Otherwise, coding issues have been discounted. Given the strong performance in September it is possible that activity/income levels will at least partially recover across the remainder of the year. However, activity levels are very unpredictable.

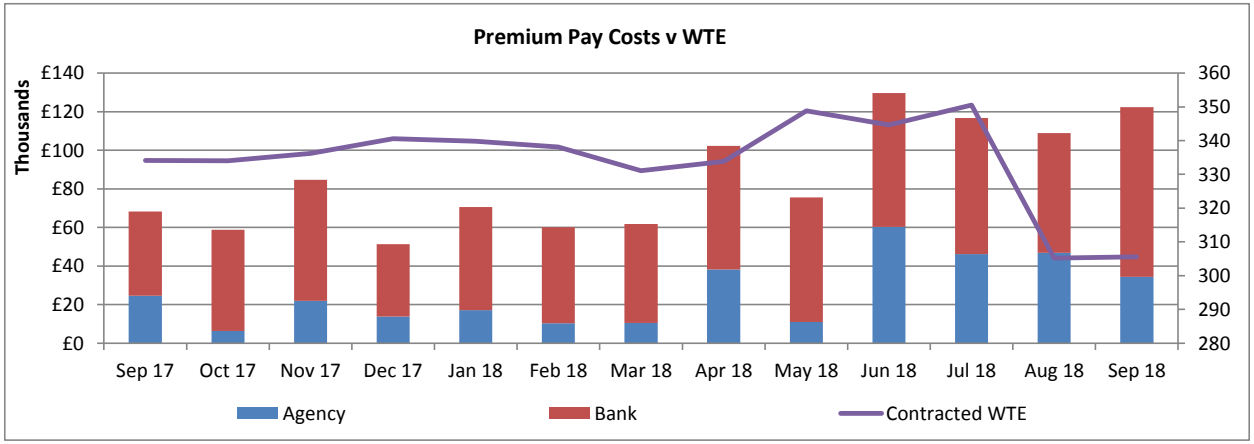
Overall outpatient income was below plan in month. This is predominantly driven by underperformance in Gynaecology and Paediatrics. Some gynaecology capacity was switched in order to focus on elective activity/breach avoidance. Paediatrics continue to divert junior/middle grade resource to support provision of a safe medical rota. Capacity issues in these areas are being offset by overperformance in Oncology.

The adverse performance in the 'Other NHS Clinical' category is driven by lower than planned activity in NICU/SCBU, the maternity pathway, palliative care and renal dialysis. All these areas have struggled to reach planned levels over the year to date. Maternity pathway income was particularly low in month and is subject to further investigation.

Overall pay was significantly overspent in September and year to date. Savings shortfalls (£130k in month) are a key driver. Temporary pay costs are also, on average, £83k a month higher than last year with junior/middle grade vacancies/sickness/maternity leave being a particular issue. Improved recruitment in the second half of 2017/18 has also put pressure on the pay budget. The non-pay underspend in month is predominantly driven by the achievement of the CNST discount savings scheme, as well as high cost drugs underspends. CIP performance was favourable to plan in September and is £240k favourable year to date. The turnaround in performance is due to recognition of the CNST discount CIP scheme. However there are significant risks to schemes scheduled in the remainder of the year and the Division is forecasting a £200k shortfall against the annual plan.

Strategic Development and Capital Planning
Month 06 (September) 2018/19

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	0	0	0	0	0	0
Non-Electives	0	0	0	0	0	0
Accident & Emergency	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0
High Cost Drugs	0	0	0	0	0	0
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	0	0	0	0	0	0
Prior Month Adjustment	0	0	0	0	0	0
Total Clinical Income	**0**	**0**	**0**	**0**	**0**	**0**
Non Clinical Income	841	882	40	5,576	5,977	401
Total Income	**841**	**882**	**40**	**5,576**	**5,977**	**401**
Expenditure						
Substantive Staff	(974)	(969)	6	(6,546)	(6,037)	509
Bank	(60)	(88)	(28)	(309)	(418)	(109)
Agency	(27)	(34)	(7)	(164)	(237)	(73)
Total Pay	**(1,062)**	**(1,091)**	**(29)**	**(7,019)**	**(6,692)**	**328**
Non Pay	(3,707)	(3,606)	101	(20,200)	(20,633)	(434)
Total Expenditure	**(4,768)**	**(4,697)**	**72**	**(27,219)**	**(27,325)**	**(106)**
Contribution	**(3,927)**	**(3,815)**	**112**	**(21,643)**	**(21,348)**	**295**



The position as at month 6 is £295k favourable. The inc/exp positions are showing large variances due to implementation of the SaCP/PAS project, these net each other off. Income (excl SaCP/PAS) is £269k favourable YTD. Pay £328k favourable YTD and Non Pay (excl SaCP/PAS) £(302)k adverse YTD.

Income is £151k favourable in month and £269k favourable YTD (both excl SaCP/PAS).
The position in month is mainly due to laundry end of season orders £61k, accommodation income £36k, yet adverse YTD and Procurement recharges to 2gether are offset by pay and non-pay.
The position YTD is mostly attributable to car parking, laundry, external utility recharges and income for Procurement recharges to 2gether, as indicated above.

Pay is favourable £328k YTD and adverse £(29)k in month, the vacancy rate is just under 10% which are mainly at senior level. The adverse position in month is due to a prior period recode and is currently being validated and Procurement (2gether) bank staff spend are offset by income.
Bank staff expenditure is mostly within Facilities for Oakleaf/Junior Drs transportation project drivers , funded centrally, There is also bank spend in Strategic Development Management department supporting the 2gether implementation and also within Procurement, as above.
Agency is mostly within Laundry and Procurement which is supported by increased income/delivery of the Trusts savings plan, there is also support for the vacant Deputy Director of Estates post and projects around the future of service delivery.

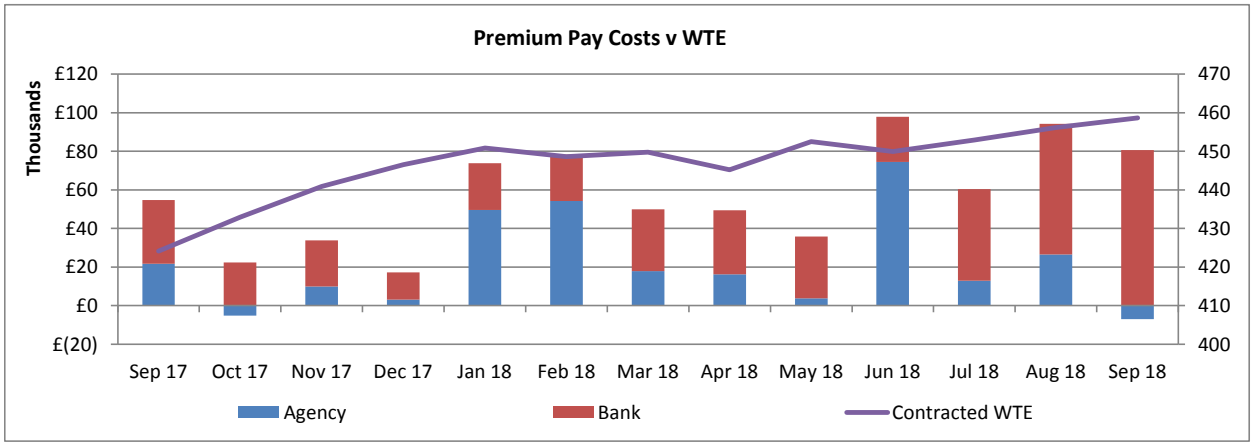
Non Pay is adverse £(302)k YTD (excluding SaCP/PAS). The main areas are as follows:
Waste adverse £(79)k YTD, approx. £(39)k is due to prior year costs due to data issues from the supplier and the rest is due to the sharps bins saving scheme not being funded via divisions - this is currently being validated.
Utilities is adverse £(180)k YTD due to:

- A gas valve issue at QEQM earlier in the year meant that the site was run on oil, which is 3 times more expensive than gas. This resulted in an overspend of approx. £46k.
- Water and waste water bills rate increase is yet to be funded, overspend across all sites is £(123)k YTD. In addition , the waste water % rate of clean water at WHH has increased from 35% to 67% since the previous supplier Southern Water was bought by Business Stream back in March 2017, this is currently being looked into by the dept and a/c is currently on hold.
- Estates day to day across the Trust is £(128)k adverse YTD.
- Ring-fenced (PEIC/ Legionella/ Statutory Compliance() is breakeven

Favourable variances are in IT £70k YTD and Strategic Estates, carbon tax and rent £71k YTD. All the variances are being continuously monitored alongside with the relevant departmental leads.

Savings are £(8)k adverse against plan due to procurement work plan schemes being validated, the divisional schemes are all on plan. All of the schemes are continually being monitored. Forecast savings to be achieved in full.

Statement of Comprehensive Income	This Month			Year to Date		
£000	Plan	Actual	Var.	Plan	Actual	Var.
Income						
Electives	0	0	0	0	0	0
Non-Electives	0	0	0	0	0	0
Accident & Emergency	0	0	0	0	0	0
Outpatients	0	0	0	0	0	0
High Cost Drugs	0	0	0	0	0	0
Private Patients	0	0	0	0	0	0
Other NHS Clinical	0	0	0	0	0	0
Other Clinical	0	0	0	0	0	0
Prior Month Adjustment	0	0	0	0	0	0
Total Clinical Income	**0**	**0**	**0**	**0**	**0**	**0**
Non Clinical Income	1,447	1,477	30	8,747	8,747	
Total Income	**1,447**	**1,477**	**30**	**8,747**	**8,747**	
Expenditure						
Substantive Staff	(2,024)	(1,919)	105	(11,850)	(11,151)	699
Bank	(3)	(81)	(78)	(15)	(284)	(270)
Agency	0	7	7	0	(127)	(127)
Total Pay	**(2,027)**	**(1,992)**	**34**	**(11,865)**	**(11,562)**	**303**
Non Pay	(2,632)	(2,588)	45	(15,337)	(15,421)	(84)
Total Expenditure	**(4,659)**	**(4,580)**	**79**	**(27,201)**	**(26,983)**	**219**
Contribution	**(3,212)**	**(3,103)**	**109**	**(18,454)**	**(18,236)**	**219**



The position is £219k favourable as at month 6.

Income B/E YTD. Directorates with minor under achievements are offset by the Occupational Health income for the Diploma Course in Occupational Medicine provided by the Trust.

Pay is £303k favourable position YTD due to vacancies the current rate being just under 44 WTE. The contracted WTE in month has increased due to the transfer of Discharge Lounges (QEQM and WHH) to the Corporate Division.
The percentage vacancy rates, budgeted against contracted, are on average 10% in each directorate. Validation ongoing.

The agency and bank staff costs are attributable to Finance (temporary PMO staff, Information Team and clinical coders), CQ&PS Ops Management (Interim Deputy Chief Operating Officer post) and HR Systems. Most of these are being funded by the existing vacancies within each dept, the PMO posts have now gone out to advert.

Non pay is £(84)k adverse YTD, this mainly is due to Trust Board recruitment fees, management consultancy and transcription services for committee minutes. In addition, HR border agency permits adverse £(46)k YTD, this cost pressure raised due to the cost trebling at the end of last financial year and settlement discount not achieved in month 5 & 6, £(22)k adverse YTD.

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

Year on Year Analysis
Month 06 (September) 2018/19

	Annual	Prior Year to Date	Year on Year	
	Plan	Actual	Variance	Variance %
Income				
Electives	103,209	44,316	2,880	6.5%
Non-Electives	161,862	78,892	5,738	7.3%
Accident and Emergency	26,226	13,083	1,723	13.2%
Outpatients	81,011	37,946	974	2.6%
High Cost Drugs	55,662	27,502	(592)	(2.2%)
Private Patients	248	118	37	31.8%
Other NHS Clinical Income	109,496	56,882	3,474	6.1%
Other Clinical Income	1,845	936	(19)	(2.1%)
Total Clinical Income	**539,558**	**259,674**	14,215	5.5%
Non Clinical Income	44,059	25,640	(575)	(2.2%)
Total Income	**583,617**	**285,315**	13,640	4.8%
Expenditure				
Substantive Staff	(326,479)	(149,512)	(8,794)	(5.9%)
Overtime	0	(2,423)	(405)	(16.7%)
Waiting List Payments	(2,723)	(854)	(633)	(74.0%)
Medical Locums/Short Sessions	(3,766)	(1,862)	308	16.5%
Bank	(13,411)	(6,686)	(719)	(10.7%)
Agency	(15,883)	(7,817)	(11,030)	(141.1%)
Direct Engagement - Agency	(3,548)	(2,334)	1,935	82.9%
Total Pay	**(365,810)**	**(171,489)**	(19,337)	(11.3%)
Non-Pay				
Drugs	(67,802)	(33,766)	1,795	5.3%
Clinical Supplies and Services	(66,208)	(33,994)	(814)	(2.4%)
Non-Clinical Supplies and Services	(22,245)	(10,424)	(1,420)	(13.6%)
Purchase of Healthcare	(9,138)	(3,751)	(1,284)	(34.2%)
Education & Training	(2,951)	(1,225)	79	6.4%
Consultancy	(861)	(325)	(61)	(18.9%)
Premises	(20,552)	(9,145)	(2,449)	(26.8%)
Clinical Negligence	(21,336)	(10,818)	188	1.7%
Transport	(3,877)	(1,779)	(92)	(5.2%)
Establishment	(3,296)	(1,731)	(154)	(8.9%)
Misc Other Operating Expenses	(3,880)	(2,728)	607	22.3%
Total Non-Pay	**(222,146)**	**(109,686)**	(3,605)	(3.3%)
Total Expenditure	**(587,956)**	**(281,175)**	(22,942)	(8.2%)
EBITDA	**(4,339)**	**4,140**	(9,301)	(224.7%)
Non-Operating Expenses	(26,648)	(12,626)	(122)	(1.0%)
Income and Expenditure Surplus/(Deficit)	**(30,987)**	**(8,486)**	(9,424)	(111.1%)

Clinical Income

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

Non Clinical Income

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

Pay

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

Non Pay

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

Cash Flow

Month 06 (September) 2018/19

Year to Date		This Month			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual		Plan	Actual	Variance	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
7,157	**Opening Bank Balance**	3,470	9,247	5,777	7,157	16,287	4,760	7,090	15,985	9,247	5,129	5,572	3,443	4,650	2,891	2,891
38,146	Ashford CCG	5,919	5,770	(149)	7,445	5,494	7,891	5,771	5,775	5,770	5,968	5,770	5,770	5,770	5,770	5,770
60,655	C4G	9,844	9,621	(223)	10,918	9,344	11,531	9,619	9,622	9,621	10,019	9,619	9,619	9,619	9,619	9,619
69,175	South Kent Coast CCG	11,105	10,829	(276)	12,809	10,529	12,943	11,220	10,846	10,829	11,590	10,827	10,827	10,827	10,827	10,827
47,103	Thanet CCG	8,048	7,835	(213)	8,180	7,824	8,233	7,195	7,835	7,835	7,839	7,835	7,835	7,835	7,835	7,835
	Additional Income	6,495		(6,495)							211					
314	Dartford, Gravesham & Swanley CCG	38	45	7	38	38	38	63	92	45	38	38	38	38	38	38
1,145	Medway CCG	164	180	15	263	165	190	174	173	180	164	164	164	164	164	164
1,538	Swale CCG	306		(306)	306	306	299	323	304			273	306	306	306	306
2,567	West Kent CCG	449	427	(22)	377	377	531	427	428	427	450	449	449	449	449	449
48,974	NHS England	9,531	7,657	(1,874)	8,082	7,728	8,453	7,346	9,707	7,657	8,059	8,059	8,059	8,059	8,059	8,059
18,194	All Other NHS Organisations	1,160	2,447	1,287	5,317	1,119	801	5,645	2,866	2,447	5,341	1,223	1,423	5,335	1,223	1,423
0	Capital Receipts															
15,729	All Other Receipts	2,242	1,672	(570)	2,664	2,277	2,274	3,976	2,866	1,672	4,263	3,377	2,429	2,383	2,309	2,746
5,603	Provider Sustainability Fund							5,603								
14,455	Working Capital Facility		5,103	5,103	2,234			3,410	3,708	5,103		6,032	5,207	2,037	2,192	6,661
	Working Capital Facility Repaid															
	Permanent Loan															
323,598	**Total Receipts**	**55,302**	**51,585**	**(3,718)**	**58,633**	**45,202**	**53,184**	**60,772**	**54,222**	**51,585**	**53,943**	**53,665**	**52,126**	**52,821**	**48,791**	**53,896**
	Payments															
(163,274)	Monthly Payroll inc NI & Super	(27,937)	(28,308)	(372)	(26,383)	(26,617)	(26,681)	(27,120)	(28,165)	(28,308)	(26,866)	(26,715)	(26,716)	(26,891)	(26,937)	(26,787)
(151,776)	Creditor Payment Run	(21,318)	(23,180)	(1,862)	(21,600)	(27,605)	(23,054)	(24,445)	(31,892)	(23,180)	(25,414)	(27,815)	(22,529)	(26,367)	(19,856)	(20,769)
(7,116)	Capital Payments	(1,012)	(861)	151	(1,503)	(2,508)	(1,085)	(312)	(848)	(861)	(1,161)	(1,265)	(1,642)	(1,262)	(1,787)	(1,828)
(2,634)	PDC Dividend Payment	(2,634)	(2,634)	(1)						(2,634)						(3,007)
(827)	Interest Payments	(719)	(719)		(18)		(34)		(55)	(719)	(57)		(30)	(61)	(210)	(704)
(325,627)	**Total Payments**	**(53,619)**	**(55,703)**	**(2,084)**	**(49,503)**	**(56,730)**	**(50,854)**	**(51,877)**	**(60,960)**	**(55,703)**	**(53,499)**	**(55,795)**	**(50,918)**	**(54,581)**	**(48,790)**	**(53,094)**
(2,029)	**Total Movement In Bank Balance**	**1,683**	**(4,118)**	**(5,801)**	**9,130**	**(11,527)**	**2,330**	**8,895**	**(6,738)**	**(4,118)**	**444**	**(2,129)**	**1,208**	**(1,760)**		**802**
5,129	**Closing Bank Balance**	**5,153**	**5,129**	**(25)**	**16,287**	**4,760**	**7,090**	**15,985**	**9,247**	**5,129**	**5,572**	**3,443**	**4,650**	**2,891**	**2,891**	**3,693**
	Plan				15,584	3,861	3,529	7,882	3,470	5,153	5,618	3,493	3,879	2,890	2,890	3,693
	Variance				704	899	3,561	8,102	5,777	(25)	(46)	(50)	771		1	()

Clinical Income - by Commissioner

Month 06 (September) 2018/19

	Annual £000	Year to Date £000			This Month £000		
Commissioner	**Plan**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
NHS Ashford CCG	69,236	34,286	37,314	3,029	5,805	6,389	585
NHS Canterbury & Coastal CCG	115,422	57,300	60,040	2,740	9,398	10,069	671
NHS South Kent Coast CCG	129,925	64,977	67,805	2,827	10,592	11,367	775
NHS Thanet CCG	94,021	46,874	48,731	1,857	7,664	8,117	452
East Kent CCGs	408,603	203,437	213,890	10,453	33,459	35,942	2,483
NCA - England	4,686	2,605	2,786	180	426	429	2
NHS England - Armed Forces	159	87	105	18	14	9	(6)
NHS England - Specialised Services	79,165	39,926	39,011	(915)	6,609	5,908	(701)
NHS England - Health In Justice	116	58	44	(14)	10	11	1
NHS England - Secondary Dentistry	6,429	3,204	3,286	82	524	450	(73)
NHS England - Public Health	7,811	3,708	3,351	(357)	684	559	(125)
Kings	264	132	129	(3)	22	21	(1)
NCA - Wales	142	71	69	(2)	12	5	(6)
NCA - Northern Ireland	5	2	6	4			
NCA - Scotland	22	11	10	(1)	2	4	2
Other Trusts	1,793	897	1,161	264	149	192	42
East Kent Overseas		17	307	291	(12)	12	25
NHS Dartford, Gravesham & Swanley CCG	455	284	258	(26)	42	52	10
NHS Medway CCG	2,075	1,104	1,015	(88)	204	203	(1)
NHS Swale CCG	3,643	1,944	1,664	(280)	325	262	(62)
NHS West Kent CCG	5,122	2,669	2,843	174	430	500	70
Other Organisations	16,059	7,087	828	(6,259)	3,073	301	(2,771)
Cancer Drugs Fund	3,007	1,504	1,709	206	251	276	26
Adjust Prior Month Reported Position						33	33
Prior year Income			1,418	1,418		1,650	1,650
Total	539,558	268,746	273,891	5,145	46,224	46,819	598

East Kent Commissioner contracts are all over performing YTD, and in month. NHSE Specialised Services is once again behind plan YTD following a large under performance in month. However, this is likely to change as the level of uncoded activity reduces levels of which have been high due to the PAS implementation and the downtime experienced by the coding team. The Cancer Drugs Fund and West Kent CCG are both ahead of plan, while the North Kent CCG's are collectively behind plan. Other Organisations include provisions for risks along with the planned CIP schemes and £2.5m ytd unplanned income to fund AfC pay awards.

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

The Expert Determination items from 17-18 that roll into 18-19 are being actively progressed. The unbundled radiology challenge has now been resolved with a credit to commissioners for 17-18 of £1.5m. The dermatology challenge has now also been resolved. The Trust holds a provision in its accounts to cover these. There are no material contracting issues with any of our other Commissioners.

KPIs

Month 06 (September) 2018/19

		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Clinical Income	**Plan**	42,848	45,649	46,985	46,015	44,480	46,915	47,069	46,849	43,841	47,000	43,204	47,002
Consolidated	**Actual**	42,369	47,016	47,467	47,702	46,857	47,609						
	Variance	-479	1,367	482	1,687	2,377	694						
	Quarterly rolling average spend	43,089	44,782	45,617	47,395	47,342	47,389						
Other Income	**Plan**	3,475	3,534	3,566	3,508	3,529	3,552	3,587	3,613	3,546	3,574	3,570	3,628
Consolidated	**Actual**	3,329	3,588	4,824	5,604	3,633	3,691						
	Variance	-146	54	1,258	2,096	104	139						
	Quarterly rolling average spend	5,875	6,087	3,914	4,672	4,687	4,309						
Pay	**Plan**	-30,772	-30,911	-31,066	-30,623	-30,634	-30,717	-30,686	-30,953	-30,960	-31,294	-30,721	-30,717
Consolidated	**Actual**	-31,253	-32,237	-32,156	-32,254	-34,168	-33,635						
	Variance	-481	-1,326	-1,090	-1,631	-3,534	-2,918						
	Quarterly rolling average spend	-31,203	-31,818	-31,882	-32,216	-32,859	-33,352						
Non Pay Operating Expenses	**Plan**	-18,693	-19,143	-18,927	-17,936	-19,125	-18,308	-19,439	-18,979	-18,303	-19,074	-17,944	-18,545
Consolidated	**Actual**	-17,358	-19,394	-19,634	-20,118	-18,502	-17,558						
	Variance	1,335	-251	-707	-2,182	623	750						
	Quarterly rolling average spend	-19,920	-20,168	-18,795	-19,715	-19,418	-18,726						
Non Operating	**Plan**	-2,228	-2,228	-2,228	-2,229	-2,235	-2,238	-2,236	-2,246	-2,259	-2,257	-2,260	-2,280
Consolidated	**Actual**	-2,118	-2,214	-2,179	-2,213	-2,176	-1,949						
	Variance	110	14	49	16	59	289						
	Quarterly rolling average spend	-1,942	-1,971	-2,170	-2,202	-2,189	-2,113						
Agency	**Plan**	-1,849	-1,702	-1,617	-1,552	-1,460	-1,450	-1,432	-1,292	-1,289	-1,278	-1,279	-1,258
Unconsolidated	**Actual**	-3,186	-3,921	-3,264	-3,411	-2,949	-2,983						
	Variance	-1,337	-2,219	-1,647	-1,859	-1,489	-1,533						
	Quarterly rolling average spend	-3,237	-3,484	-3,457	-3,532	-3,208	-3,114						
CIPS	**Plan**	1,502	1,533	1,552	3,357	2,156	1,289	2,895	2,927	2,944	3,208	3,267	3,370
Unconsolidated	**Actual**	1,155	1,758	1,629	4,081	1,777	1,598						
	Variance	-348	225	77	723	-378	309						
Cash	**Plan**	15,584	3,861	3,529	7,882	3,470	5,153	5,618	3,493	3,879	2,890	2,890	3,693
Unconsolidated	**Actual**	16,287	4,762	7,090	15,985	9,247	5,129						
	Variance	704	901	3,561	8,102	5,777	-25						

Cost Improvement Summary
Month 06 (September) 2018/19

Planned Summary	2018 - 2019			Target Variance	
Programme Divisions £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Clinical Support	4,159	3,522	3,401	(637)	(1,132)
Specialist	4,075	3,858	3,786	(217)	(350)
Surgery	7,015	5,852	5,356	(1,163)	(1,936)
UC&LTC	6,400	6,887	6,887	487	(230)
Corporate - Other	71	86	86	15	(1)
SD&CP	1,300	1,365	1,240	65	(172)
Procurement	2,693	1,604	1,511	(1,088)	(412)
Medicines Value	871	1,457	1,426	586	(3)
Sub-total	**26,584**	**24,632**	**23,693**	**(1,952)**	**(4,236)**
Central	3,416	4,624	4,220	1,207	1,024
Grand Total	**30,000**	**29,255**	**27,913**	**(745)**	**(3,212)**

Planned Summary	2018 - 2019			Target Variance	
Programme Themes £000	**Plan**	**Net**	**RAG Adj**	**vs Net**	**vs RAG**
Patient Flow/LOS	1,000	1,000	1,000	-	-
Agency	7,469	5,321	5,321	(2,147)	(2,148)
Workforce *	169	402	402	233	233
Procurement	1,982	1,213	1,119	(770)	(863)
Medicines Value	871	1,457	1,426	586	555
Division Schemes **	15,534	15,939	14,756	405	(778)
Sub-total	**27,025**	**25,332**	**24,024**	**(1,693)**	**(3,001)**
Central	2,975	3,924	3,895	949	920
Grand Total	**30,000**	**29,255**	**27,919**	**(745)**	**(2,081)**

Cost Improvement Phasing
Month 06 (September) 2018/19

Work stream Gross £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	-	-	-	-	167	167	167	167	167	167	1,000
Agency	622	631	622	822	776	(132)	623	655	648	720	744	737	7,469
Workforce	2	2	2	4	20	20	20	20	20	20	20	20	169
Procurement	50	69	87	129	199	206	207	207	207	207	208	208	1,982
Medicines Value	30	45	50	55	66	68	70	79	88	98	108	116	871
Clinical Support	184	165	166	251	248	251	250	246	243	271	269	270	2,817
Specialist	69	74	79	89	112	78	443	443	443	447	447	447	3,173
Surgery	413	413	413	419	419	419	636	636	636	719	744	744	6,615
UC&LTC	19	19	19	85	85	85	208	208	208	208	208	208	1,558
Corporate - Other	6	6	6	6	6	6	6	6	6	6	6	6	71
SD&CP	108	109	108	108	108	108	108	108	108	108	108	107	1,300
Sub-total	**1,502**	**1,533**	**1,552**	**1,969**	**2,039**	**1,110**	**2,738**	**2,775**	**2,775**	**2,971**	**3,030**	**3,031**	**27,025**
Central	-	-	-	1,388	117	179	157	152	169	237	237	339	2,975
Grand Total	**1,502**	**1,533**	**1,552**	**3,357**	**2,156**	**1,289**	**2,895**	**2,927**	**2,944**	**3,208**	**3,267**	**3,370**	**30,000**

Workstream RAG adj £'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Flow/LOS	-	-	-	-	-	-	167	167	167	167	167	167	1,000
Agency	646	365	448	408	347	206	307	464	487	610	509	524	5,321
Workforce	22	53	2	25	44	44	35	35	35	35	35	35	402
Procurement	35	44	59	106	54	52	125	125	125	132	132	130	1,119
Medicines Value	42	57	109	222	194	161	88	94	104	111	119	126	1,426
Clinical Support	157	184	234	330	357	144	178	187	187	234	234	234	2,663
Specialist	127	163	185	206	183	482	292	312	312	294	345	345	3,245
Surgery	14	628	380	475	316	271	414	435	435	433	433	433	4,668
UC&LTC	(9)	56	96	188	209	226	281	289	362	323	323	323	2,665
Corporate - Other	-	11	7	7	7	7	39	39	39	39	39	39	274
SD&CP	20	198	108	113	172	105	92	92	92	92	92	61	1,240
Sub-total	**1,055**	**1,758**	**1,629**	**2,081**	**1,883**	**1,698**	**2,018**	**2,239**	**2,346**	**2,471**	**2,430**	**2,418**	**24,024**
Central	100	-	-	2,000	(100)	(100)	613	211	211	272	343	345	3,895
Grand Total	**1,155**	**1,758**	**1,629**	**4,081**	**1,783**	**1,598**	**2,631**	**2,451**	**2,557**	**2,743**	**2,772**	**2,763**	**27,919**

Debtor Balances

Month 06 (September) 2018/19

Debtor	Top ten debtor balances outstanding as at 30/09/2018						Creditor balance as at 30/09/2018	Notes
	Current	1-30 Days	31-60 Days	61-90 Days	Over 90	Total		
62033-NHS THANET CCG	399,261.07	12,247.89	12,718.42	(349,003.05)	2,069,219.75	2,144,444.08	80,522.00	Over 90 days invoices to be cleared with unallocated cash receipts in M7 with agreement from the CCG
51136-EAST KENT MEDICAL SERVICES	134,341.72	158,935.12	179,564.73	134,297.60	1,283,041.42	1,890,180.59	1,047,788.52	Reciprocal payment arrangement in place
61865-NHS CANTERBURY AND COASTAL CCG	280,833.53	10,052.36	(11,769.17)	(952,775.38)	2,444,732.49	1,771,073.83	80,426.00	Over 90 days invoices to be cleared with unallocated cash receipts in M7 with agreement from the CCG
62003-NHS SOUTH KENT COAST CCG	465,999.16	28,938.10	12,490.26	(1,517,018.30)	2,590,822.10	1,581,231.32	99,968.00	Over 90 days invoices to be cleared with unallocated cash receipts in M7 with agreement from the CCG
61818-NHS ASHFORD CCG	441,477.79	6,849.40	3,570.00	(1,366,818.88)	2,245,921.50	1,330,999.81	57,352.00	Over 90 days invoices to be cleared with unallocated cash receipts in M7 with agreement from the CCG
50010-MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	110,214.51	102,019.12	40,296.07	40,100.75	541,388.65	834,019.10	1,420,814.05	Reciprocal payment arrangement in place
62048-NHS WEST KENT CCG	24,408.09	0.00	20,246.31	11,382.84	736,118.83	792,156.07		16/17 overperformance in dispute
51708-MEDWAY NHS FOUNDATION TRUST	10,473.89	45,631.62	76,962.21	17,890.50	554,778.10	705,736.32	933,588.77	Reciprocal payments to keep outstanding balances in line
62138-NHS ENGLAND SOUTH EAST COMMISSIONING HUB (14G)	73,900.17	73,900.17	73,900.17	73,900.17	295,600.68	591,201.36		Unpaid Hep C Drugs invoices
95741-KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	203,261.54	201,152.98	121,299.16	292.56	(506.28)	525,499.96	275,297.95	Current invoices
Other Govn.	1,537,898.28	(245,231.47)	837,845.24	172,759.75	2,748,789.66	5,052,061.46		
Other Non Govn.	656,000.26	162,757.26	182,903.69	211,151.91	1,192,766.60	2,405,579.72		
	4,338,070.01	557,252.55	1,550,027.09	(3,523,839.53)	16,702,673.50	19,624,183.62	3,995,757.29	

Creditor Balances

Month 06 (September) 2018/19

Unpaid at last Payment Run

Supplier Name	Total
Other Creditors	2,139
NHS Supply Chain 8HD71 - Stock	825
NHS Professionals Ltd	646
Abbott Laboratories Ltd	426
NHS Business Services Authority Prescription Pricing D	300
NHS Blood & Transplant T1460	217
Novartis Pharmaceuticals UK Ltd	160
Bayer PLC	125
Alcura UK Ltd	106
Roche Products Ltd	92
Allscripts Healthcare (IT) UK Ltd	91
Total	**5,128**

At the last payment run of the period we had a total of £9.87m of invoices authorised and ready for payment.

Of the £9.87m, £4.77m was released leaving £5.1m unpaid due to low liquidity. Aged Creditors now stands at £34.3m.

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

Top Ten Aged Creditor

Supplier Name	Current	1-30	31-60	60-90	90 +	Total
Other Creditors	11,709	5,476	1,044	569	1,431	20,229
NHS Professionals Ltd	2,434	1,407	5	5	10	3,862
NHS Supply Chain 8HD71 - Stock	1,020	825				1,846
Scottish Water Business Stream Ltd	1,034	466		2	0	1,501
Maidstone & Tunbridge Wells NHS Trust (RWF)	399	420	174	199	228	1,421
Healthcare At Home Ltd	996	90	15			1,101
East Kent Medical Services Ltd T/a The Spencer Wing		173	151	123	601	1,048
TFS Healthcare	660	361				1,021
Medway NHS Foundation Trust (RPA)	149	30	316	2	437	934
Abbott Laboratories Ltd	253	476				729
Zimmer Biomet UK Ltd	292	151	111	52	72	678
Total	**18,945**	**9,877**	**1,817**	**951**	**2,779**	**34,369**

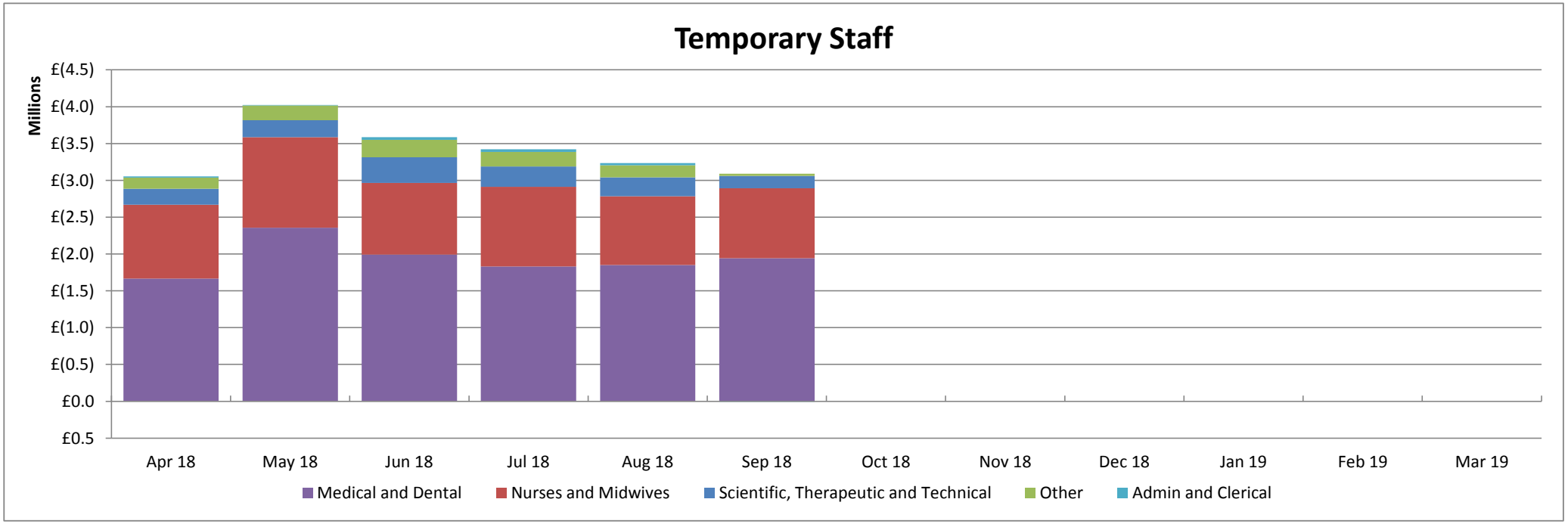
Aged Creditor By Reason

Reason Description	Current	1-30	31-60	60-90	90 +	Total
Current	18,945					18,945
Cash Flow		5,127				5,127
Waiting on a GRN		1,927	725	354	541	3,547
Not Recorded		1,549	199	228	39	2,016
Disputed		60	262	87	1,322	1,611
Waiting on Authorisation		937	338	30	124	1,429
Creditor Debit Balance		173	151	123	557	1,004
Price Query		140	23	40	84	288
Purchase Order Value Exceeded		26	87	58	59	230
Order Raised after Invoice Received		58	11	31	50	151
Other		0	20	0	2	23
Total	**18,945**	**9,877**	**1,817**	**951**	**2,779**	**34,369**

Pay Analysis - Temporary Staff

Month 06 (September) 2018/19

In Month £000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Medical and Dental	**(1,667)**	**(2,356)**	**(1,990)**	**(1,832)**	**(1,851)**	**(1,942)**						
Agency	(1,476)	(2,079)	(1,571)	(1,702)	(1,515)	(1,741)						
Medical Locum and Short Session	(191)	(277)	(420)	(130)	(336)	(201)						
STAFFflow												
Scientific, Therapeutic and Technical	**(217)**	**(231)**	**(348)**	**(275)**	**(257)**	**(168)**						
Agency	(217)	(231)	(348)	(275)	(257)	(168)						
Nurses and Midwives	**(1,002)**	**(1,230)**	**(974)**	**(1,080)**	**(933)**	**(951)**						
Agency	(1,002)	(1,230)	(974)	(1,080)	(933)	(951)						
Admin and Clerical	**(18)**	**(6)**	**(33)**	**(36)**	**(28)**	**7**						
Agency	(18)	(6)	(33)	(36)	(28)	7						
Other	**(150)**	**(201)**	**(239)**	**(198)**	**(164)**	**(29)**						
Agency	(150)	(201)	(239)	(198)	(164)	(29)						
Total	**(3,054)**	**(4,018)**	**(3,551)**	**(3,385)**	**(3,205)**	**(3,090)**						



Pay Analysis - Temporary Staff

Month 06 (September) 2018/19

Temporary Staff Actual £m	M & D	N & M	PAMS	A&C Other	Total	Variance v 2018/19	Variance v 2017/18
Urgent Care & LongTerm Conditions	1.01	0.80	0.02	(0.01)	1.81	(0.26)	0.32
Surgical Services	0.61	0.13	0.03		0.77	0.14	0.22
Clinical Support Services	0.06		0.13		0.19	(0.10)	(0.05)
Specialist Services	0.18	0.03			0.21	(0.01)	0.03
Strategic Development and Capital Planning				0.03	0.03	(0.01)	0.02
Corporate				(0.01)	(0.01)	(0.03)	(0.03)
Central	(0.18)				(0.18)	(0.07)	(0.13)
Total	**1.68**	**0.96**	**0.18**	**0.01**	**2.83**	**(0.34)**	**0.38**
Variance v 2018/19 average	(0.01)	(0.08)	(0.08)	(0.16)	(0.33)		
Variance v 2017/18 average	0.06	0.35	0.02	(0.04)	0.38		

Temporary Staff Year to Date £m	M & D	N & M	PAMS	A&C Other	Total	Average per Month
Urgent Care & LongTerm Conditions	6.51	5.07	0.15	0.70	12.43	2.07
Surgical Services	2.69	0.85	0.21	0.01	3.76	0.63
Clinical Support Services	0.60		1.17	0.01	1.77	0.30
Specialist Services	1.12	0.22			1.34	0.22
Strategic Development and Capital Planning				0.24	0.24	0.04
Corporate	0.01	0.01		0.12	0.14	0.02
Central	(0.73)	0.03	(0.02)	0.02	(0.70)	(0.12)
Total	**10.20**	**6.18**	**1.51**	**1.10**	**18.99**	**3.16**
Average per month	1.70	1.03	0.25	0.18	3.16	

REPORT TO:	**BOARD OF DIRECTORS (BoDs)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**INTEGRATED PERFORMANCE REPORT (IPR)**
BOARD SPONSOR:	**CHIEF EXECUTIVE**
PAPER AUTHOR:	**CHIEF EXECUTIVE / EXECUTIVE DIRECTORS**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: INTEGRATED PERFORMANCE REPORT – SEPTEMBER DATA**

BACKGROUND AND EXECUTIVE SUMMARY

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

A&E 4 Hour Compliance

September performance for the 4 hour target was 77.1%; against the NHS Improvement (NHSI) trajectory of 85.4%.This represents a 3% decrease in performance compared to the previous month. There were no 12 Hour Trolley Waits in September.

The number of patients who left the department without being seen remained compliant, but significantly decreased to 0.5%. This sudden and significant decrease in this indicator is currently undergoing validation for accuracy.

Unplanned re-attendances improved, but remained non-compliant at 8.6%. Time to treatment declined from August, remaining non-compliant at 45.5% for September.

An update on performance against our improvement plan can be found within the detail of the IPR.

18 Weeks Referral to Treatment (RTT) Standard

September performance of the RTT standard was reported as 76.27% against a trajectory of 81.32%. All specialities failed to meet their trajectory with the exception of cardiothoracic, general medicine and Healthcare of Older People (HCOOP).

The total waiting list reported 55,800 against trajectory of 50,857, which is a shortfall of 4,943.

The total waiting list is split into 45,938 on the non-admitted waiting list and 9,531 on the admitted waiting list.

52 week patients reported 129 against a trajectory of 175.

September performance has been impacted by the Patient Administration System (PAS) go

live due to data capture issues and reduced validation.

An update on performance against our improvement plan can be found within the detail of the IPR.

Cancer 62 day GP Referral to Treatment Standard

September performance is currently 77.05% against the improvement trajectory of 62.76%, validation continues until the beginning of November in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,955 and there were 15 patients waiting 104 days or more for treatment or potential diagnosis.

An update on performance against our improvement plan can be found within the detail of the IPR.

6 Week Referral to Diagnostic Standard

The standard has not been met for September 2018 with a compliance of 98.53%. As at the end of the month there were 187 patients who had waited over 6 weeks for their diagnostic procedure.

An update on performance against our improvement plan can be found within the detail of the IPR.

Patient Experience, Safety and Effectiveness

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

- The rate of falls has again remained below the national average - registering green for September. Pressure ulcers also improved in September, also registering as green.
- New harms, as reported in the harm free care metric, remains positive and similar to last month. Overall harm free care has improved this month rising from below the lower control limit last month to above the upper control limit this month.
- The number of mixed sex breaches has reduced from 73 last month to 19 in September 2018. Performance against our improvement trajectory of 30% by December is on plan.
- The ratio of compliments to complaints is positive with a high number of recorded compliments to every single complaint. In addition, our acknowledgement of complaints within 3 working days has improved, now reporting at 95%. However, the management of our complaints process remains a challenge. This month we have reported 'amber' for complaints responded to within timescales, linked to work ongoing to address the backlog position and seeking resolution with clients whose complaints have been open beyond the agreed date.
- Acknowledgement of complaints.
- The Friends and Family test inpatient satisfaction rate remains positive at 97% and the percentage not recommending the Trust has reduced in September 2018. The overall patient experience is registering green this month and reported an improved position.

August data reported a significant improvement in the omitted medicines safety metric. This has plateaued in September 2018 and requires more work in each of the different ward areas.

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

VTE assessment recording has worsened this month. This is being investigated to ensure it is not related to data capture.

Challenges around maintaining clinical safety and quality within the Emergency Departments (EDs) during periods of high pressure, highlighted within the recent Care Quality Commission (CQC) report. Actions to address this is linked to the ED improvement plan, focussing on improved patient flow, appropriate staffing and skill mix and embedding monitoring and assurance systems.

Financial Performance

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

The Trust's detailed finance position can be found on page 43 of the report. The Trust delivered a year to date deficit at Month 6 at £17.1m deficit, which is £1.3m behind plan. This is a consolidated position including Spencer Wing and after technical adjustments.

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

Human Resources

The Turnover rate in month increased slightly to 12.3%, and the 12 month average has increased to 13.6%. Focus remains on hard to recruit roles to replace agency, but also to identify new ways and methods of attracting to hard to recruit roles. Exit data is reviewed to highlight any areas of concern.

The vacancy rate increased to 12.6% for the average of the last 12 months, which is higher than last year. More work is being undertaken to target hard to fill vacancies, particularly within nursing and some Medical specialties.

Our Human Resources Team is working hard with Care Groups to identify new ways and methods of recruitment in a more timely way and to explore different workforce models. Exit interviews are constantly reviewed and analysed and a detailed report is provided periodically to the Board's Strategic Workforce Committee and reported to Board through the Chair Report.

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

A full report on the HR metrics can be found from page 33 in the IPR.

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

RESOURCE IMPLICATIONS:	N/A
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	Executive Performance Reviews. Management Board. Quality Committee. Finance and Performance Committee. Strategic Workforce Committee.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board is asked to discuss and note the report.

NHS
East Kent Hospitals University
NHS Foundation Trust

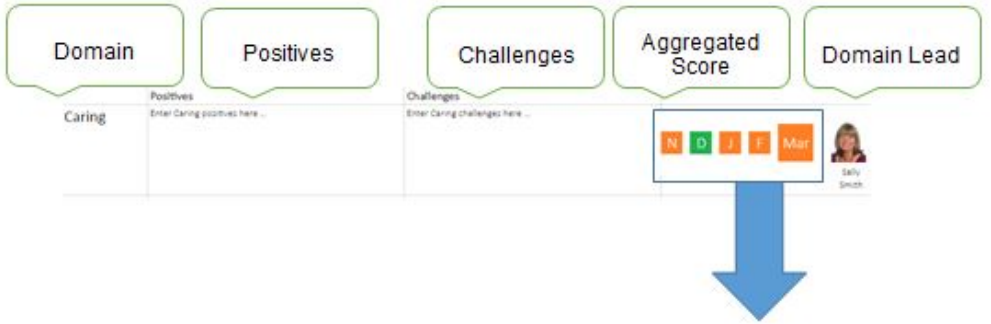
SEPTEMBER 2018

INTEGRATED PERFORMANCE REPORT

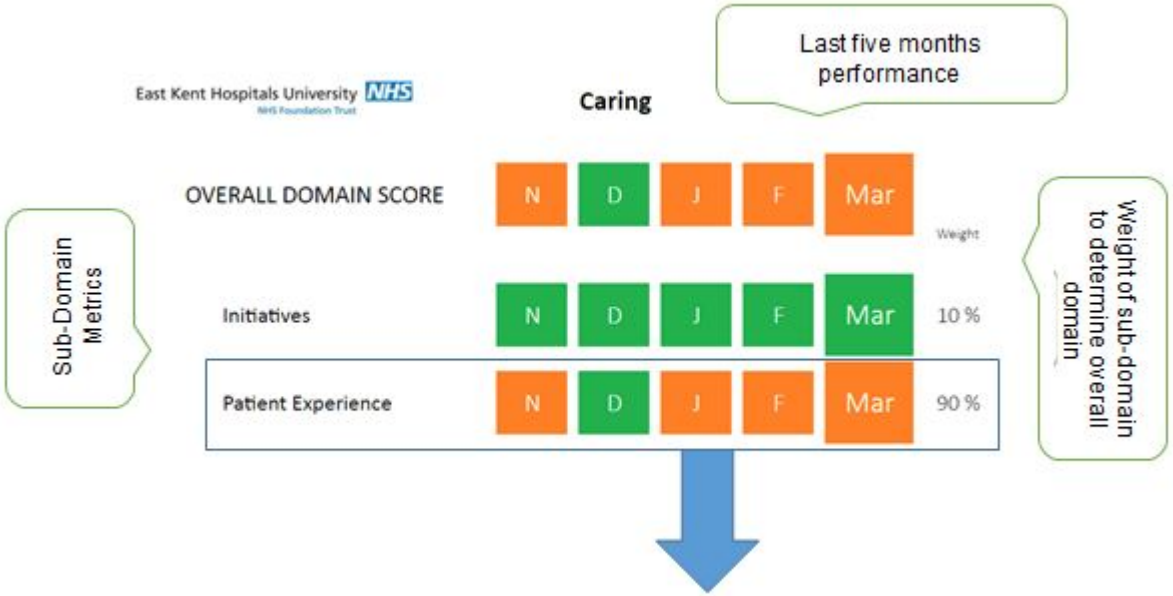
East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

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



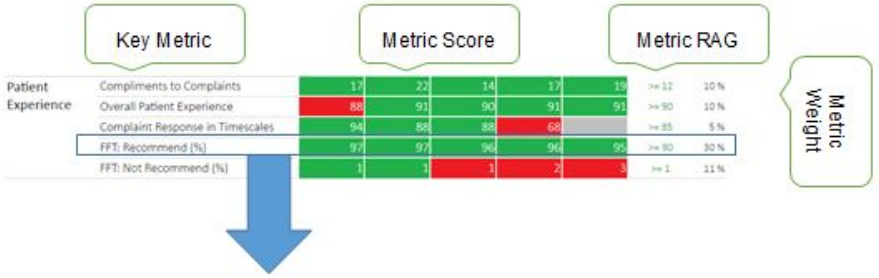
2 **Domain Metrics**: Each domain will have two pages; one showing overall aggregated scores split by sub-domain and another showing a selection of key metrics which help form the sub-domain aggregated metric scores. The first page indicates the sub-domain weighting % which is used to calculate the overall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



East Kent Hospitals University NHS Foundation Trust

Understanding the IPR

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



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

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

NHS
East Kent Hospitals University
NHS Foundation Trust

Strategic Priorities

East Kent Hospitals University NHS Foundation Trust

Contents

East Kent Hospitals University NHS Foundation Trust

Headlines

	Positives	Challenges	
Caring	The Friends and Family test inpatient satisfaction rate remains positive at 97%. And the percentage not recommending the Trust has reduced in September. The overall patient experience this month has improved and is registering green. We have seen improvements in the patients' satisfaction around cleanliness, food and being able to discuss their worries with a nurse. The ratio of compliments to complaints is positive with a high number of recorded compliments to every single complaint. The number of mixed sex breaches has reduced from 73 last month to 19 in September. Our improvement trajectory of a 30% reduction by December is on track.	The management of our complaints process remains a challenge. This month we have reported 'amber' for complaints responded to within timescales. This is because we are addressing the backlog and seeking resolution with clients whose complaints have been open beyond the agreed date. In September we received 78 formal complaints (an increase on August) and 336 PALS enquiries, also an increase. Our acknowledgement of complaints within 3 working days was 95% this month which is an improvement. Actions to address these challenges includes monthly meetings with Care Groups, reducing the backlog, a peer review by a local Trust and recruiting into the corporate team. There remains a challenge to maintaining clinical safety and quality within the emergency departments during periods of high pressure, highlighted within the recent CQC report. Actions to address this include focussing on improving patient flow, assuring the appropriate staffing in terms of numbers and skill mix and embedding monitoring and assurance systems such as the Bristol Safety checklist.	M J J A Sep  Sally Smith

Effective	There has been continued improvement in DTOC's which are averaging at 48 per day; however, this remains higher than the Trust internal target of 30 DTOC's per day. There are weekly reviews of all 7 and 21 day patients on each site and a whole system focus on resolving complex discharge issues. Discharges before 12 noon have deteriorated from 17% to 13%. It continues to be a priority to increase the number of discharges before midday and the process of identifying at least one 'golden' patient who can be discharged before 10am has been restated. Theatre utilisation has reduced slightly to 77%, with theatre start time within 30 minute performance reduced to 20%. The number of patients cancelled on the day has improved to 40. Non-clinical cancellations is much improved at 0.5%. The number of DNA's for new and follow up patients has improved to 7.8 and 7.2% respectively.	Although the DTOC numbers are improving, there is concern regarding the number of 'stranded' patients with a length of stay higher than 7 days and the number of 'super stranded' complex patients with a length of stay higher than 21 days. This is a daily challenge due the impact such delays have on patient flow across the whole emergency pathway. The implementation of the new PAS has created challenges for staff across all the Constitutional and internal standards creating delays in the delivery of activity. This has been due to staff becoming familiar with the new system and some operational issues which are being proactively managed through daily operational meetings and a weekly senior meeting chaired by the Chief Operating Officer.	M J J A Sep	 Lee Martin

Responsive

4 hour Emergency Access Standard
September performance for the 4 hour target was 77.15%, excluding the community MIU activity and against a NHS Improvement trajectory of 85.4%. This represents a 3% decrease in performance compared to the previous month. There were no 12 Hour Trolley Waits in September. The number of patients who left the department without being seen continued to be compliant at 0.48%, whilst unplanned re-attendances remained non-compliant at 8.5%. Time to treatment (60 minutes) also decreased to 45.5% and became non-compliant against the 48% internal standard.

RTT
September performance reduced to 76.27% against an improvement trajectory of 81.32%.

The number of patients waiting over 52 weeks for first treatment has decreased further to 129. This is within the trajectory of 175 submitted to NHSI.

DM01
The standard has not been met for September 2018 with a compliance of 98.53%, which is a slight improvement on last month. As at the end of the month there were 187 patients who had waited over 6 weeks for their diagnostic procedure.

The increase in demand for Sleep Studies has impacted on Respiratory performance and resulted in 123 breaches. There were also 42 breaches for patients waiting for an echo in the cardiac department.

Cancer
September performance is currently 77.05% against the improvement trajectory of 62.76%, validation continues until the beginning of November in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,955 and there were 15 patients waiting 104 days or more for treatment or potential diagnosis. This is a significant improvement.

All patients on a 2ww pathway and who are over 104 days are reviewed at the cancer PTL meetings weekly and daily review is being progressed by the speciality to ensure timely investigations and treatment for patients.

During September a large amount of effort was put into

4 hour Emergency Access Standard
The A&E four hour standard remains a priority for the Trust. The new PAS system has resulted in some delays in process whilst staff became familiar with the new system. During the downtime staff were also working with an electronic and paper process.

RTT
Planned reduction in activity, together with some operational issues related to the new PAS system which have resulted in an increase in the number of 'no outcome' patients who have not been cashed up in clinic; and a reduction in validation of the waiting lists due to staff focussing on supporting staff in out patient clinics or Patient Service Centre.

DM01
Demand for diagnostics has increased due to efforts to reduce cancer and RTT waiting times.
Identifying sustainable elective capacity to mitigate the risk of RTT and cancer breaches. Staffing issues due to vacancy and sickness in the cardio/respiratory departments has resulted in breaches in echo and sleep studies.

Cancer
Due to increases in demand some tumour groups, such as gynaecology and dermatology there is insufficient dedicated capacity to meet the 2ww demand. Out patient clinic template reviews are underway to identify sufficient substantive capacity.

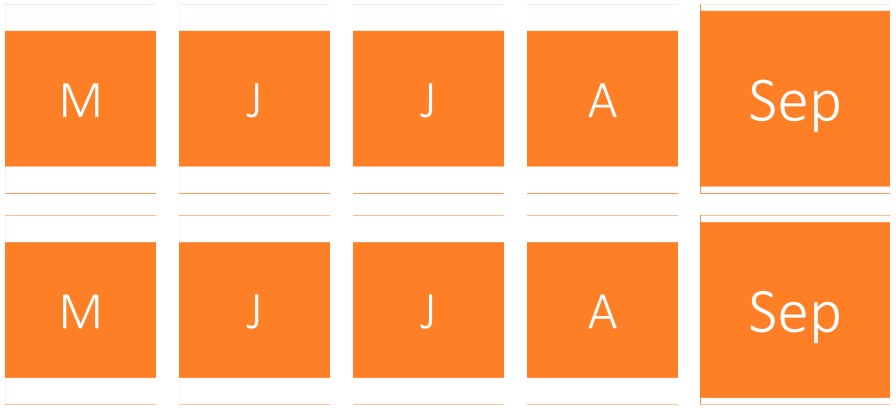
M J J A Sep

Lee Martin

	preparing for the new PAS; this included allocation of additional human resources to support the downtime and go live; planned reduction in activity to allow staff more time to become familiar with the new system and processes.		
Safe	The rate of falls has again remained below the national average registering green and this month pressure ulcers have also improved and are also registering green. These are 2 of the main metrics contributing to our new harms rate which also therefore remains good.	The improvement in missed doses of medicines and missed critical doses has plateaued and requires more work in each of the different ward areas VTE assessment recording has significantly worsened this month - across the Board including the areas that have been above target for over 12 months. This will be further investigated to ensure it is not related to data capture. Infection prevention and control continues to be a concern despite some potential improvement in E.coli bacteraemia rates.	M J J A Sep  Paul Stevens
Well Led	Vacancy (M6 - 14% , M5 - 13.4%), Appraisal (M6 - 76.5%, M5 - 76%) and Agency % (M6 - 7.1% , M5 - 7.6%) rates have all improved in month. I&E CIPS of £12m are reported up to Month 6 against a plan of £11.4m. Risks remain in relation to finalising CIP schemes and full delivery of some identified schemes (e.g. 2gether Solution savings) in order that the full net £30m of savings can be delivered by the year end.	The Trust delivered a £1.7m deficit (after NHSi adjustments) in Month 6 which was £1.1m behind plan. This brings the YTD position to a deficit of £17.1M which is behind plan by £1.3m (consolidated position including Spencer Wing and after technical adjustments). Trust Pay is £1.6m over plan in month and £8.2m over plan YTD. The main overspend is in Agency costs (£10.3m over plan YTD) offset by an underspend on permanent staffing (£2.7m under plan YTD). The key driver for the overspend against plan are the continuing Medical and Nursing pressures in U&LTC and increased pressures in Medical pay in Surgery. Risks remain in relation to the impact on Income of the Expert Determination although 2017/18 has been agreed verbally. The Trust is working with Commissioners to agree the final impact for 2018/19. Total Cash borrowed has risen to £60.7m Staff sickness (M6 - 4.8%, M5 3.8%) and Staff turnover (M6 14.2% , M5 - 13.9%) rates have both worsened in month.	M J J A Sep  Susan Acott

East Kent Hospitals University NHS Foundation Trust

Caring



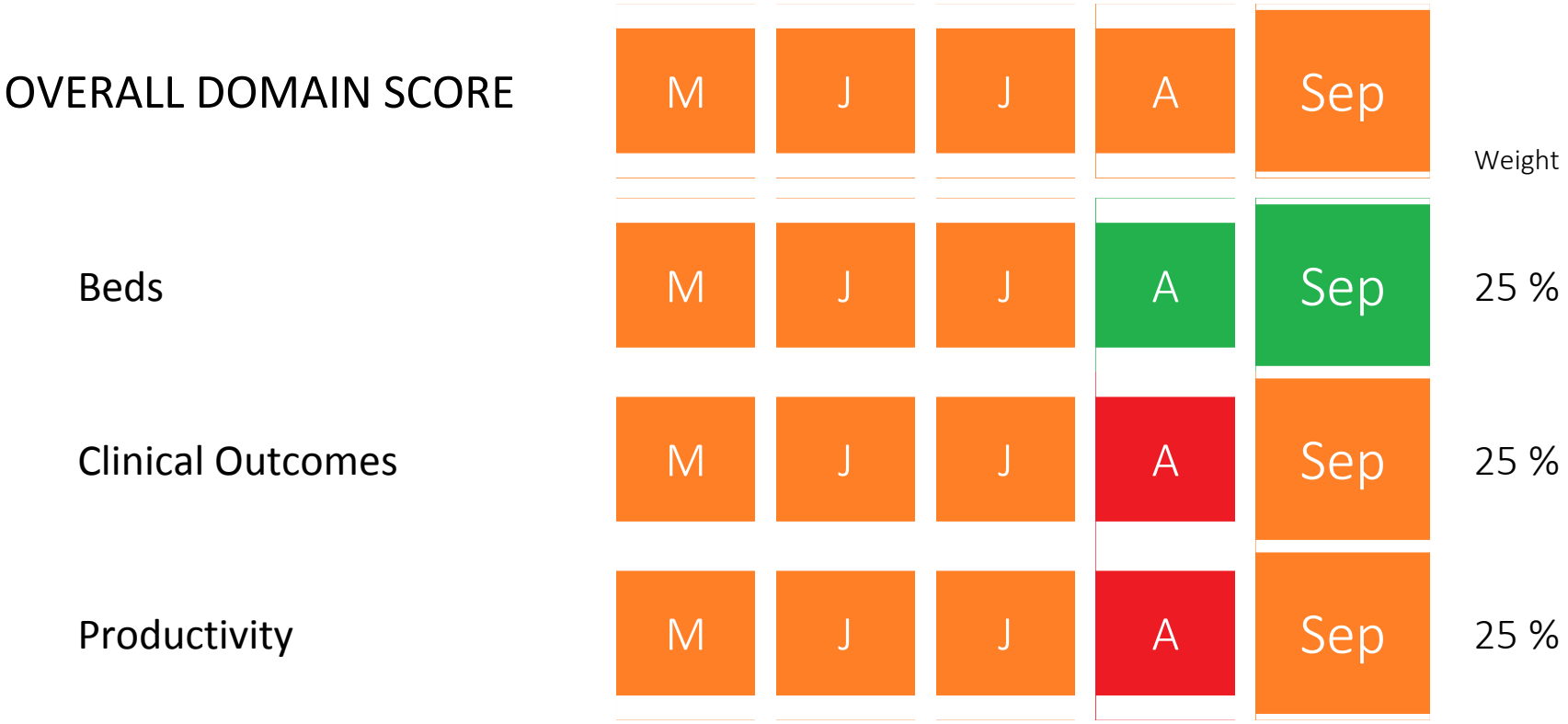
East Kent Hospitals University NHS Foundation Trust

Caring

		May	Jun	Jul	Aug	Sep	Green	Weight
Patient Experience	Mixed Sex Breaches	69	98	50	73	19	>= 0 & <1	10 %
	AE Mental Health Referrals	104	134	106	115	81		5 %
	Compliments to Complaints (#/1)	28	28	30	24	17	>= 12	10 %
	Overall Patient Experience %	91.4	91.1	91.9	89.8	90.1	>= 90	10 %
	FFT: Recommend (%)	97	97	97	96	97	>= 90	30 %
	FFT: Not Recommend (%)	1.8	0.9	1.1	1.7	1.2	>= 0 & <1	10 %
	Complaint Response in Timescales %	91.4	92.0	87.3	90.2	75.7	>= 85	5 %

East Kent Hospitals University NHS Foundation Trust

Effective



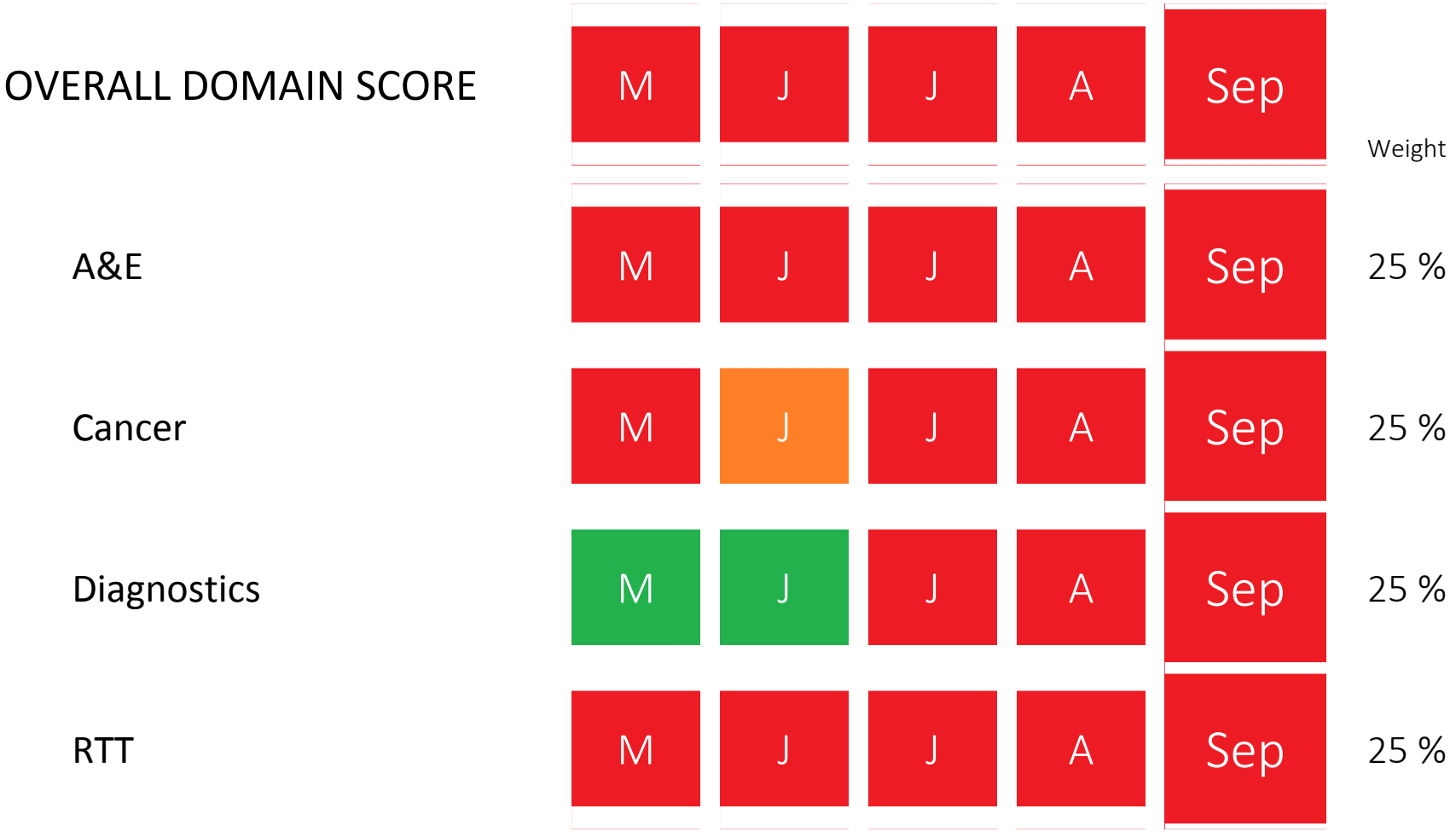
NHS
East Kent Hospitals University
NHS Foundation Trust

Effective

		May	Jun	Jul	Aug	Sep	Green	Weight
Beds	DToCs (Average per Day)	61	61	57	52	48		30 %
	Bed Occupancy (%)	5	5	5	5	5	>= 0 & <92	60 %
	IP - Discharges Before Midday (%)	14	14	14	13	17	>= 35	10 %
Clinical Outcomes	Readmissions: EL dis. 30d (12M%)	3.8	3.7	3.9	4.4		>= 0 & <2.75	20 %
	Readmissions: NEL dis. 30d (12M%)	15.9	15.2	14.4	15.2		>= 0 & <15	15 %
	Audit of WHO Checklist %	100	100	96	98	100	>= 99	10 %
Demand vs Capacity	DNA Rate: New %	7.0	6.8	7.8	8.5	7.8	>= 0 & <7	
	DNA Rate: Fup %	6.7	6.8	6.9	7.3	7.2	>= 0 & <7	
	New:FUp Ratio (1:#)	1.9	1.9	1.9	1.8	1.8	>= 0 & <7	
Productivity	LoS: Elective (Days)	3.5	3.2	3.5	2.9	3.2		
	LoS: Non-Elective (Days)	6.4	6.2	6.2	6.1	6.1		
	Theatres: Session Utilisation (%)	80	80	79	80	77	>= 85	25 %
	Theatres: On Time Start (% 30min)	70	67	69	70	66	>= 90	10 %
	Non-Clinical Cancellations (%)	2.2	2.1	1.8	1.7	0.5	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	1	3	0	0	0	>= 0 & <5	10 %
	EME PPE Compliance %	81	80	81	78	79	>= 80	20 %

East Kent Hospitals University NHS Foundation Trust

Responsive



NHS
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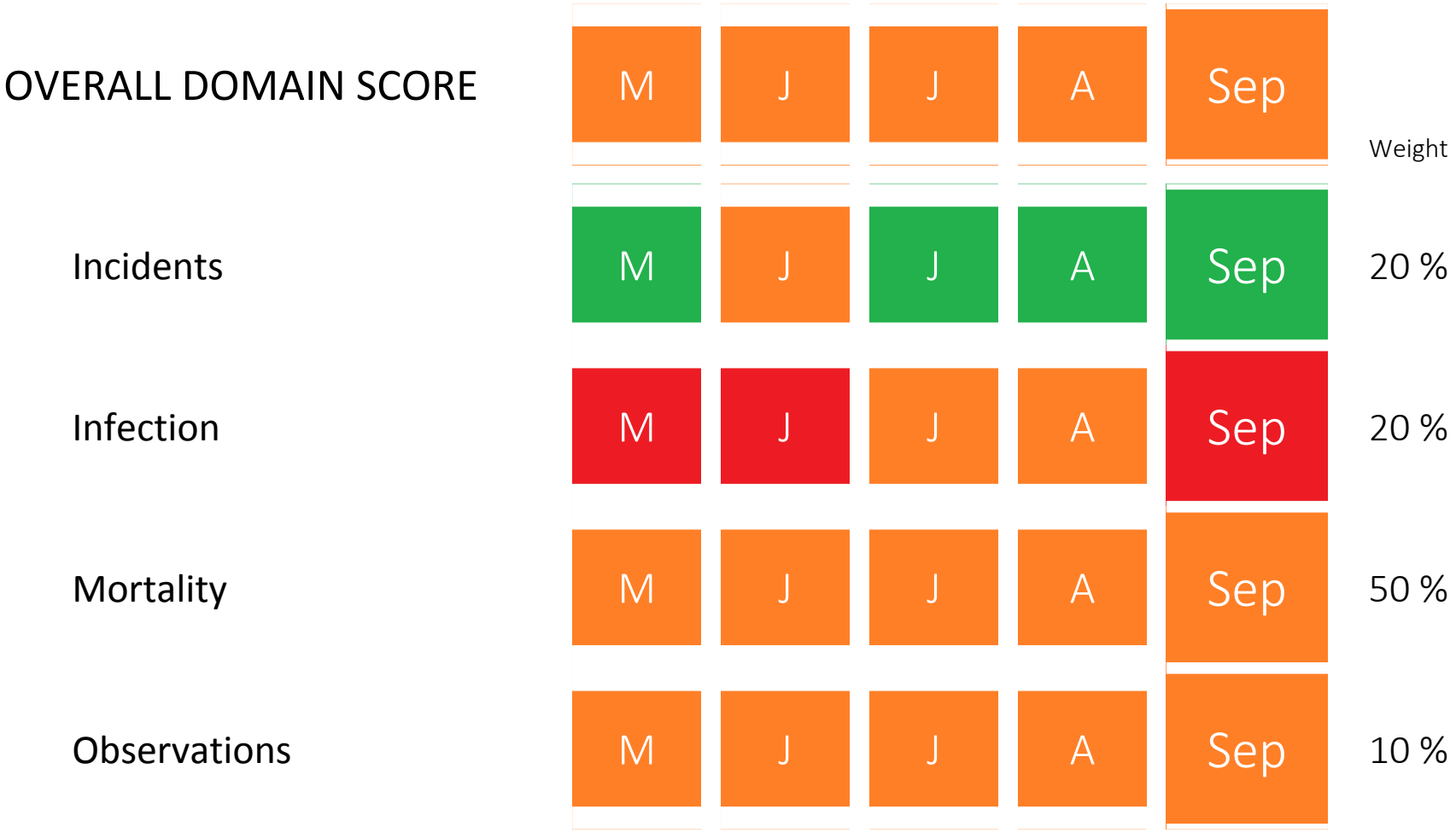
Responsive

		May	Jun	Jul	Aug	Sep	Green	Weight
A&E	ED - 4hr Compliance (incl KCHFT MIUs) %	83.95	86.92	82.95	81.95	81.17	>= 95	100 %
	ED - 4hr Performance (EKHUFT Sites) %	80.80	82.73	79.18	80.04	77.15	>= 95	1 %
Cancer	Cancer: 2ww (All) %	93.81	94.22	94.94	93.64	90.91	>= 93	10 %
	Cancer: 2ww (Breast) %	84.46	94.12	93.18	86.32	94.39	>= 93	5 %
	Cancer: 31d (Diag - Treat) %	96.33	96.45	95.66	95.24	96.89	>= 96	15 %
	Cancer: 31d (2nd Treat - Surg) %	82.05	82.61	94.59	95.56	95.74	>= 94	5 %
	Cancer: 31d (Drug) %	98.88	98.11	99.17	98.97	97.78	>= 98	5 %
	Cancer: 62d (GP Ref) %	65.01	65.47	65.39	65.85	71.19	>= 85	50 %
	Cancer: 62d (Screening Ref) %	84.09	100.00	81.63	94.37	84.31	>= 90	5 %
	Cancer: 62d (Con Upgrade) %	75.86	84.38	85.00	94.74	72.73	>= 85	5 %
Diagnostics	DM01: Diagnostic Waits %	99.30	99.09	98.44	98.03	98.53	>= 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 (%)	78.56	79.02	79.65	79.06	76.27	>= 92	100 %
	RTT: 52 Week Waits (Number)	218	201	167	125	129	>= 0	

East Kent Hospitals University NHS Foundation Trust

Safe



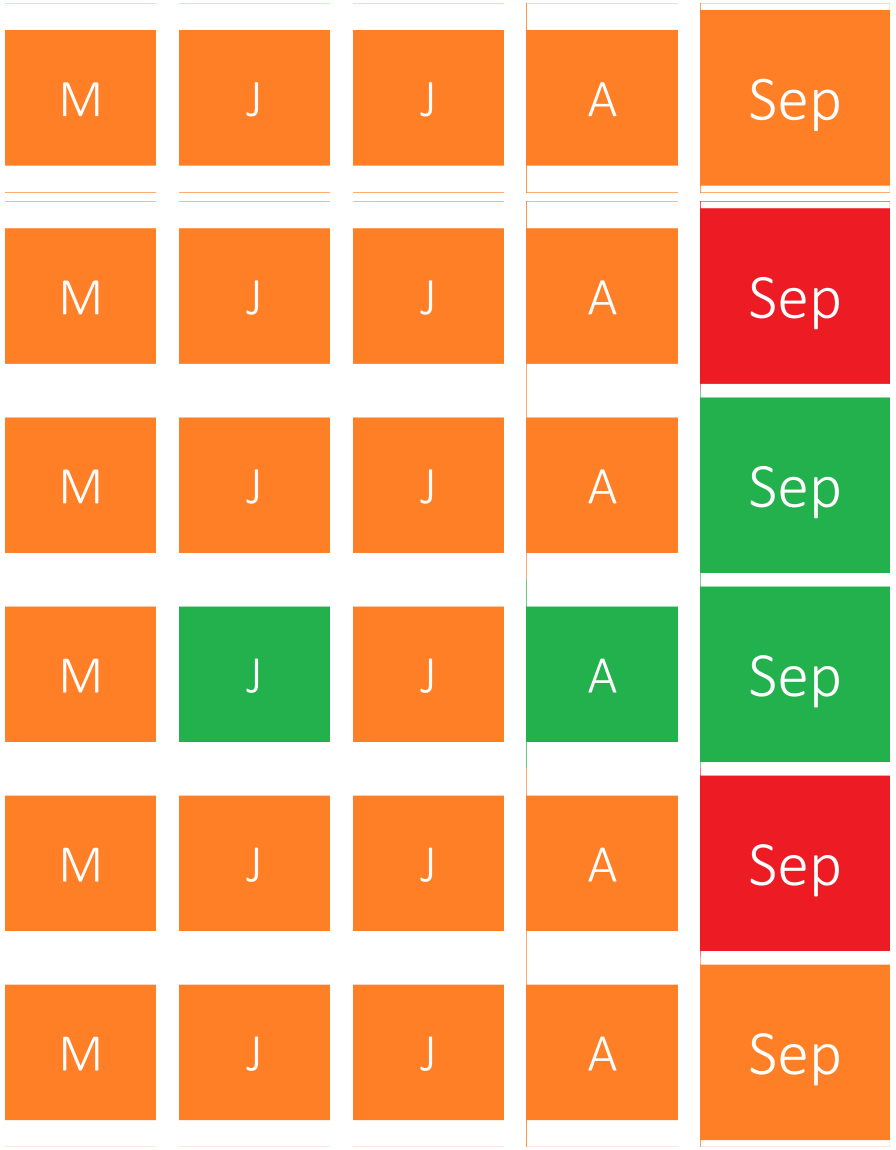
NHS
East Kent Hospitals University
NHS Foundation Trust

Safe

		May	Jun	Jul	Aug	Sep	Green	Weight
Incidents	Clinical Incidents: Total (#)	1,477	1,347	1,481	1,281	1,198		
	Serious Incidents (STEIS)	13	12	9	11	11		
	Harm Free Care: New Harms (%)	98.7	98.3	98.3	99.3	99.0	>= 98	20 %
	Falls (per 1,000 bed days)	5.09	5.04	5.02	4.93	5.40	>= 0 & <5	20 %
	Pressure Ulcers Cat 2 (per 1,000)	0.14	0.15	0.18	0.17	0.14		10 %
Infection	Cases of C.Diff (Cumulative)	12	16	19	22	25	<= Traj	40 %
	Cases of MRSA (per month)	1	1	0	0	1	>= 0 & <1	40 %
	Hand Hygiene Audit	96	96	95	94	97	>= 95	
Mortality	HSMR (Index)	95	96	96			>= 0 & <90	35 %
	Crude Mortality EL (per 1,000)	0.8	0.4	0.8	0.9	0.7	>= 0 & <0.33	10 %
	Crude Mortality NEL (per 1,000)	26.6	25.5	29.1	24.8	27.8	>= 0 & <27.1	10 %
	RAMI (Index)	89	89	90	89	89	>= 0 & <87.45	30 %
Observations	Cannula: Daily Check (%)	70.0	71.8	70.8	68.9	65.5	>= 50	10 %
	Catheter: Daily Check (%)	40.6	41.8	39.2	43.7	36.9	>= 50	10 %
	Central Line: Daily Check (%)	67.8	68.1	66.9	66.1	62.3	>= 50	10 %
	VTE: Risk Assessment %	94.5	94.3	93.2	93.0	90.2	>= 95	20 %
	Obs. On Time - 8pm-8am (%)	92.1	92.5	91.9	92.0	91.5	>= 90	25 %
	Obs. On Time - 8am-8pm (%)	89.6	90.0	89.1	89.6	89.4	>= 90	25 %

East Kent Hospitals University NHS Foundation Trust

Well Led



East Kent Hospitals University NHS Foundation Trust

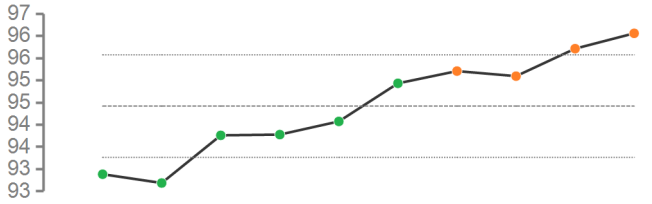
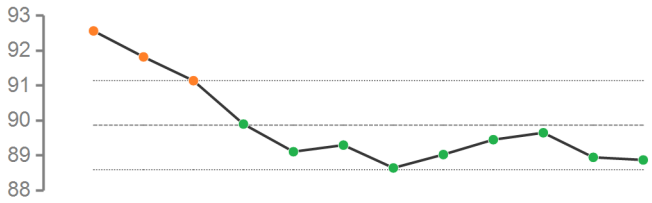
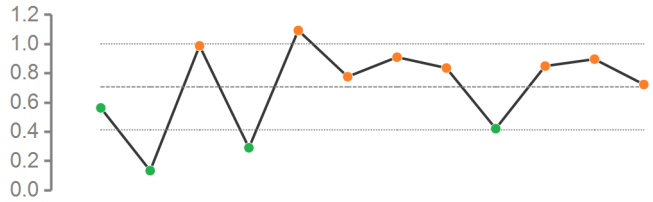
Well Led

		May	Jun	Jul	Aug	Sep	Green	Weight
Data Quality & Assurance	Not Cached Up Clinics %	1.5	1.0	1.0	1.1	2.2	>= 0 & <0.2	25 %
	Uncoded Spells %	0.4	0.3	0.1	0.4	14.2	>= 0 & <0.25	25 %
Finance	Forecast £m	-30.0	-30.0	-30.0	-30.0	-29.9	>= 0	10 %
	Total Cost £m (Trust Only)	-53.2	-53.1	-54.0	-54.0	-52.5	>= 0	20 %
	Cash Balance £m	4.8	7.1	16.0	9.2	5.1	>= 0	20 %
	I&E £m (Trust Only)	-3.2	-1.7	-1.3	-4.4	-2.1	>= 0	30 %
Health & Safety	Formal Notices	0	0	0	0	0	>= 0 & <1	15 %
	RIDDOR Reports (Number)	1	2	0	2	1	>= 0 & <3	20 %
Staffing	Sickness (%)	3.7	3.8	3.8	3.8	4.8	>= 0 & <3.3	10 %
	Agency %	7.0	7.2	7.4	7.6	7.1	>= 0 & <10	
	Bank Filled Hours vs Total Agency Hours	57	59	59	60	60		1 %
	Shifts Filled - Day (%)	100	99	96	93	93	>= 80	15 %
	Shifts Filled - Night (%)	105	104	108	105	103	>= 80	15 %
	Care Hours Per Patient Day (CHPPD)	11	11	10	11	11		
	Staff Turnover (%)	13.2	13.0	15.0	13.9	14.2	>= 0 & <10	15 %
	Vacancy (%)	13.1	14.0	13.3	14.0	13.4	>= 0 & <7	15 %
	Total Staff In Post (SiP)	7042	7045	7105	6994	7043		1 %
Training	Appraisal Rate (%)	71.8	67.2	70.6	76.0	76.5	>= 85	50 %
	Statutory Training (%)	90	91	91	92	92	>= 85	50 %

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Mortality

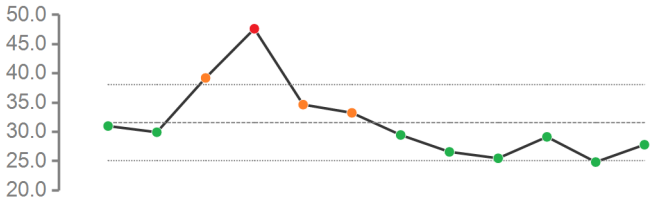
Sep	HSMR (Index)	94 (0.6%)		Hospital Standardised Mortality Ratio (HSMR), via CHKS, compares number of expected deaths vs number of actual in-hospital deaths. Data's adjusted for factors associated with hospital death & scores number of secondary diagnoses according to severity (Charlson index). Arrow indicates average of last 12 months data.
Sep	RAMI (Index)	90 (1.9%)		Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.
Sep	Crude Mortality EL (per 1,000)	0.7 (0.2%)		"The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Strategic Theme: Patient Safety

Sep

Crude Mortality NEL (per 1,000)

31.6 (16.1%)



"The number of deaths per 1,000 non-elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Highlights and Actions:

Crude mortality and RAMI (risk adjusted mortality index) are unchanged in comparison to recent months and both remain between upper and lower control limits, both are in 50th-75th quartile by peer distribution. Our SHMI (summary hospital mortality index) is also unchanged and is again 1.02 for this period under study for SHMI (April 2017-March 2018).

HSMR shown in the report here has breached the upper control limit for the last 2 months and it is believed that this is still a consequence of the re-basing exercise. The CHKS report actually suggests a reduction in HSMR but even with re-basing is within control limits for the last 2 years.

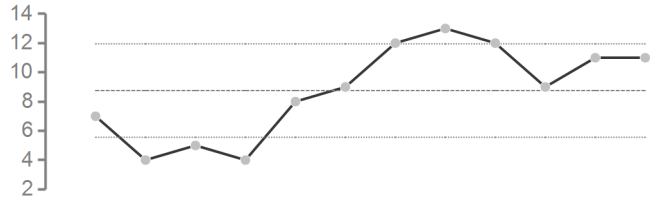
Actions

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

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Serious Incidents

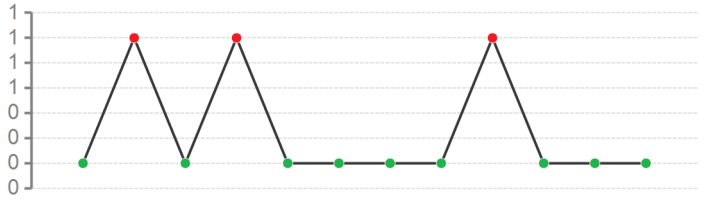
Sep	Serious Incidents (STEIS)	105 (41.9%)		"Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."

Strategic Theme: Patient Safety

Sep

Never Events (STEIS)

3
(-25.0%)



"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:

Total open SIs on StEIS in September 2018: 89 (including 11 new)
SIs under investigation: 43
Breaches: 3
Non-breaches: 40
Waiting EKHUFT non-closure response: 12
Waiting CCG response: 34

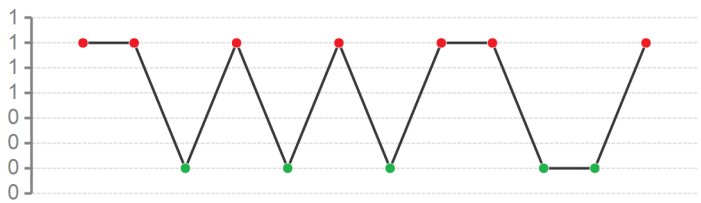
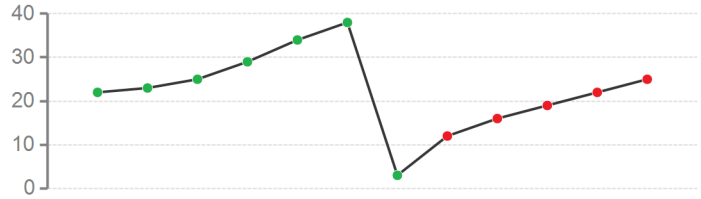
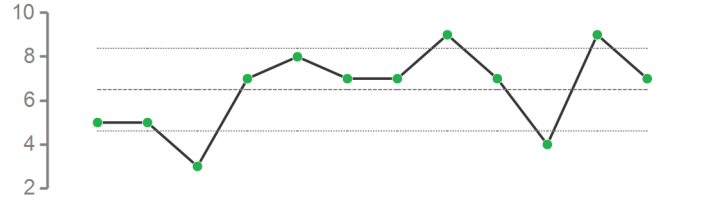
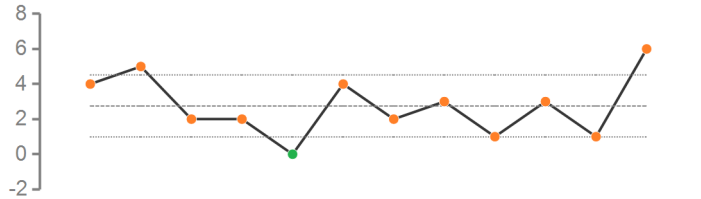
Supporting Narrative:
The number of breached cases is 3. Breaches were mainly due to delays in report writing and gaps in and the rigour of the analysis. The Root Cause Analysis Panel and weekly corporate/divisional governance team meetings continue to support completion of and the quality of the investigations. The corporate team now attend many of the RCA meetings and are aligned to individual cases to support completion of the analysis and reports. Additionally the corporate team aim to link with the lead investigator early in the process. The Chief Nurse and Medical Director now receive weekly updates on the breached cases and a trajectory for submission for these cases is in place for September. A new SI panel is being set up weekly chaired by the Medical Director and present will be the Chief Nurse and Chief Operating Officer. This action will provide greater oversight of learning and case management.

The 11 new SIs are:
- a medication incident with possible anaphylaxsis
- two abuse cases (one was patient on patient and one related to a doctor and a patient)
- an obstetric case relating to the baby (HSIB will be investigating)
- a treatment delay in ophthalmology
- a VTE case within maternity
- three suboptimal care of deteriorating patients - one in ED, one on Invicta Ward and one on King's A
- a screening incident relating to neonatal hip screening
- a pressure ulcer case

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Infection Control

Sep	Cases of MRSA (per month)	7 (-30.0%)		Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.
Sep	Cases of C.Diff (Cumulative)	25 (13.6%)		"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."
Sep	E. Coli	78 (-17.0%)		"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."
Sep	MSSA	33 (10.0%)		"The total number of MSSA bacteraemia recorded, post 48hrs.

Strategic Theme: Patient Safety

Highlights and Actions:

C.difficile

C.difficile data is presented as the cumulative number of cases and resets to zero each April. In the new reporting period since April to date the number of cases at the end of September (25) is above the trajectory set for the year by the Department of Health (22). In future years we will also be viewing all C.difficile, ie those pre and post 48 hrs from admission. To give an idea of the problem that number for this year is 75 year to date.

All of the hospital onset C.difficile infections to date have been in either the surgical or Urgent Care & Long Term Conditions divisions with no cases recorded in specialist services (renal, haematology, obstetrics, gynaecology). Ribotyping has not suggested transmission of C.diff between patients.

Actions:

1. Learn from wards that have experienced no episodes of C.diff to understand what they are doing differently
2. Continued programme of anti-microbial stewardship targeting areas of high and inappropriate broad spectrum antibiotic usage
3. Reinforcement of basic infection prevention and control procedures throughout the Trust
4. Work with community over community onset C.diff

MRSA

From April 2018, all post 48 hour MRSA bacteraemias have been automatically assigned to the Trust and all pre 48 hour cases to the CCG. Year to date there have been 3 hospital onset MRSA bacteraemias and 5 attributable to the CCGs. Root cause analysis in the 3 hospital onset cases indicated heavy colonisation with MRSA in skin ulcers at time of admission.

MSSA

The number of Trust apportioned MSSA bacteraemias year to date is 16, there have been a further 51 cases of community onset MSSA bacteraemias. MSSA is reported as an SPC run chart in this report and this month has breached the upper control limit.

Actions:

Staphylococcus aureus, whether MRSA or MSSA, is found on people's skin and in the respiratory tract and therefore easily colonises ulcers. Care of indwelling devices that breach natural defences is therefore an integral part of prevention of both MRSA and MSSA bacteraemias.

1. revisit the 5 moments of hand hygiene with all clinical teams (before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings).
2. Implement the aseptic non-touch technique and audit compliance with ANTT guidance for wound care and care of indwelling devices

E.coli

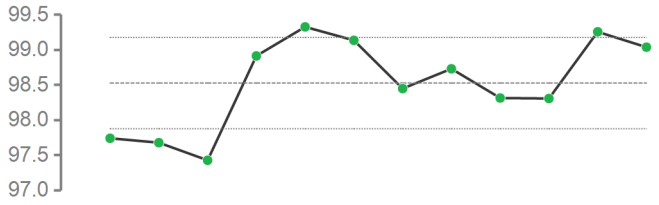
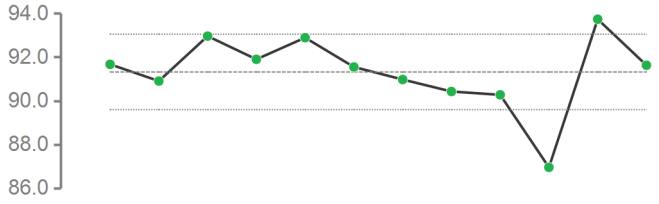
The number of E.coli bacteraemias (hospital onset) year to date is 40, month by month this metric is also presented as an SPC run chart but is highly variable as can be seen, ranging from below to above to between lower and upper control limits in successive months. The number of community onset year to date is 246, comparable figures for last year were 45 for hospital onset and 253 for community onset.

E.coli bacteraemia in hospital is almost exclusively associated with pathology in the urinary and digestive tracts and other than infection associated with indwelling urethral catheters is largely unpreventable. The underlying causes of community onset E.coli bacteraemia are similar and work to reduce E.coli bacteraemia centres around a collaborative aiming to reduce those bacteraemias associated with urinary tract infection through introduction of catheter bundles in both hospital and community.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Harm Free Care

Sep	Harm Free Care: New Harms (%)	98.5 (-0.2%)		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.
Sep	Harm Free Care:All Harms (%)	91.3 (-1.7%)		"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 September-18 (91.64%) shows a slight fall since last month (93.75% August-18). The prevalence of catheters & New UTIs has improved for September 18 and decreased to 0.10% (0.11% - August-18), which is lower than both the overall National Average (0.28%) and the Acute Hospital only average (0.34%).

The total of Harm Free Care experienced in our care (New Harms only) at 99.04% fell slightly since last month (99.26% August-18). A marked improvement for the prevalence of New VTEs (0.38%) are lower than the national average for Acute Hospitals (0.64%) and New Pressure Ulcers (0.58%) are lower the national average for Acute Hospitals (0.73%). The prevalence of Catheters and New UTIs , and Falls with Harm continue to remain below the national average for Acute Hospitals.

Falls - Actions
1. Fall Stop programme continues with a set rollout programme Trustwide, focusing on rapid assessment of patients at high risk of falls in CDUs and frailty wards.
2. EKHUFT are now involved with the 2nd phase of the NHS Improvement Falls Collaborative

Recommendations:
• Lying and standing blood pressures are monitored and being discussed at the board round daily.

Pressure Ulcers – Actions:
1. Events held in QII HUB
2. Mattress strategy meeting to plan for winter pressures
3. Visit to Ami group by TVN and manual Handling Lead
4. Acute Hospital Bed trials have taken place
5. TV Tuesday commenced at WHH

Recommendations:
• Continue improvement work with regards to documentation
• Share results of trust-wide annual audit
• Trial equipment of active mattress/Hybrid to ensure sufficient supply for winter
• 'React to Risk' event to be held in November to coincide with Worldwide stop the pressure day. PROMPT card launching and Waterlow risk assessment guides

VTEs –

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

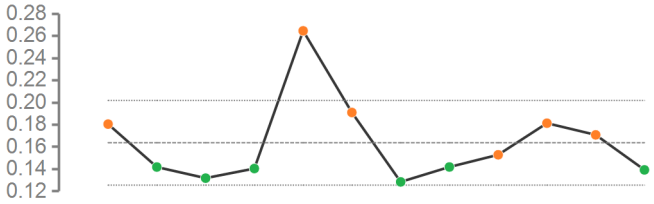
UTIs – Action's:
1. Awaiting completion of Kent & Medway wide catheter guidelines to roll out
2. Planned launch of the catheter passport
3. Further work will continue to explore admission source, and identify any themes, for patients admitted with a urinary catheter to drive improvement priorities.

Recommendations:
• Continue improvement work trustwide
• Ensure robust validation of prevalence data

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Pressure Damage

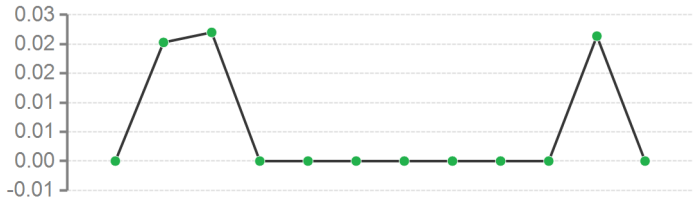
Sep	Pressure Ulcers Cat 2 (per 1,000)	0.17 (-65.3%)		"Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

Strategic Theme: Patient Safety

Sep

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

0.01
(-70.9%)



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

Highlights and Actions:

September 2018

In September 2018 there were a total of 41 pressure ulcers reported. 28 of these were category 2 ulcers which is an increase of 10 from last month. The trust came under the 0.15 avoidable incidence/1000 bed days for the first time since April 2018 with a result of 0.0901/1000 bed days. 3 were avoidable, 5 less than last month. 1 of these affected the sacrum and 1 the hip. These were avoidable due to lack of evidenced repositioning and delay in pressure relieving equipment. The remaining avoidable ulcers affected the heel due to lack of evidenced heel offloading.

There was 1 confirmed category 3 which was unavoidable. There were no category 4 ulcers. We have remained consistently under the set 0.15/1000 for avoidable category 3 and 4 ulcers.

Twelve potential deep ulcers were reported. 5 of these were avoidable an increase of 3 from last month. Two heel ulcers and 3 on the sacrum due to lack of offloading. The trust came marginally over the 0.15 avoidable incidence/1000 bed days with a result of 0.1501/1000 bed days. The figures that are reported will be altered as the decision has been taken to now include any incidents that are reported by KCHFT which have previously been categorised separately.

Actions in September 2018:

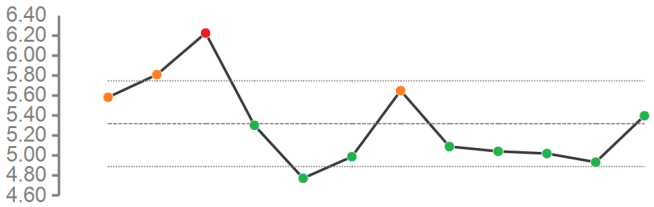
- Events held in QII HUB
- Mattress strategy meeting to plan for winter pressures
- Visit to Ami group by TVN and manual Handling Lead
- Acute Hospital Bed trials have taken place
- TV Tuesday commenced at WHH

Recommendations:

- Continue improvement work with regards to documentation
- Share results of trust-wide annual audit
- Trial equipment of active mattress/Hybrid to ensure sufficient supply for winter period
- ‘React to Risk’ event to be held on 15th November to coincide with Worldwide stop the pressure day. PROMPT card launching and Waterlow risk assessment guides

Strategic Theme: Patient Safety

Falls

Sep	Falls (per 1,000 bed days)	5.32 (-56.5%)		"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 increased slightly in September, but still remain within the control limits and registering green. There were a total of 170, 58 at K&CH, 50 at QEQMH and 62 at WHH. 1 fall on Quex resulted in a head injury and the patient later died. The patient had a history of falls prior to admission so it is unclear if the fall in hospital caused the death, but it is being treated as such, based on the balance of probabilities, but is being fully investigated. there were 2 unavoidable hip fractures at QEQMH, an unavoidable ankle fracture and an unavoidable pelvic fracture AT K&CH.There were 8 falls on Invicta where 3 patients fell twice and 13 on Kingston where 3 patients fell twice and 1 fell 3 times (at K&CH).

Actions:

1. The Fall Stop programme continues with a set rollout programme Trustwide, focusing on rapid assessment of patients at high risk of falls in CDUs, frailty wards and medical wards. Targetted work is still required on Cambridge J at WHH due to ward changes and CDUs at WHH and QEQMH. Training has been undertaken extensively and has been particularly well attended by ward staff at QEQMH.

2. EKHUFT are involved with the 2nd phase of the NHS Improvement Falls Collaborative. The key focus is managing postural hypotension, by measuring lying and standing blood pressures with appropriate medication review. Harbledown and Cambridge J wards are 'intervention' wards and Cambridge L is the control ward. Education has taken place and wards have posters demonstrating the correct method of taking blood pressures. This is a multi professional project involving therapy, pharmacy, nursing and medical teams and utilising the Board rounds to address postural hypotension. The project has been very successful on Harbledown with 88% compliance with blood pressures and a clear process of medication review. Cambridge J have had less success due to huge ward challenges. However, both ward have reduced falls.

3. A Falls master class was held in September, for falls link workers from across the Trust. This was hugely successful and will be an annual event.

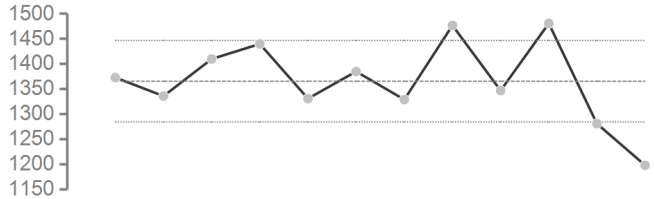
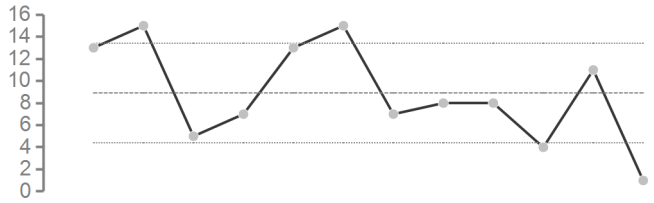
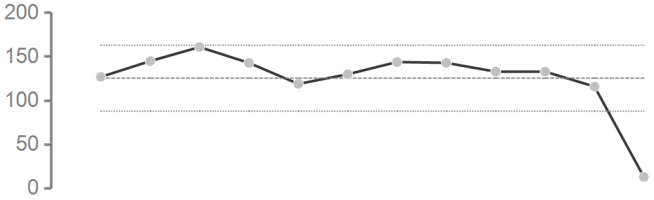
4. Work is underway to assess the gap between actual and reported falls, in accordance with our action plan.

5. The Trust has registered for the next national inpatient falls audit which will focus on individual hip fractures, occurring in hospital.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Incidents

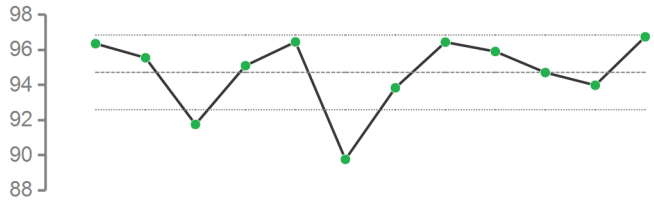
Sep	Clinical Incidents: Total (#)	16,388 (-0.7%)		"Number of Total Clinical Incidents reported, recorded on Datix.
Sep	Blood Transfusion Incidents	107 (-32.7%)		"The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."
Sep	Medicines Mgmt. Incidents	1,507 (6.5%)		"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

Sep

Hand Hygiene Audit



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

Highlights and Actions:

Clinical incidents overall summary
A total of 1213 clinical incidents have been logged as occurring in Sep-18 compared with 1282 recorded for Aug-18 and 1296 in Sep-17.

In Sep-18, 11 incidents have been reported on StEIS. 15 serious near miss incidents have been reported. Comparison of moderate harm incidents reported: 15 in Sep-18 and 17 in Aug-18, and 3 in Sep-17.

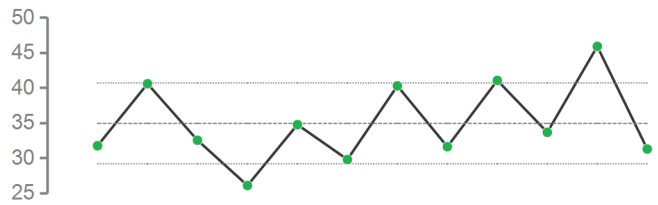
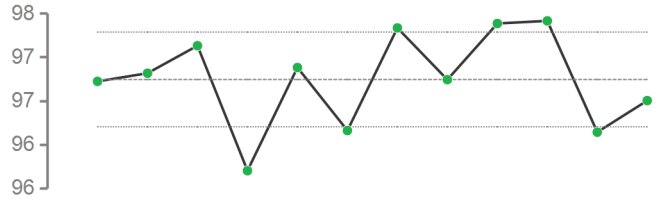
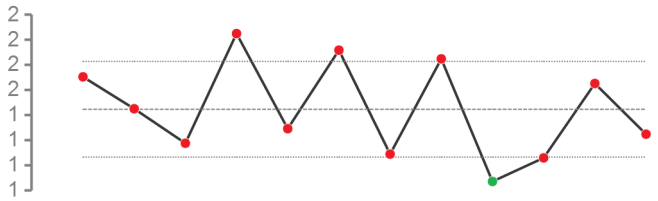
Over the last 12 months incident reporting remains constant at QEH and K&CH, and is declining at WHH.

Blood transfusion (submitted by the Blood Transfusion Coordinator)
There were 8 Blood Transfusion related incidents for September 2018 (12 in August 2018 and 14 in September 2017).
Of the 8 incidents 7 were graded as no harm and 1 as low harm.
Three incidents were due to poor documentation of the transfusion, two of these were failure to return the traceability sheet to the laboratory so that the units are fated as 'assumed transfused' and the third was inaccurate start time recording on the prescription chart so that the unit ran longer than prescribed.
Other incidents included a wrong blood in tube, IT issues linked to the interfaces from the analysers not transmitting results and a query transfusion reaction; which was found to be due to the underlying clinical condition of the patient.
There were no themes identified in the incidents reported.
Reporting by site: 4 at QEQM, 2 at K&CH and 2 at the WHH

Medication incidents (submitted by the Medication Safety Officer)
As of 15/10/2018 the total number of medication related incidents reported in September 2018 was 126. These included 85 no harm, 37 low harm, 3 moderate harm and 1 death incident. The severity of medication related incidents in September 2018 shows that 67.5% of medication related incidents reported were no harm incidents. There was 1 medication related incident reported in September that required RCA investigation and 2 incidents sTEIS reported.
The death incident involved the potential allergic reaction of a patient to teicoplanin, this is still under investigation and awaits RCA findings. The other incident that was reported to sTEIS involved a post-partum patient who was prescribed and given a sub-optimal dose of enoxaparin and was re-admitted with a pulmonary embolism.
The areas of concern for September focus around the general prescribing and administration of anti-coagulants to obstetric patients, particular at discharge. Several other anti-coagulant incidents in the Trust centre around missed doses at the administration stage and poor prescribing of warfarin that led to a patient missing 4 doses of warfarin.
There were 24 incidents in September 2018 categorised as 'omitted medicine/ingredient', representing 19% of all medication related incidents in September. The data produced by the Medication Safety Thermometer in September 2018 was taken from 19 wards across the sites, and has shown that the percentage of patients with an omitted dose of medication was 18.8% and the percentage of patients with a missed critical medicine was 7.1% in September. This included 7 wards with less than 10% of patients with a missed dose of medication and 12 wards with less than 5% of patients with an omitted critical medicine.

Strategic Theme: Patient Safety

Friends & Family Test

Sep	FFT: Response Rate (%)	35 (-4.2%)		"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Sep	FFT: Recommend (%)	97 (0.4%)		
Sep	FFT: Not Recommend (%)	1.4 (-21.9%)		"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 2541 responses were received (16.4% eligible patients). Overall response rates increased for Day Cases and fell within inpatients, Maternity and EDs. Response rate for the EDs was 13.1% (16.2% August-18), inpatients 31.3% (45.9% August-18), maternity; birth only 51.9% (70.0% August-18) and day cases 24.7% (22.1% August -18).

The Trust star rating in September is 4.51 (4.57 August-18). Recommendations by patients in September remained the same for inpatients however, fell in EDs, outpatients, day cases and maternity. The total number of inpatients, including paediatrics, who would recommend our services 96.5% (96.1% August-18), EDs 80.1% (83.7% August-18), maternity 96.8% (98.5% August-18), outpatients 90.4% (91.0% August-18) and day cases 94.3% (95.1% August-18).

Care, Staff attitude and Implementation of care as the three top positive themes for September-18. The three top negative themes for the trust were Waiting times, Care and Staff attitude demonstrating the importance of improving patients' waiting times, ensuring that staff attitude is positive and that the care given is improved to ensure that patients receive safe, compassionate, consistent and high quality care, in order for a good patient experience.

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

East Kent Hospitals University NHS Foundation Trust

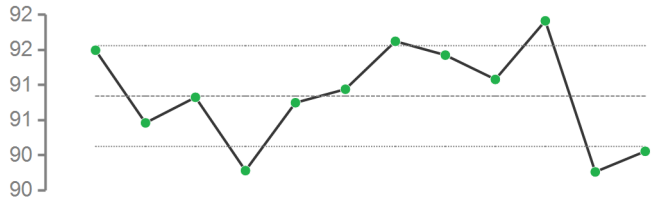
Strategic Theme: Patient Safety

Patient Experience 1

Sep

Overall Patient Experience %

90.9
(-1.4%)



Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.

Highlights and Actions:

Overall patient experience, as a calculated average of the 5 key questions within the local inpatient survey, which enables our patients to record their experience in real-time, shows a deterioration this month.

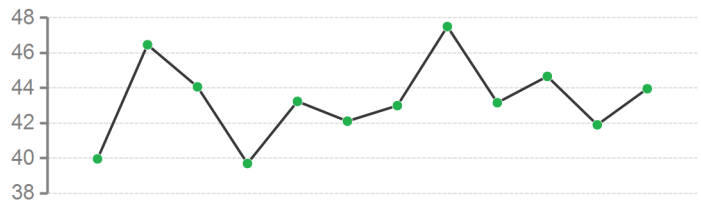
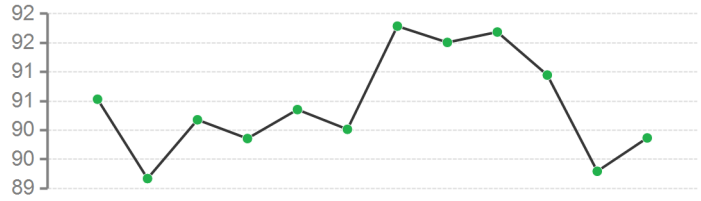
This month we received 1,962 completed inpatient surveys. Baseline performance in ensuring privacy when discussing patients' condition or treatment, ensuring patients are aware of which nurse is looking after them each shift and ensuring patients are able to discuss their worries and fears demonstrated significant opportunity for improvement.

This month improvement is seen in these three important elements of patient experience. The results of the 2017 national adult inpatient survey shows improvement across all three of these indicators of patient experience. An improvement plan has been drafted and the questions within this local survey will be amended to reflect improvement priorities, with progress monitored through the Patient Experience Group.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Patient Experience 2

Sep	Discuss Worries with Nurses %	43 (-14.7%)		Discuss Worries with Nurses
Sep	Cleanliness %	90 (-0.4%)		Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

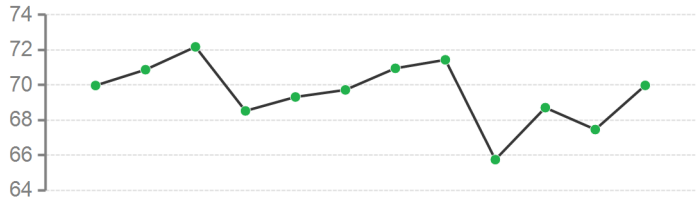
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Patient Safety

Sep

Hospital Food? %

70
(-3.3%)



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. The majority of the wards have reported their performance (against the patient experience metrics) through the inpatient survey in September -18. Due to the problems with the New Allscripts switchover data that had been entered by the wards had not been captured correctly. The IT team are currently working to solve this issue and the wards I pads have been reconfigured.

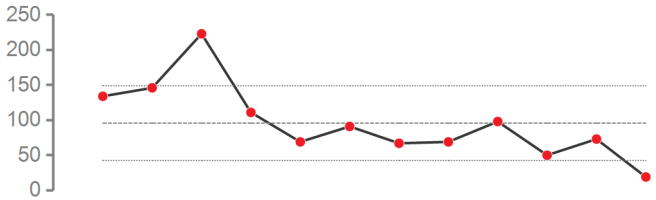
Strategic Theme: Patient Safety

Mixed Sex

Sep

Mixed Sex Breaches

1150
(101.0%)



"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:

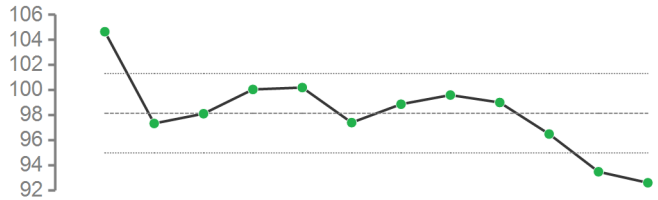
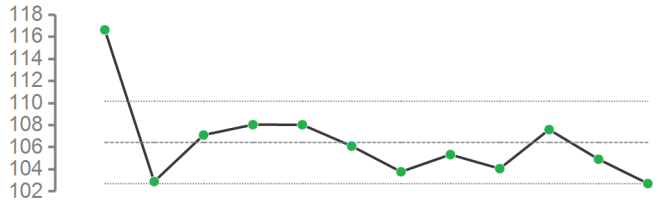
There were 7 mixed sex accommodation occurrences in total, affecting 101 patients.
Incidence of mixed sex accommodation breaches decreased this month breaching the lower control limit (which is good news). There were 3 non-justifiable occurrences within the WHH CDU linked to flow and capacity issues. This information has been reported to NHS England. The remaining incidents occurred in the WHH CCU (4), which were justifiable based on clinical need.
We are currently delivering on our improvement trajectory of a 30% reduction by December 18.

Actions:
During September planned changes to patient flow within CDU WHH is now reducing same sex accommodation occurrences.
Implementation of the action plan continues as the Trust is working closely with the CCGs and NHSI on the Mixed Sex Accommodation Improvement Collaborative. This will support the trust in achieving compliance with the national definition of mixed sex accommodation.

East Kent Hospitals University NHS Foundation Trust

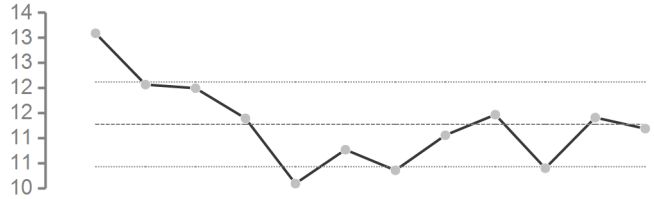
Strategic Theme: Patient Safety

Safe Staffing

Sep	Shifts Filled - Day (%)	98 (-0.1%)		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.
Sep	Shifts Filled - Night (%)	106 (-1.4%)		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.

Strategic Theme: Patient Safety

Sep	Care Hours Per Patient Day (CHPPD)	11 (29.9%)



Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.

Highlights and Actions:

Percentage fill of planned (funded establishment) and actual (filled shifts) by hours is required to be reported monthly by registered nurse and care staff, by day and by night, in line with National Quality Board expectations. Reported data is derived from the Healthroster system. the fill rate during September reduced from August's rates and breached the lower control limits.

Low fill rates were seen on several wards due to a combination of high sickness, maternity leave and vacancies.

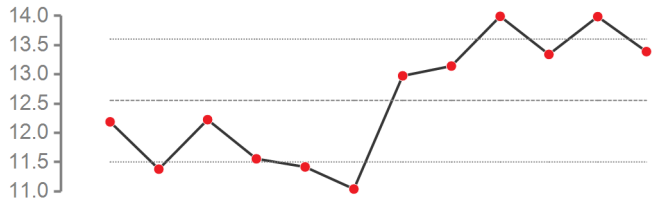
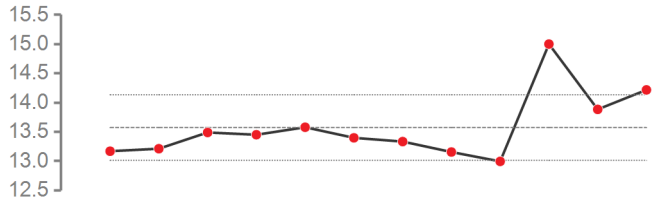
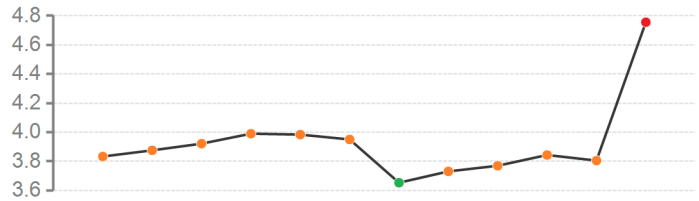
Care Hours per patient day (CHPPD) relates actual staffing to patient numbers and includes registered staff and care staff hours against the cumulative total of patients on the ward at 23.59 hrs each day during the month. CHPPD remained similar to August and within the control limits. The range is from around 5.5 hours of care per patient on medical wards to over 25 within critical care areas where one to one care is required. Comparative data within the Model Hospital Dashboard (Apr-18 data) shows EKHUFT average CHPPD is in the mid to low 25% (Quartile 2) and in line with our recommended peer group and peer median based on spend and clinical output.

Actions;
There is a Trust wide recruitment and retention improvement plan in place
Incentives have been implemented such recruitment and retention premium for hard to recruit areas
A financial reward for each person a staff member attracts to the Trust once that person starts in the orgnaisation
All vacant posts are being recruited to on nhs jobs as well as via open days and recruitment fairs
Personal development programmes are in place for staff
All of the above is being monitored weekly for assurance purposes.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Gaps & Overtime

Sep	Vacancy (%)	12.6 (16.2%)		"% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Sep	Staff Turnover (%)	13.6 (6.0%)		"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."
Sep	Sickness (%)	4.0 (-0.3%)		% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the

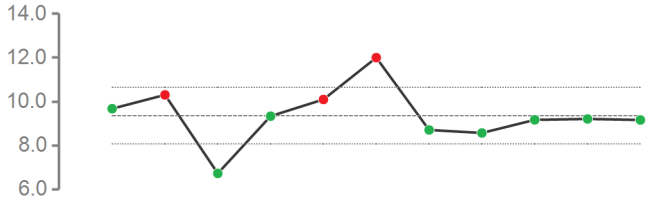
East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Sep

Overtime %

9.4
(4.6%)



% of Employee's that claim overtime.

Highlights and Actions:

Gaps and Overtime

The vacancy rate increased to 12.6% (up from 12.4%) for the average of the last 12 months, which is higher than last year. More work is being undertaken to target hard to fill vacancies, particularly within nursing and some Medical specialties. There are currently over 700 candidates in the recruitment pipeline - i.e. those who have been offered positions and are gaining pre-employment clearances. This includes approximately 400 Nursing and Midwifery staff (including ODPs) and 78 Medical and Dental staff.

The Turnover rate in month increased slightly to 12.3% (last month 12.1%), and the 12 month average increased to 13.6%. Focus remains on hard to recruit roles to replace agency, but also to identify new ways and methods of attracting to hard to recruit roles. Exit data is reviewed to highlight any areas of concern. The Trust has introduced a Refer A Friend scheme, and also a recruitment and retention scheme for medical staff in hard to recruit areas and ED nursing staff.

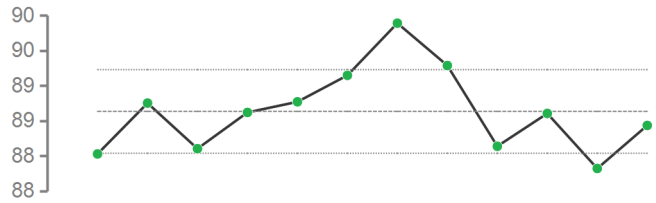
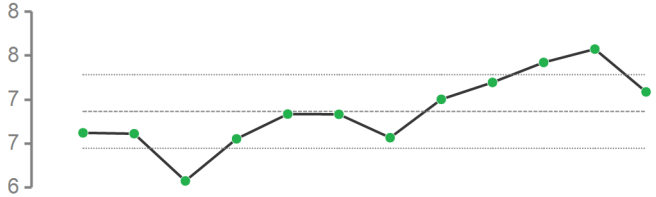
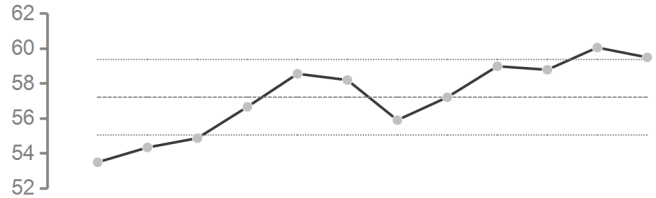
The in month sickness absence position for September was over 4.6% - which is an increase from 3.8% in August. The 12 month average is 4.0%. Care Groups have developed sickness absence reduction plans, with a focus on long term sickness absence and an integrated approach to proactively managing absence with Occupational Health through case conferencing and regular contact. This includes supporting stress, anxiety and compassion fatigue through Respect & Resilience workshops, Mindfulness Courses and Mental Health First Aid training. A Sickness Absence Helpline is being piloted by the Occupational Health department with the Surgical Services wards across the Trust to see if this can support improvements in early referrals to OH in order to get staff back to work.

Overtime as a % of wte remained the same as last month. The average over the last 12 months remained 9.4%. 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

Sep	Employed vs Temporary Staff (%)	88.6 (-0.8%)		"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."
Sep	Agency %	6.9 (21.4%)		% of temporary (Agency and Bank) staff of the total WTE
Sep	Bank Filled Hours vs Total Agency Hours	57 (-1.0%)		% 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 from 7044 in July to 7096 in August, which left a vacancy factor of approx. 834 wte across the Trust.

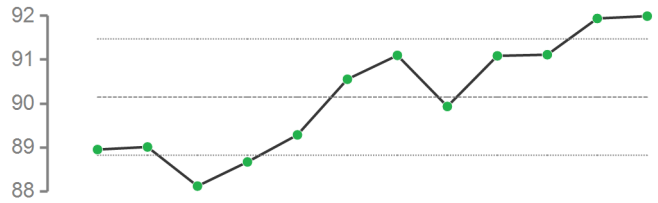
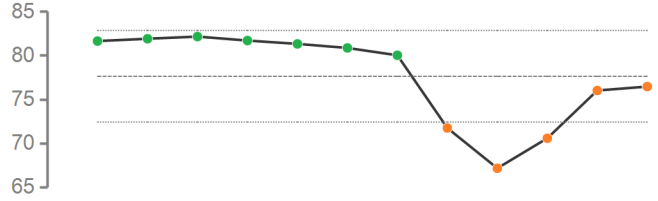
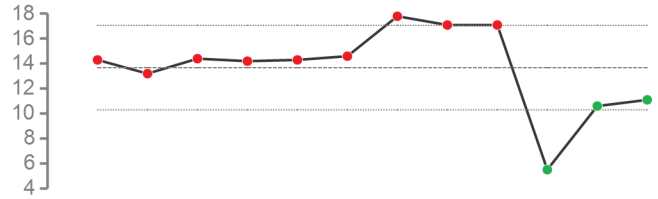
The average percentage of employed staff vs temporary staff over the last 12 months increased slightly to 88.6% (88.4% last month).

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

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Human Resources

Workforce & Culture

Sep	Statutory Training (%)	90 (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. "
Sep	Appraisal Rate (%)	77.6 (-4.7%)		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.
Sep	Time to Recruit	14 (13.7%)		"Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."

East Kent Hospitals University NHS Foundation Trust

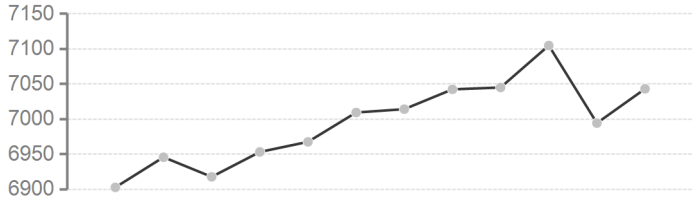
Strategic Theme: Human Resources

Sep

Total Staff In Post (SiP)

7043

(0.7%)



Count of total staff in post (WTE)

Highlights and Actions:

Workforce & Culture

Average Statutory training 12 month average is 90% but decreased to 88% in month for September. This remains above the target of 85%. Care Groups are monitored at EPR on how they are addressing those staff who have never completed one or more of the statutory training requirements.

The Trust staff average appraisal rate remained 76% in month for September(76% in August). Care Groups are working on plans to complete outstanding appraisals as well as to avoid a further drop in appraisal rates for those due to be renewed in coming months. Targeted work within the Urgent Care Division has seen the appraisal compliance increase from 51% to 73% since July.

The average time to recruit is 11 weeks, which is a slight increase on last month, but an improvement on the previous 12 months. The 12 month average time to recruit was 14 weeks. The Resourcing Ream are on track to reduce time to recruit to below 8 weeks to ensure recruitment time meets the demands of our services.

Strategic Theme: Activity

East Kent Hospitals University NHS Foundation Trust

Activity vs. Internal Business Plan

Key Performance Indicators

Sep

	Sep-18				YTD				YTD vs Last Yr				
	Activity	Plan	Var #	Var %	Activity	Plan	Var #	Var %	Activity	Last Yr	Var #	Var %	Green
Referral Primary Care	13,942	14,233	(-291)	-2%	86,654	86,185	469	1%	86,654	87,376	(-722)	-1%	<=0%
Referral Non-Primary Care	10,862	13,136	(-2,274)	-17%	85,521	82,542	2,979	4%	85,521	82,651	2,870	3%	<=0%
OP New	15,158	18,010	(-2,852)	-16%	108,156	112,220	(-4,064)	-4%	108,156	107,918	238	0%	>=0%
OP Follow Up	31,713	40,508	(-8,795)	-22%	232,853	244,227	(-11,374)	-5%	232,853	234,268	(-1,415)	-1%	>=0%
Elective Daycase	5,381	6,731	(-1,350)	-20%	37,714	39,730	(-2,016)	-5%	37,714	36,696	1,018	3%	>=0%
Elective Inpatient	1,485	1,316	169	13%	7,711	8,020	(-309)	-4%	7,711	7,418	293	4%	>=0%
A&E	18,396	17,384	1,012	6%	111,215	107,308	3,907	4%	111,215	106,538	4,677	4%	>=0 & <5%
Non-Elective Inpatient	6,488	6,575	(-87)	-1%	40,219	40,696	(-477)	-1%	40,219	40,374	(-155)	0%	>=0 & <5%
Chemotherapy	1,036	1,128	(-92)	-8%	7,179	7,040	139	2%	7,179	7,158	21	0%	>=0%
Critical Care	1,682	1,690	(-8)	0%	10,729	9,880	849	9%	10,729	11,049	(-320)	-3%	>=0%
Dialysis	6,512	6,980	(-468)	-7%	40,675	41,852	(-1,177)	-3%	40,675	41,014	(-339)	-1%	>=0%
Maternity Pathway	1,029	1,214	(-185)	-15%	6,725	7,140	(-415)	-6%	6,725	7,162	(-437)	-6%	>=0%
Pre-Op Assessments	2,547	3,298	(-751)	-23%	19,846	19,955	(-109)	-1%	19,846	17,197	2,649	15%	>=0%
Diagnostic	446,428	440,832	5,596	1%	2,751,348	2,646,467	104,881	4%	2,751,348	2,636,042	115,306	4%	<=0%
Other	4,530	4,587	(-57)	-1%	30,282	28,385	1,897	7%	30,282	28,453	1,829	6%	>=0%

The 2018/19 Internal Business Plan has been developed at specialty level by our Operational Teams; Demand uses the 2017/18 Outturn as a baseline, growth was applied to all points of delivery for key areas where evidence supports exponential activity growth from referrals. The plan is capped at our total capacity and as such further activity (or demand reduction schemes would be required to achieve sustainable elective services. Further adjustments for patient safety/best practice issues such as reductions or increases in new to follow up rates have been applied. Finally EKHUFT have taken a view on the viability of CCG QIPP schemes achieving a reduction in demand in 2018/19. It should be noted that this does not reflect demand levels agreed within the 2018/19 contract. All trajectories to support attainment of the Sustainability and Transformation Funding have been based on this activity plan.

The capacity levels within the plans should be considered achievable although in many instances will stretch our services beyond their internal substantive capacity, efficiency programmes, workforce recruitments plans and it is anticipated therefore that substantial elements of the plan will continue to be delivered though additional waiting list payments.

September 2018

Elective Care

In September Primary Care referrals were 2% below expected levels reducing the YTD variance to +1% (+469). An administrative error within the Paediatric service has now been resolved however Paediatric Blood Clinics where the recording issue was identified remain in the YTD position. Since Go Live of the new PAS, Data Quality issues have impacted on the mapping of referral types, specifically ERS referrals. Significant work is in progress to rectify the issues.

The Trust under-achieved the new outpatient plan in September with appointments 16% below planned levels, generating a YTD variance of -4%. Following the introduction of the new PAS system on 10th September 2018, the Trust has experienced some delays with the timely recording of outpatient attend statuses. The September data presented in this report was extracted on the 2nd of October and at that time it was estimated a further 10,000 appointments require outcome details. The Trust has identified extra resource to address the backlog, and despite these challenges, services are continuing to actively produce quantified recovery plans intended to respond to specialty level underperformance and deliver the full new outpatient plan.

The impact of the Virtual Fracture Clinic implemented in mid-February is likely to render the Orthopaedic plan unachievable due to high discharge rates that were not anticipated. The Ophthalmology service continues to provide additional weekend capacity at KCH delivered through an insourcing provider. It is expected this will recover the Ophthalmology YTD underperformance and support the RTT backlog recovery. During September the Trust observed a 1% increase in the DNA rate across the Trust, it is believed this increase was related to the PAS migration and rates have since returned to normal levels.

The Trust under-performed the Follow up plan in September (-22%) with YTD performance now underachieving by -5% , as with New Outpatient activity it is expected that the position will improve significantly after all activity is administered with the appropriate outcome details. A Task and Finish group is to be established along with daily reports for operational teams to prioritise and action.

In September the Trust under-achieved the Daycase plan by 1,350 patients with YTD performance now underachieving by -5%. Following the introduction of the PAS system the trust experienced a small number of isolated recording issues relating to Pain Management, Rheumatology, Clinical Oncology, Ambulatory Care and Paediatrics, these user issues have been addressed with plans in place to validate and correct recording are in place where required. A large number of specialties continue to experience significant workforce issues affecting the delivery of elective activity. A mandated change in recording will render the Dermatology plan unachievable, it is anticipated an over performance in Outpatient procedures will offset the Daycase underperformance. The Trust has identified a small number of records that were not entered onto the new PAS system following down time procedures and processes have been put into place to address this this immediately.

Whilst the Trust delivered the Elective Admission plan in September with YTD performance now underachieving by (-4%), it is believe this will be largely eradicated when validation of the recording issues are completed. Significant work is in progress to rectify the issues. Underperformance remains in the Urology service (-303). Due to emergency pressures, elective inpatient activity was limited for the service at the start of the financial year. In order to ensure theatre utilisation was maximised additional daycase patients were booked.

Non Elective Care

The Trust sees non elective admissions to all of its 3 sites. These are typically some of the patients who attend the Trust Accident & Emergency departments, or are admitted directly through to the wards upon agreement with General Practitioners. These patients have an urgent clinical need that cannot wait for an elective pathway or outpatient appointment to be given, and so are monitored within the hospital site as diagnosis and treatment for their clinical condition is conducted.

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

The Bed Occupancy of the Trust continued to be at challenging levels and increased again in September to an overall Trust wide position of 95.0% of funded beds. Queen Elizabeth the Queen Mother Hospital demonstrated the most challenge with the bed occupancy position at 100.1% for September, a declining position from August of 99.3%. The William Harvey Hospital position remained the same with an overall bed occupancy of 94.7% in September. Bed occupancy positions are taken from midnight snapshots of Trust systems and compared against the number of available funded bed establishment.

The Medical Outliers metric shows the daily average number of medical patients which were bedded in non-medical wards. This can happen for a variety of reasons; such as care being recently transferred to a medical specialty consultant, or as a result of the ward in question having free beds available for patients at the time of clinical need. Patients remain under the medical consultant responsible for their care for the purpose of treatment and clinical review. During September the number of medical outliers decreased slightly to a monthly average of 46 outliers across the Trust compared to August with a monthly average of 50. Individual site levels of medical outliers over the month were 13 at the Queen Elizabeth the Queen Mother Hospital and 27 at William Harvey Hospital.

An increased volume of patients through the Accident & Emergency Department contributes to increased pressures in non-elective care. The demand on the department in September declined slightly to 22,077 attendances compared to August (22,606 attendances). The Trust has identified a small number of records that were not entered onto the new PAS system following down time procedures and processes have been put into place to address this this immediately.

Outstanding Patient Administration System

At this stage we believe following completion of the outstanding administrative tasks the Trust will remain under plan in September and we have forecast variances to be in the region of; OP New Appointments -2,000 (~10%), Follow Up Appointments -6,000 (~15%) & Elective Daycases -700 (-10%). It is expected Elective and Non Elective Admissions will achieve planned levels.

YTD Exception Reporting: Top 10 Outliers

Referral Primary Care

Specialty	Activity	Plan	Var (%)	Significance
130 - Ophthalmology	7,199	8,624	-17%	-1,425
300 - General Medicine	85	799	-89%	-714
120 - Ear, Nose & Throat	5,232	5,753	-9%	-521
502 - Gynaecology	4,992	5,468	-9%	-476
100 - General Surgery	1,619	2,015	-20%	-396
302 - Endocrinology	655	228	187%	427
410 - Rheumatology	1,957	1,506	30%	451
103 - Breast Surgery	4,051	3,470	17%	581
330 - Dermatology	7,544	6,909	9%	635
110 - Trauma & Orthopaedics	5,274	4,484	18%	790
Total	**86,654**	**86,185**	**1%**	**469**

Referral Non-Primary Care

Specialty	Activity	Plan	Var (%)	Significance
320 - Cardiology	16,735	17,904	-7%	-1,169
650 - Physiotherapy	6,245	6,735	-7%	-490
800 - Clinical Oncology	5,478	5,951	-8%	-473
502 - Gynaecology	3,208	3,603	-11%	-395
420 - Paediatrics	1,101	1,466	-25%	-365
655 - Orthoptics	1,151	847	36%	304
100 - General Surgery	1,963	1,515	30%	448
300 - General Medicine	1,689	839	101%	850
130 - Ophthalmology	8,082	6,283	29%	1,799
110 - Trauma & Orthopaedics	11,723	9,749	20%	1,974
Total	**85,521**	**82,542**	**4%**	**2,979**

OP New

Specialty	Activity	Plan	Var (%)	Significance
101 - Urology	4,197	5,424	-23%	-1,227
502 - Gynaecology	6,755	7,740	-13%	-985
420 - Paediatrics	4,079	4,892	-17%	-813
400 - Neurology	2,295	2,953	-22%	-658
120 - Ear, Nose & Throat	6,786	7,412	-8%	-626
300 - General Medicine	1,076	1,570	-31%	-494
110 - Trauma & Orthopaedics	9,015	9,366	-4%	-351
800 - Clinical Oncology	2,377	2,059	15%	318
307 - Diabetic Medicine	547	206	166%	341
330 - Dermatology	7,179	6,330	13%	849
Total	**108,156**	**112,220**	**-4%**	**-4,064**

OP Follow Up

Specialty	Activity	Plan	Var (%)	Significance
110 - Trauma & Orthopaedics	19,564	23,266	-16%	-3,702
130 - Ophthalmology	25,138	27,553	-9%	-2,415
410 - Rheumatology	4,970	6,889	-28%	-1,919
300 - General Medicine	1,199	2,759	-57%	-1,560
120 - Ear, Nose & Throat	7,955	8,840	-10%	-885
400 - Neurology	4,115	4,875	-16%	-760
650 - Physiotherapy	30,516	31,263	-2%	-747
101 - Urology	11,220	10,702	5%	518
340 - Respiratory Medicine	4,218	3,693	14%	525
800 - Clinical Oncology	21,626	21,037	3%	589
Total	**232,853**	**244,227**	**-5%**	**-11,374**

Elective Daycase

Specialty	Activity	Plan	Var (%)	Significance
330 - Dermatology	1,935	2,743	-29%	-808
110 - Trauma & Orthopaedics	2,364	3,163	-25%	-799
191 - Pain Management	1,045	1,591	-34%	-546
130 - Ophthalmology	2,358	2,691	-12%	-333
502 - Gynaecology	1,206	1,531	-21%	-325
120 - Ear, Nose & Throat	1,270	1,535	-17%	-265
140 - Maxillo Facial	1,007	1,150	-12%	-143
100 - General Surgery	1,012	822	23%	190
301 - Gastroenterology	778	442	76%	336
800 - Clinical Oncology	2,923	2,324	26%	599
Total	**37,714**	**39,730**	**-5%**	**-2,016**

Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
101 - Urology	1,417	1,720	-18%	-303
502 - Gynaecology	562	847	-34%	-285
100 - General Surgery	556	672	-17%	-116
110 - Trauma & Orthopaedics	1,724	1,823	-5%	-99
320 - Cardiology	103	173	-40%	-70
430 - HCOOP	51	89	-43%	-38
800 - Clinical Oncology	51	8	526%	43
303 - Clinical Haematology	158	49	220%	109
503 - Gynaecology Oncology	224	114	97%	110
300 - General Medicine	1,071	787	36%	284
Total	**7,711**	**8,020**	**-4%**	**-309**

Non-Elective Inpatient

Specialty	Activity	Plan	Var (%)	Significance
300 - General Medicine	12,124	13,026	-7%	-902
430 - HCOOP	4,910	5,512	-11%	-602
180 - Accident & Emergency	1,742	2,147	-19%	-405
560 - Midwifery	1,231	1,458	-16%	-227
420 - Paediatrics	4,327	4,225	2%	102
104 - Colorectal Surgery	174	49	254%	125
301 - Gastroenterology	342	177	93%	165
340 - Respiratory Medicine	366	186	96%	180
101 - Urology	2,184	1,986	10%	198
100 - General Surgery	3,431	2,956	16%	475
Total	**40,219**	**40,696**	**-1%**	**-477**

Other

Specialty	Activity	Plan	Var (%)	Significance
Diagnostic	2751348	2646467	4%	104,881
A&E	111215	107308	4%	3,907
Other	30282	28385	7%	1,897
Dialysis	40675	41852	-3%	-1,177
Critical Care	10729	9880	9%	849
Maternity Pathway	6725	7140	-6%	-415
Chemotherapy	7179	7040	2%	139
Pre-Op	19846	19955	-1%	-109

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

4 Hour Emergency Access Standard

Key Performance Indicators

77.15%

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Green
4 Hour Compliance	70.66%	76.21%	69.13%	69.33%	73.75%	75.08%	76.93%	80.80%	82.55%	79.18%	80.04%	77.15%	95%
12 Hour Trolley Waits	0	0	2	2	0	2	1	0	0	0	0	0	0
Left without being seen	3.67%	2.73%	3.45%	2.75%	2.29%	2.70%	2.71%	2.42%	2.12%	2.81%	2.47%	0.48%	<5%
Unplanned Reattenders	8.69%	8.33%	9.05%	8.97%	8.91%	8.92%	9.23%	9.09%	9.29%	9.76%	9.81%	8.57%	<5%
Time to initial assessment (15 mins)	90.6%	91.1%	88.6%	93.6%	96.0%	94.4%	94.6%	95.4%	92.8%	94.7%	91.7%	73.2%	90%
% Time to Treatment (60 Mins)	47.8%	54.6%	53.3%	55.5%	47.8%	42.5%	46.2%	49.5%	51.7%	42.6%	48.0%	45.5%	50%

2018/19 Trajectory (NHSI return 2nd May)

-8.24 %

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Green
Trajectory	78.6%	77.5%	78.5%	83.9%	85.4%	85.4%	87.4%	89.9%	88.6%	88.4%	87.6%	87.6%	
Performance	76.9%	80.8%	82.6%	79.2%	80.0%	77.1%							

*The historic 4 Hour compliance position differs slightly from that previously published. While this means that the figures contained here from those submitted nationally, they have been re-stated to be reflective of EKHUFT site performance and in order to align against the NHSI trajectory over 2018-19.

Summary Performance

September performance for the 4 hour target was 77.1%; against the NHS Improvement trajectory of 85.4%.This represents a 3% decrease in performance compared to the previous month. There were no 12 Hour Trolley Waits in September. The number of patients who left the department without being seen remained compliant, but significantly decreased to 0.5%. This sudden and significant decrease is currently undergoing validation for accuracy. Unplanned re-attendances improved, but remained noncompliant at 8.6%. Time to treatment declined from August, remaining noncompliant at 45.5% for August.

Issues

Significant issues with access to inpatient beds have affected ED flow; the number of 7 day and super stranded patients has significant increased. The new PAS system was implemented in September and although performance was not affected during downtime, there was an impact when the new PAS system went live due to clinical staff being slower as they became used to using the PAS and in particular the Ordercoms aspects of the system to request diagnostics.

Also a number of improvements have been planned to be fully implemented to support delivery of the trajectory. The improvement areas are:

- Triage: Triage & Streaming Tool implemented on 20 August 2018. ED Leadership Teams are progressing training, competency and capacity in receiving areas.

- Silver Role: Escalation Pack circulated. Training programmes are in place to ensure appropriate escalation to specialty and site teams.

- Acute Medical Unit: Go live dates planned for 16 October 2018 at both Queen Elizabeth, The Queen Mother Hospital and William Harvey Hospital. Streaming processes and Standard Operating Procedures are being finalised. Work is progressing with partners to include primary and secondary care integrated service.

- Frailty: Work is progressing with partners to confirm the model of care and service provision for an integrated approach within the AMU (Hot Floor) by 1 November 2018.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

Cancer Compliance

Key Performance Indicators

71.19 %

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Green
62 day Treatments	74.37%	71.97%	74.17%	74.87%	73.40%	71.88%	66.13%	65.01%	65.47%	65.39%	65.85%	71.19%	>=85%
>104 day breaches	29	28	23	28	26	32	33	34	40	42	25	15	0
Demand: 2ww Refs	3,505	3,464	2,799	3,528	3,206	3,738	3,694	3,934	3,682	3,700	3,585	4,264	2990 - 3305
2ww Compliance	94.63%	96.43%	96.28%	95.76%	97.10%	91.42%	89.06%	93.81%	94.22%	94.94%	93.64%	90.91%	>=93%
Symptomatic Breast	94.29%	94.44%	92.37%	89.84%	98.50%	90.28%	75.16%	84.46%	94.12%	93.18%	86.32%	94.39%	>=93%
31 Day First Treatment	98.97%	97.00%	95.67%	94.06%	97.74%	96.08%	95.37%	96.31%	96.43%	95.65%	95.24%	96.89%	>=96%
31 Day Subsequent Surgery	95.12%	85.71%	84.85%	87.23%	91.43%	89.47%	88.57%	82.05%	82.61%	94.59%	95.56%	95.74%	>=94%
31 Day Subsequent Drug	100.00%	100.00%	94.59%	98.85%	98.33%	98.21%	97.94%	98.88%	98.11%	99.17%	98.97%	97.80%	>=98%
62 Day Screening	92.86%	89.29%	93.33%	90.91%	79.31%	100.00%	93.75%	84.09%	100.00%	81.63%	94.37%	84.31%	>=90%
62 Day Upgrades	82.98%	84.00%	92.11%	85.00%	77.27%	100.00%	89.19%	75.86%	84.38%	85.00%	94.74%	72.73%	>=85%

2018/2019 Trajectory

8.43 %

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Green
STF Trajectory	65.08%	61.38%	61.13%	55.57%	57.87%	62.76%	73.66%	79.01%	83.12%	85.31%	85.24%	86.17%	Jan
Performance	66.13%	65.01%	65.47%	65.39%	65.85%	71.19%							Jan

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

Summary Performance

September performance is currently 71.02% against the improvement trajectory of 62.76%, validation continues until the beginning of November in line with the national time table. The total number of patients on an active cancer pathway at the end of the month was 2,955 and there were 15 patients waiting 104 days or more for treatment or potential diagnosis.

62 Day Performance Breakdown by Tumour Site

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
01 - Breast	100.0%	96.6%	96.2%	88.9%	83.3%	100.0%	92.9%	96.6%	95.8%	93.8%	80.0%	87.5%
03 - Lung	46.4%	70.0%	84.6%	90.3%	100.0%	81.0%	61.4%	91.7%	73.0%	72.3%	73.3%	61.5%
04 - Haematological	53.3%	40.0%	58.3%	75.0%	33.3%	33.3%	50.0%	25.0%	50.0%	70.6%	13.3%	66.7%
06 - Upper GI	71.1%	81.0%	78.3%	70.0%	64.3%	73.3%	66.7%	69.2%	85.2%	93.3%	72.0%	65.0%
07 - Lower GI	70.8%	53.7%	61.3%	65.9%	43.8%	63.2%	62.9%	47.6%	65.9%	68.3%	78.6%	63.2%
08 - Skin	92.3%	95.0%	92.5%	92.7%	100.0%	88.9%	88.0%	89.3%	97.1%	97.7%	97.1%	100.0%
09 - Gynaecological	73.3%	52.4%	57.1%	80.0%	63.6%	75.0%	30.8%	32.0%	42.1%	55.6%	72.7%	82.6%
10 - Brain & Nervous System							100.0%					100.0%
11 - Urological	63.8%	55.7%	63.7%	52.0%	63.5%	63.2%	57.7%	50.8%	38.2%	39.4%	51.0%	51.4%
13 - Head & Neck	73.3%	87.5%	28.6%	66.7%	85.7%	78.6%	18.2%	30.0%	93.3%	60.0%	60.0%	50.0%
14 - Sarcoma		0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%		
15 - Other		42.9%	0.0%	0.0%	0.0%		50.0%	0.0%	50.0%	83.3%	50.0%	66.7%

Significant improvement plans have been placed on cancer pathways and initiatives are beginning to show improvement. Daily reviews of 2ww demand and capacity continue with a focus on clinic utilisation and also validation, post PAS implementation.

The redesign and improvement in cancer access continues and strong gains are being made in increasing the number of treatments and capacity. Redesign to implement sustained timed pathways continues and the Cancer Improvement Steering Committee agreed the investment into specific tumour streams of the funding allocated from the Cancer Alliance. Further work on timed pathways is underway and will assist with maintaining progress.

An improvement programme has been implemented to improve waiting times for cancer patients. There is also a weekly focused meeting to ensure actions are being carried out to improve the patients 62 day cancer pathway.

There are 15 patients waiting 104 days and over for diagnosis/commencement of treatment for cancer as of 30 September 2018. This is a marked reduction from last month from 31 patients. 10 of these patients are diagnosed with cancer. 3 patients have treatment planned in September and we are awaiting the outcome/being treated today. 3 patients have treatment planned in October. 4 patients are awaiting decision to treat OPAs which are booked within the next week. There are 5 patients without a cancer diagnosis. 3 patients have had diagnostics and we are awaiting histology following this, 1 patient has a treatment planned in October and 1 patient is awaiting a CT scan on 8th October.

The new Care Group leadership teams have been appointed and will be provided with training to ensure understanding of the national constitutional targets, delivery and implementation plans, and escalations.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

18 Week Referral to Treatment Standard

Key Performance Indicators

76.27 %

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Green
Performance	81.18%	80.87%	78.67%	77.62%	77.03%	76.08%	76.66%	78.56%	79.02%	79.65%	79.06%	76.27%	>=92%
52w+	64	67	80	108	141	201	222	218	201	167	125	129	0
Waiting list Size	54,783	54,777	54,383	52,942	54,306	54,519	54,979	54,964	53,411	53,193	53,552	54,712	<38,938
Backlog Size	10,312	10,481	11,599	11,847	12,474	13,039	12,830	11,785	11,207	10,824	11,212	12,983	<2,178
Demand: PC Referrals	16,666	16,111	12,585	15,579	14,600	15,668	15,249	16,501	15,748	15,347	13,888	2,216	<15,484

2018/2019 Trajectory

-5.04 %

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Green
Performance Trajectory	77.03%	78.20%	79.31%	80.21%	81.02%	81.32%	81.69%	81.84%	81.40%	81.16%	80.87%	80.76%	87%
Performance	76.66%	78.56%	79.02%	79.65%	79.06%	76.27%							Sept

-46

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Green
52w Trajectory	250	241	225	225	200	175	150	125	150	125	115	99	Sept
Performance	222	218	201	167	125	129							Sept

An RTT Recovery Plan has been developed jointly with local CCGs in order to address both short term backlog clearance and longer term increases in recurrent demand. The aim of the plan is to improve performance during 18/19 with a focus on reducing waiting times and decreasing the number of 52 week waits by over 50%.

Summary Performance

- September performance of the RTT standard was reported as 76.27% against a trajectory of 81.32%. All specialities failed to meet their trajectory with the exception of cardiothoracic, general medicine and HCOOP.
- The total waiting list reported 55,800 against trajectory of 50,857, which is a shortfall of 4,943.
- The total waiting list is split into 45,938 on the non admitted waiting list and 9,531 on the admitted waiting list.
- 52 week patients reported 129 against a trajectory of 175.

RTT Trajectory VS Performance 2018/19

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Trustwide	77.0%	78.2%	79.3%	80.2%	81.0%	81.3%
Actual Performance:	76.7%	78.6%	78.9%	78.8%	79.1%	75.6%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
100 - General Surgery	72.1%	73.2%	74.4%	75.9%	77.5%	78.1%
Actual Performance:	70.5%	72.4%	73.7%	75.9%	77.6%	75.7%
101 - Urology	85.3%	86.9%	88.1%	88.9%	89.0%	88.9%
Actual Performance:	83.8%	83.2%	83.7%	80.9%	78.1%	71.5%
110 - Trauma & Orthopaedics	67.9%	69.2%	70.5%	71.8%	73.2%	72.8%
Actual Performance:	67.7%	70.0%	71.2%	72.6%	73.3%	69.9%
120 - Ear, Nose & Throat	71.7%	74.7%	77.7%	81.1%	84.7%	87.1%
Actual Performance:	70.0%	72.2%	70.9%	68.8%	67.8%	63.8%
130 - Ophthalmology	71.5%	72.4%	73.4%	74.4%	75.5%	76.3%
Actual Performance:	70.5%	75.1%	77.6%	77.8%	78.4%	75.1%
140 - Maxillo Facial	82.8%	84.2%	85.6%	87.1%	88.6%	89.9%
Actual Performance:	82.2%	83.0%	80.3%	78.9%	80.5%	78.4%
170 - Cardiothoracic	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Actual Performance:	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

300 - General Medicine	90.6%	92.2%	93.3%	94.2%	95.0%	95.5%
Actual Performance:	66.7%	68.4%	100.0%	100.0%	92.9%	94.3%
301 - Gastroenterology	78.6%	79.4%	80.2%	81.2%	82.2%	83.4%
Actual Performance:	78.9%	80.8%	79.7%	80.4%	80.9%	77.3%
320 - Cardiology	86.8%	84.7%	82.7%	80.6%	78.6%	76.9%
Actual Performance:	91.6%	95.4%	96.2%	95.3%	93.1%	88.5%
330 - Dermatology	71.6%	72.2%	72.6%	71.1%	69.2%	67.5%
Actual Performance:	77.1%	80.3%	82.1%	81.0%	83.1%	78.5%
340 - Respiratory Medicine	94.5%	94.4%	94.3%	94.1%	93.8%	93.6%
Actual Performance:	91.8%	94.1%	96.2%	95.6%	97.0%	88.2%
400 - Neurology	79.4%	83.6%	88.2%	89.8%	90.5%	91.4%
Actual Performance:	77.8%	80.0%	81.3%	77.6%	83.0%	80.4%
410 - Rheumatology	93.7%	93.5%	93.3%	93.1%	92.9%	92.7%
Actual Performance:	94.0%	95.0%	92.5%	89.1%	84.9%	79.2%
430 - HCOOP	91.6%	92.5%	93.2%	93.9%	94.5%	94.9%
Actual Performance:	90.7%	96.5%	98.4%	97.5%	97.2%	93.6%
502 - Gynaecology	71.6%	72.4%	72.9%	73.6%	74.4%	75.1%
Actual Performance:	67.2%	68.5%	67.9%	68.7%	69.1%	67.4%
X01 - Other Specs	87.6%	88.4%	89.0%	89.7%	90.2%	90.2%
Actual Performance:	88.9%	88.1%	87.3%	87.3%	86.6%	83.2%

OP Waiters by specialty are detailed below, it is green if it has improved compared to the previous month

Heat Map	Primary Metrics					Improvement			
Specialty	Perf	Traj	52+	Waiting List	Backlog	% OP WL Dated	OP Waits	% IP WL Dated	35w Undated
Surgical Division									
100 - General Surgery	76.5%	-1.6%	21	1216	378	57%	14.4	34%	330
101 - Urology	73.0%	-15.9%	3	657	715	63%	11.0	14%	38
110 - Trauma & Orthopaedics	69.8%	-3.1%	12	522	313	68%	8.6	22%	158
120 - Ear, Nose & Throat	64.3%	-22.8%	3	584	1171	72%	18.1	20%	178
130 - Ophthalmology	75.7%	-0.6%	2	-1095	-227	66%	11.7	35%	125
140 - Maxillo Facial	78.7%	-11.2%	2	52	297	19%	11.5	13%	42
Specialist Division									
330 - Dermatology	78.9%	11.4%	4	-444	-577	70%	12.6	33%	30
502 - Gynaecology	67.9%	-7.2%	81	515	427	82%	12.6	9%	458
Urgent & Long Term Conditions Division									
170 - Cardiothoracic	100.0%	0.0%	0	7	0				0
300 - General Medicine	94.1%	-1.4%	0	-320	-14	80%	17.0		0
301 - Gastroenterology	78.2%	-5.2%	0	1468	483	74%	10.8	64%	75
320 - Cardiology	90.8%	13.9%	0	-460	-421	91%	12.0	74%	10
340 - Respiratory Medicine	89.7%	-3.9%	0	48	45	81%	6.9		3
400 - Neurology	81.8%	-9.6%	0	544	238	65%	17.0		17
410 - Rheumatology	79.4%	-13.3%	0	427	223	58%	13.0	0%	8
430 - HCOOP	93.7%	-1.2%	0	-299	-12	71%	6.6		0
Other									
X01 - Other Specs	83.6%	-6.6%	1	613	455	76%	15.8	35%	34

Following the implementation of PAS, the following backlog of validation is required:

- No outcome – As of the 30 September there were approximately 9,000 patients who had attended an outpatient clinic and there clinic appointment had not been cashed up. The reason for this delay is due to staff becoming familiar with working with the new PAS system and also the Consultants working with a new clinic outcome form. Additional staff; such as medical secretaries have been providing additional support to ensure that the outcoming is urgently progressed.
- Other validation issues have included ensuring that the outpatient clinic templates are updated; to correct patient allocation errors whereby patients have been added to the wrong lists; out coming and coding issues.
- Daily conference calls are in place to address the issues log, with a weekly COO chaired meeting to update and escalate the action log.

Production plans are in place. However, the following specialities are significantly behind plan – down by 15% plus in a POD (point of delivery):

- Gynaecology – elective in patient and elective day case
- Dermatology – elective day case and elective in patients
- Urology – elective in patient
- Trauma & Orthopaedics – elective day case
- ENT – elective day case
- Anaesthetics – elective day case, new and FU OPA
- Paediatric urology – FU OPA
- Paediatric T&O – new OPA
- GIM – new and FU OPA
- Stroke – new and FU OPA
- Neurology – new OPA
- Rheumatology – FU OPA

Actions

- Review of production plans underway, with maximising capacity.
- Review of 6-4-2 theatre booking.
- Validation plan agreed to reduce no outcome clinic episodes.
- Each 52 week wait patients have been reviewed and appointment/admission dates agreed.
- ERS went live in August 2018 and work continues with CCG and GPs to embed electronic referral management.

Strategic Theme: KPIs

East Kent Hospitals University NHS Foundation Trust

6 Week Referral to Diagnostic Standard

Key Performance Indicators

98.53 %

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Green
Performance	99.59%	99.85%	99.64%	99.45%	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%	98.53%	>=99%
Waiting list Size	15,419	14,321	14,345	13,637	14,125	14,174	14,597	15,192	16,350	16,888	15,126	12,753	<14,000
Waiting > 6 Week Breaches	63	22	52	75	62	49	91	106	149	264	298	187	<60
Average Wait													<4

2018/19 Trajectory

-0.57 %

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	
STF Trajectory	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.10%	99.11%	Sep-18
Performance	99.59%	99.85%	99.64%	99.45%	99.56%	99.65%	99.38%	99.30%	99.09%	98.44%	98.03%	98.53%	Sep-18

Summary Performance

The standard has not been met for September 2018 with a compliance of 98.53%. As at the end of the month there were 187 patients who had waited over 6 weeks for their diagnostic procedure, Breakdown by Speciality is below:-

- Radiology: 15; 13 in Computed Tomography, 2 in Non-Obstetric ultrasound,
- Cardiology: 42
- Urodynamic: 5
- Sleep Studies : 123
- Cystoscopy : 1

- Colonoscopy : 1

The DMO1 was not achieved in September due to the continued demand for Sleep Studies. A robust plan was developed in June 2018 in response to the increased demand and also to achieve sustainability. The plan included purchasing additional equipment, which is now in place and organising additional administrative staff to maximise booking and clinics. The 42 cardiology breaches were in echo and have been due to a medical locum leaving and also staff sickness. There have been ongoing and significant workforce issues in the cardio/respiratory departments due to long term sickness and vacancy which are being actively managed. The E-referral system is also creating breaches due to the GP's being able to book outside of the 6 week standard. This has been escalated to the CCG's for urgent resolution.

There is an increasing demand for cardiac CT, a test which requires both a Cardiologist and Radiologist to be available to perform the test. This diagnostic is recommended as best practice and therefore there is now an urgent requirement to identify increased and sustainable capacity to meet the demand.

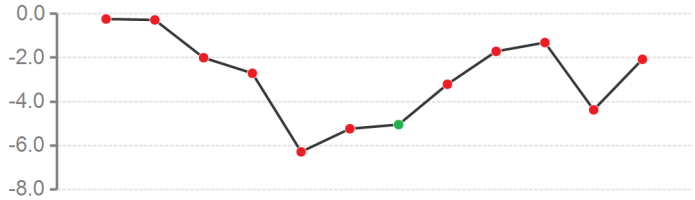
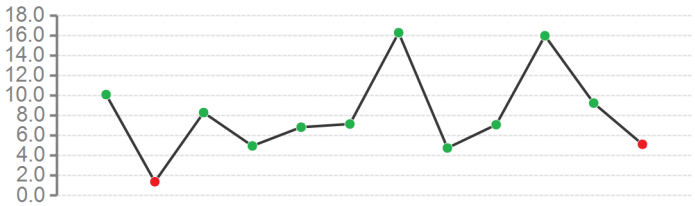
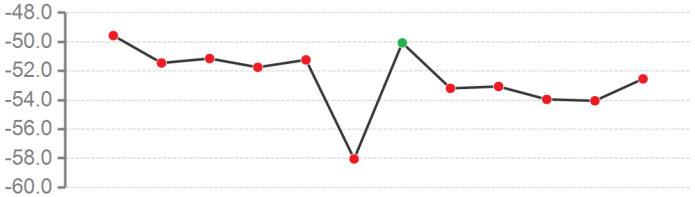
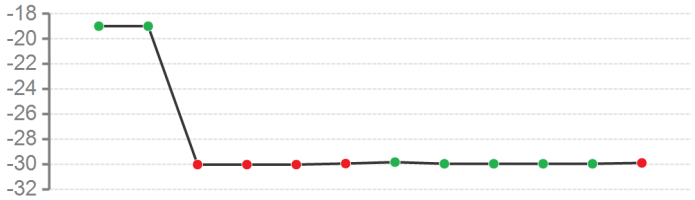
Actions:

- Recruitment to respiratory technician posts.
- Communication to GPs and CCG to request them to book within 6 weeks on the E-referral system.
- Providing additional capacity through outsourcing and internal additional lists for Cardiac CT.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Finance

Finance

Sep	I&E £m (Trust Only)	-17.7 (-52.7%)		The graph shows the Income and Expenditure result for each month. The arrow shows latest YTD figure together with % variance against previous reported position.
Sep	Cash Balance £m	5.1 (-44.5%)		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.
Sep	Total Cost £m (Trust Only)	-52.5 (-2.8%)		Total costs (Total Expenditure + Non-Operating Expenses) or "Run Rate". The graph shows the Total Costs (including non-operating expenses) for each month. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Forecast £m	-29.9 (-0.2%)		This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.

Strategic Theme: Finance

Highlights and Actions:

The Trust has generated a consolidated deficit in month of £1.8m and a year to date (YTD) deficit of £17.4m which is £1.2m behind plan. YTD position includes some significant variances the drivers for which remain similar to last month.

However in month 6 clinical income has suffered as a result of PAS go live and would be £1.1m under plan if it were not for the release of £1.7m of prior year expert determination reserve which CCGS have now settled. In addition the Trust operational and information teams are reviewing the activity recording for September to confirm the estimates which have had to be included in this months income position due to some missing data. In previous months over performance in income has offset the pay overspends, unfortunately this month due to the above reasons this has not happened. The plan assumes increased elective activity over the coming six months which, if not delivered, will lead to failure to deliver the financial plan.

As the Trust is in FSM it is measured against its performance excluding technical adjustments. After these are removed the Trust's YTD I&E deficit to Month 6 (September) was £17.1m (consolidated position including Subsidiaries and after technical adjustments) against a planned deficit of £15.7m, £1.4m worse than plan.

Trust unconsolidated pay costs in the month of £32m are £0.5m less than August. However the prior month included a net £1m of pay areas and once this is taken into account the net position is an increase of £0.5m in month. After removing the pay award adjustments, substantive staff costs were £0.2m more than last month due to increasing permanent staff numbers. Temporary staffing costs have also increased in month with Bank costs increasing £0.3m (driven by medical and nursing increases) and Agency spend increasing £0.1m driven by medical staffing. Agency costs are now £11.5m more than plan YTD driven by operational pressures. Permanent staff costs (including Overtime and waiting list work) are £2.7m less than plan YTD driven by all staff groups other than HCA's. U&LTC have managed to reduce agency in month by initiatives such as removal of TFS.

Clinical income was ahead of plan by £0.6m in month (£0.2m once the impact of central pay award funding is removed). The net YTD position is now £2.7m ahead of plan. The key drivers to this remain over performance of non-electives, A&E and ITU offset by under performance in elective and Outpatient activity. In month clinical income has over performed slightly mainly due to a favourable resolution of 2017/18 disputes with commissioners and high NEL and A&E performance however this is offset by underperformance in Elective and Outpatient work driven by a PAS go live and an increasing plan. Other income is on plan in month and above plan YTD driven mainly by the SERCO termination payment.

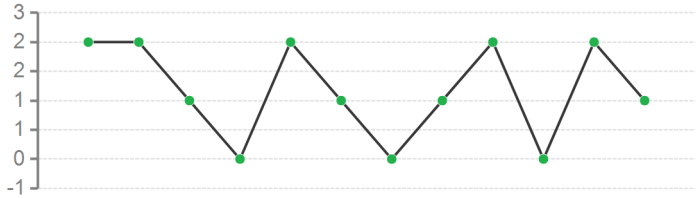
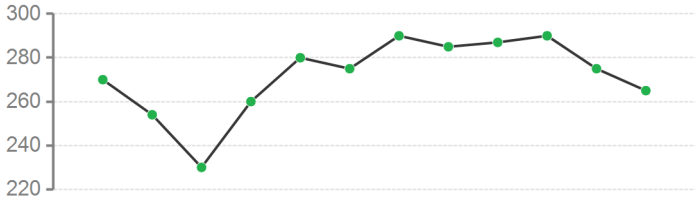
CIPS: Against the full year £30m target, including income, £12m has been reported YTD against a target of £11.4m, £0.6m ahead of plan. CIPs achieved in M06 were £1.6m against a plan of £1.3m. Medicines Value and Divisions over performed in month and YTD. Agency is above plan in month, but adverse YTD, whilst Procurement is below plan in month and YTD. CIPs in September amounted to £1.5m recurrent and £0.1m on a non-recurrent basis. The YTD position is recurrent £6.8m and non-recurrent £5.2m.

Cash: The Trusts cash balance as at the end of September was £5.1m, which is on plan. The Trust's total cash borrowing is now £60.7m.

Risk: The Trust carries and estimated £7.3m of risk to the year end position in relation to expert determination and challenges on income, CIP delivery and activity related costs. The Trust will seek to mitigate these risks as we move through the year.

Strategic Theme: Health & Safety

Health & Safety 1

Sep	Representation at H&S	835 (23.5%)		"% of Clinical Divisions representation/attendance at each site's Health & Safety Committee.
Sep	RIDDOR Reports (Number)	14 (-30.0%)		"RIDDOR reports sent to HSE each month.
Sep	Formal Notices			"Formal notices from HSE (Improvement Notices, Prohibition Notices).
Sep	Health & Safety Training	3261 (26.7%)		H&S Training includes all H&S and risk avoidance training including manual handling

Highlights and Actions:

Representation at H&S meetings increased positively last month. We are working to ensure that the newly formed Care groups are in place so as to continue supporting the positive work.

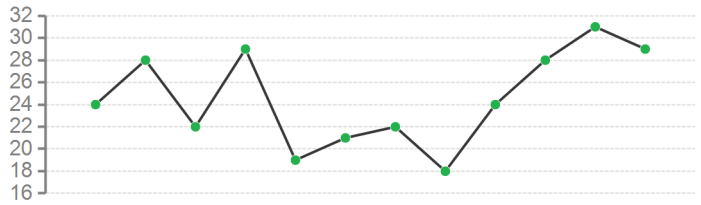
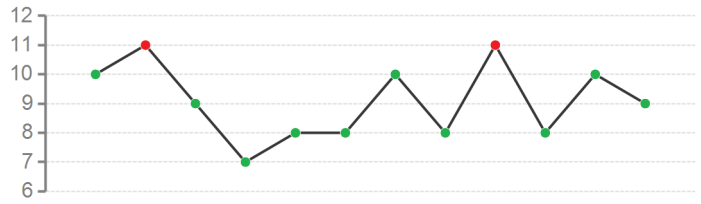
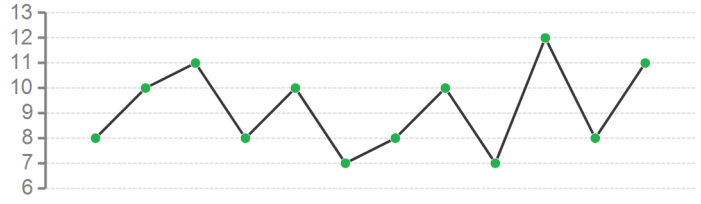
There was 1 RIDDOR to report in September - relating to a patient bed movement which resulted in a staff member hurting their back.

There where no formal notices this month.

H&S training remains high and inline with previous months.

Strategic Theme: Health & Safety

Health & Safety 2

Sep	Accidents	295 (-4.5%)		"Accidents excluding sharps (needles etc) but including manual handling.
Sep	Fire Incidents	109 (-12.1%)		"Fire alarm activations (including false alarms).
Sep	Violence & Aggression	361 (-12.0%)		"Violence, aggression and verbal abuse.
Sep	Sharps	110 (-33.7%)		"Incidents with sharps (e.g. needle stick).

Highlights and Actions:

The number of accidents decreased this month by 4.5% which continues to place this metric in the green. As previously reported there is no real pattern or theme to highlight in this at this point.

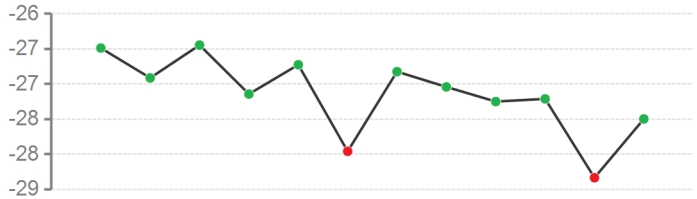
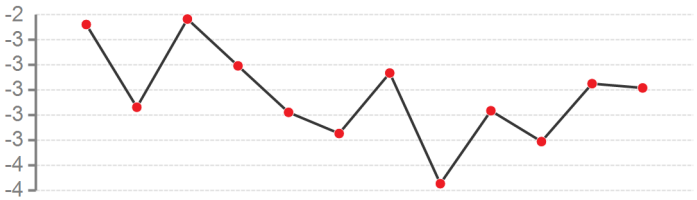
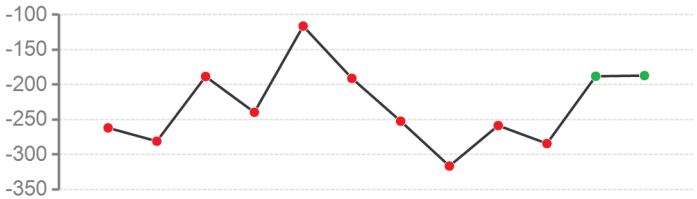
The number of Fire incidents decreased slightly in month. The KPI remains positive.

V&A and sharps both increased in September but with both still remaining within acceptable range.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Use of Resources

Pay Independent

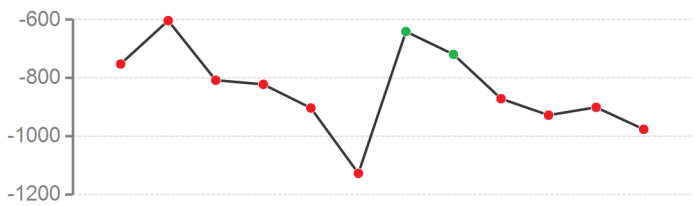
Sep	Payroll Pay £m	-27.5 (-3.0%)		Payroll Pay (Permanent+Overtime). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Agency Spend £m	-3.0 (1.2%)		Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.
Sep	Additional sessions £k	-187 (-0.5%)		Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.

Strategic Theme: Use of Resources

Sep

Independent Sector £k

-976 (8.4%)



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 adverse to plan in September by £1.6m and by £8.2m ytd (4.5%). Pay CIPs are adverse to plan in month by £0.5m and by £2.0m ytd.

Total expenditure on pay in September was £32.0m, £0.5m lower than in August. However, August spend included a net cost of £1.0m relating to non medical pay award arrears offset by the release of medical pay award accruals. Expenditure on temporary staffing, medical locum sessions and waiting list payments increased in total by £0.2m when compared to spend in August.

Substantive staff expenditure is favourable to plan by £0.3m in September and favourable to plan by £2.5m ytd. All substantive pay groups are underspent against plan in month and ytd except Other staff which are overspent by £0.3m in month and £1.4m ytd. This overspend relates predominantly to HCAs which are adverse to plan in month by £0.2m and by £0.9m ytd. CIP schemes for Other staff account for the remainder of the variance.

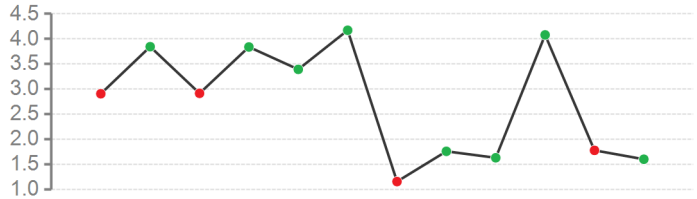
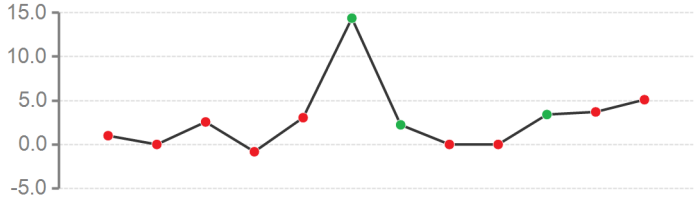
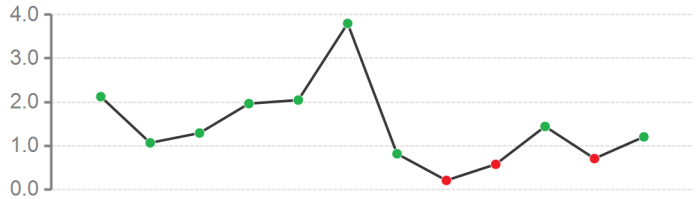
Bank staff are adverse to plan £0.4m in month and by £0.7m ytd with underspends on medical staff offsetting overspends on all other staffing groups.

Agency and Direct Engagement performance is again adverse to plan with an overspend in month of £1.6m and ytd of £10.3m. September has seen a marginal reduction in actual spend when compared to August and A&C and Other staff are marginally favourable to plan in month. TFS agency usage of HCAs at premium rates in UC&LTC ceased in September and staff are now being sourced via NHSP which is reflected in the breakeven position against plan. Adverse variances remain in the usage of all other staffing groups, particularly medical and nursing.

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Use of Resources

Balance Sheet

Sep	CIPS £m	12.0 (-10.0%)		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.
Sep	Cash borrowings £m	60.7		Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.
Sep	Capital position £m	5.0 (70.5%)		Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow.

Highlights and Actions:

DEBT
Total invoiced debtors have decreased from the opening position of £28.5m by £8.9m to £19.6m. The largest debtors at 30th September were East Kent CCGs £6.8m and East Kent Medical Services £1.9m.

CAPITAL
Total YTD expenditure for Mth 6 2018/19 is £1.0m below the NHSI plan

CASH
The closing cash balance for the Trust as at 30th September was £5.1m.

FINANCING
£931k of interest was incurred in respect of the drawings against working capital facilities to 31st March 2018 (£46.2m) and April 2018 (£2.2m), July 2018 (£3.4m), August (£3.7m) and September (£5.1m)

East Kent Hospitals University NHS Foundation Trust

Strategic Theme: Improvement Journey

		May	Jun	Jul	Aug	Sep	
MD02 - Emergency Pathway	ED - 4hr Compliance (incl KCHFT MIUs) %	83.95	86.92	82.95	81.95	81.17	>= 95
	ED - 1hr Clinician Seen (%)	49	51	43	48	45	
MD04 - Flow	DToCs (Average per Day)	61	61	57	52	48	
	IP - Discharges Before Midday (%)	14	14	14	13	17	>= 35
	Medical Outliers	57	48	47	51	51	
MD05 - 62 Day Cancer	Cancer: 62d (GP Ref) %	65.01	65.47	65.39	65.85	71.19	>= 85
MD07 - Maternity	Midwife:Birth Ratio (%)	28	28	30	28	27	>= 0 & <28
	Staff Turnover (Midwifery)	13	13	14	13	13	>= 0 & <10
	Vacancy (Midwifery) %	7	7	6	6	5	>= 0 & <7
MD08 - Recruitment & Staffing	Staff Turnover (%)	13.2	13.0	15.0	13.9	14.2	>= 0 & <10
	Vacancy (%)	13.1	14.0	13.3	14.0	13.4	>= 0 & <7
	Staff Turnover (Nursing)	13	13	14	13	14	>= 0 & <10
	Staff Turnover (Medical)	13	13	14	13	14	>= 0 & <10

MD08 - Recruitment & Staffing	Vacancy (Nursing) %	14	15	15	16	16	>= 0 & <7
	Vacancy (Medical) %	11	13	13	13	13	>= 0 & <7
MD09 - Workforce Compliance	Appraisal Rate (%)	71.8	67.2	70.6	76.0	76.5	>= 85
	Statutory Training (%)	90	91	91	92	92	>= 85
KF01 - Complaints	Complaint Response within 30 days %	38.6	44.7	47.4	30.6	16.0	>= 85
	Complaint Response in Timescales %	91.4	92.0	87.3	90.2	75.7	>= 85
KF09 - Medicines Management	Pharm: Drug Trolleys Locked (%)	97	88	96	99	99	
	Pharm: Resus. Trolley Check (%)	95	94	94	95	92	
	Pharm: Drug Cupboards Locked (%)	84	74	67	88	78	
	Pharm: Fridges Locked (%)	81	83	78	85	86	>= 95
	Pharm: Fridge Temps (%)	89	89	86	89	82	>= 100

East Kent Hospitals University NHS Foundation Trust

Glossary

Domain	Metric Name	Metric Description	Green	Weight
A&E	ED - 1hr Clinician Seen (%)	% of A&E attendances seen within 1 hour by a clinician		
	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	DToCs (Average per Day)	The average number of delayed transfers of care		30 %
	IP - Discharges Before Midday (%)	% of Inpatients discharged before midday	>= 35	10 %
	Medical Outliers	Number of patients recorded as being under a Medical specialty but was discharged from a Surgical Ward (Patients admitted to a ward which is not related to their clinical reason, mainly due to capacity reasons)		
Cancer	Cancer: 2ww (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: 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	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		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 %
	Audit of WHO Checklist %	An observational audit takes place to audit the World Health Organisation (WHO) checklist	>= 99	10 %
	Pharm: Drug Trolleys Locked (%)	Data taken from Medicines Storage & Waste Audit - percentage of drug trolley's locked		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		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	Not Cached Up Clinics %	Outpatients bookings that either have no outcome coded (i.e. attended, DNA or cancelled) or there is a conflict (e.g. patient discharged but no discharge date) as a % of all outpatient bookings	>= 0 & <0.2	25 %
	Uncoded Spells %	Inpatient spells that either have no HRG code or a U-coded HRG as a % of total spells (included uncoded spells).	>= 0 & <0.25	25 %
	Valid Ethnic Category Code %	Patient contacts where Ethnicity is not blank as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	5 %
	Valid GP Code	Patient contacts where GP code is not blank or G9999998 or G9999991 (or is blank/G9999998/G9999991 and NHS number status is 7) as a % of all patient contacts. Includes all OP, IP and A&E contacts	>= 99.5	5 %

Data Quality & Assurance	Valid NHS Number %	Patient contacts where NHS number is not blank (or NHS number is blank and NHS Number Status is equal to 7) as a % of all patient contacts. Includes all Outpatients, Inpatients and A&E contacts.	>= 99.5	40 %
Demand vs Capacity	DNA Rate: 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	Cash Balance £m	Closing Bank Balance. The graph shows the cash balance at the end of each month - the latest cash balance is shown in the arrow. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	20 %
	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.	>= 0	30 %
	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.	>= 0	20 %
	Forecast £m	This shows the Normalised Income & Expenditure Forecast as at 31st March 2017. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	10 %
Health & Safety	Representation at H&S	"% of Clinical Divisions representation/attendance at each site's Health & Safety Committee.	>= 76	20 %
	RIDDOR Reports (Number)	"RIDDOR reports sent to HSE each month.	>= 0 & <3	20 %
	Sharps	"Incidents with sharps (e.g. needle stick).	>= 0 & <10	5 %
	Accidents	"Accidents excluding sharps (needles etc) but including manual handling.	>= 0 & <40	15 %
	Fire Incidents	"Fire alarm activations (including false alarms).	>= 0 & <5	10 %
	Formal Notices	"Formal notices from HSE (Improvement Notices, Prohibition Notices).	>= 0 & <1	15 %
	Health & Safety Training	H&S Training includes all H&S and risk avoidance training including manual handling	>= 80	5 %

Health & Safety	Violence & Aggression	"Violence, aggression and verbal abuse.	>= 0 & <25	10 %
Incidents	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 %
	Number of Cardiac Arrests	Number of actual cardiac arrests, not calls		0 %
	Pressure Ulcers Cat 2 (per 1,000)	"Number of avoidable Category 2 hospital acquired pressure ulcers, per 1,000 bed days Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."		10 %
	Serious Incidents (STEIS)	"Number of Serious Incidents. Uses validated data from STEIS. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	All Pressure Damage: Cat 2	"Number of all (old and new) Category 2 pressure ulcers. Data source - Datix."	>= 0 & <1	
	Blood Transfusion Incidents	"The number of blood transfusion incidents sourced from Datix. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown by %) against the previous 12 months."		
	C. Diff Infections (Post 72h)	"The number of Clostridium difficile cases recorded at greater than 72h post admission. Data source - VitalPAC (James Nash)."	>= 0 & <1	0 %
	Clinical Incidents: Total (#)	"Number of Total Clinical Incidents reported, recorded on Datix.		
	Falls (per 1,000 bed days)	"Total number of recorded falls, per 1,000 bed days. Assisted falls and rolls are excluded. Data source - Datix. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <5	20 %
	Falls: Total	"Total number of recorded falls. Assisted falls and rolls are excluded. Data source - Datix."	>= 0 & <3	0 %
	Harm Free Care:All Harms (%)	"Percent of inpatients deemed free from harm as measured by the Safety Thermometer audit ie free from old and new harms: - Old and new pressure ulcers (categories 2 to 4) - Injurious falls - Old and new UTI - Old and new DVT, PE or Other VTE. Data source - Safety Thermometer (old and new harms)."	>= 94	10 %
	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 %
Infection	Bare Below Elbows Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"		
	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 %

Infection	Cases of MRSA (per month)	Number of Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined by NHS National Operating Framework (HQU01). Number of MRSA cases assigned to EKHUFT. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against previous 12 months.	>= 0 & <1	40 %
	Hand Hygiene Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"	>= 95	
	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	
	Commode Audit	"The % of ward staff compliant with hand hygiene standards. Data source - SharePoint"		
	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 %
	RAMI (Index)	Risk Adjusted Mortality (via CHKS) computes the risk of death for hospital patients and compares to others with similar characteristics. Data including age, sex, length of stay, clinical grouping, diagnoses, procedures and discharge method is used. Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 0 & <87.45	30 %
	Crude Mortality EL (per 1,000)	"The number of deaths per 1,000 elective admissions. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <0.33	10 %
Observations	Catheter: Daily Check (%)	"The % of catheters which were checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC"	>= 50	10 %
	Obs. On Time - 8pm-8am (%)	VitalPac Observations are untaken in a timely manner according to clinical need. Patients who have an early warning score of less than three are excluded, as well as patients on respiratory wards and patients on an End of Life Pathway.	>= 90	25 %
	VTE: Risk Assessment %	"Adults who have had a Venous Thromboembolism (VTE) Risk Assessment at any point during their Admission. Low-Risk Cohort counted as compliant."	>= 95	20 %
	Cannula: Daily Check (%)	"The % of cannulas checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC"	>= 50	10 %

Observations	Central Line: Daily Check (%)	"The % of central lines checked daily. Daily checks are calculated on the assumption that a patient's indwelling device should be checked at least once a day. Data source - VitalPAC"	>= 50	10 %
	Obs. On Time - 8am-8pm (%)	VitalPac Observations are untaken in a timely manner according to clinical need. Patients who have an early warning score of less than three are excluded, as well as patients on respiratory wards and patients on an End of Life Pathway.	>= 90	25 %
Patient Experience	Complaint Response in Timescales %	Complaint Response within agreed Timescales %	>= 85	5 %
	Compliments to Complaints (#/1)	Number of compliments per complaint	>= 12	10 %
	Discuss Worries with domestic %	Discuss Worries with domestic	>= 89	
	Discuss Worries with Nurses %	Discuss Worries with Nurses	>= 89	4 %
	Discuss Worries with support %	Discuss Worries with support	>= 89	
	FFT: Response Rate (%)	"The percentage of Inpatient (excluding Day Case) patients who responded to the Friends & Family Test. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 15	1 %
	Hospital Food? %	Based on a question asked within the Trust's Inpatient Survey, how would you rate the hospital food? % of inpatients who answered 'very good' or 'good'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	5 %
	Mixed Sex Breaches	"Number of patients experiencing mixed sex accommodation due to non-clinical reasons. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	Number of Compliments	% of A&E attendances who were in department less than 4 hours - from arrival at A&E to admission/transfer/discharge, for only Acute Sites (K&C, QEQM, WHH, BHD)		0 %
	Overall Patient Experience %	Based on questions asked within the Trust's Inpatient Survey, this provides an overall inpatient experience % by weighting the responses to each question (eg. Did not eat or poor = 0, fair = 0.3, good = 0.6, very good = 1). Arrow indicates average of last 12 months data together with variance against the previous 12 months.	>= 90	10 %
	Privacy for discussions with Doctors %	Privacy for discussions Doctors	>= 89	
	Privacy for discussions with Support %	Privacy for discussions Support	>= 89	
	AE Mental Health Referrals	A&E Mental Health Referrals		5 %

Patient Experience	Cleanliness? %	Based on a question asked within the Trust's Inpatient Survey, in your opinion, how clean was the hospital room or ward that you were in? % of inpatients who answered 'very clean' or 'fairly clean'. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 95	5 %
	Complaint Response within 30 days %	Complaint Response within 30 working day timescale %	>= 85	
	Discuss Worries with Doctors %	Discuss Worries with Doctors	>= 89	
	FFT: Not Recommend (%)	"Of those patients (Inpatients excluding Day Cases) who responded to the Friends & Family Test and knew their opinion, would not recommend the Trust. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <1	10 %
	FFT: Recommend (%)		>= 90	30 %
	Number of Complaints	"The number of Complaints recorded overall . Data source - Patient Experience Team"	>= 0 & <1	0 %
Productivity	BADS	British Association of Day Surgery (BADS) Efficiency Score calculated on actual v predicted overnight bed use – allowing comparison between procedure, specialty and case mix.	>= 100	10 %
	eDN Communication	% of patients discharged with an Electronic Discharge Notification (eDN).	>= 99	5 %
	LoS: Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for admitted elective patients. M.Sakel (NuroRehab) excluded for EL.		
	LoS: Non-Elective (Days)	Calculated mean of lengths of stay >0 with no trim point for non-admitted elective patients.		
	Non-Clinical Cancellations (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations as a % of the total planned procedures	>= 0 & <0.8	20 %
	Non-Clinical Canx Breaches (%)	Cancelled theatre procedures on the day of surgery for non-clinical cancellations that were not rebooked within 28days as a % of total admitted patients.	>= 0 & <5	10 %
	EME PPE Compliance %	EME PPE % Compliance	>= 80	20 %
	Theatres: On Time Start (% 30min)	The % of cases that start within 30 minutes of their planned start time.	>= 90	10 %
	Theatres: Session Utilisation (%)	% of allocated time in theatre used, including turn around time between cases, excluding early starts and over runs.	>= 85	25 %
RTT	RTT: 52 Week Waits (Number)	Zero tolerance of any referral to treatment waits of more than 52 weeks, with intervention, as stated in NHS Operating Framework	>= 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		

Staffing	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	
	Midwife:Birth Ratio (%)	The number of births compared to the number of whole time equivilant midwives per month (total midwive staff in post divided by twelve). Midwives totals are calculated by the Finance Department using Midwife Led Unit (MLU), Maternity and Community Midwives budget codes.	>= 0 & <28	2 %
	Overtime (WTE)	Count of employee's claiming overtime		1 %
	Shifts Filled - Day (%)	Percentage of RCN and HCA shifts filled on wards during the day (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %
	Sickness (%)	% of Full Time Equivalents (FTE) lost through absence (as a % of total FTEs). Data taken from HealthRoster: eRostering for the current month (unvalidated) with previous months using the validated position from ESR. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 0 & <3.3	10 %
	Stability Index (excl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage. exclude Junior medical staff, any staff with grade codes beginning MN or MT		
	Stability Index (incl JDs) %	Whole Time Equivalent (WTE) staff in post as at current month, and WTE staff in post as 12 months prior. Calculate – WTE staff in post with 12 months+ Trust service / WTE staff in post 12 month prior (no exclusions) * 100 for percentage		
	Staff Turnover (Midwifery)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Midwives. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
	Time to Recruit	"Average time taken to recruit to a new role. This metric is shown in weeks. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
	Total Staff Headcount	Headcount of total staff in post		
	Total Staff In Post (SiP)	Count of total staff in post (WTE)		1 %
	Unplanned Agency Expense	Total expediture on agency staff as a % of total monthly budget.	>= 0 & <100	5 %

Staffing

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.		
Agency %	% of temporary (Agency and Bank) staff of the total WTE	>= 0 & <10	
Agency Filled Hours vs Total Agency Hours	% hours worked which were filled by the NHSP against the total number of hours worked by agency staff		
Agency Staff WTE (NHSP)	WTE Count of NHSP Hours worked		
Bank Filled Hours vs Total Agency Hours	% hours worked which were filled by the Bank (NHSP) against the total number of hours worked by all agency staff		1 %
Bank Hours vs Total Agency Hours	% hours worked by Bank (Staffflow) against the total number of hours worked by agency staff		
Care Hours Per Patient Day (CHPPD)	Total Care Hours per Patient Day (CHPPD). Uses count of patients per day with hours of staffing available. Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.		
NHSP Hours vs Total Agency Hours	% hours worked by NHSP against the total number of hours worked by agency staff		
Overtime %	% of Employee's that claim overtime.	>= 0 & <10	
Shifts Filled - Night (%)	Percentage of RCN and HCA shifts filled on wards at night (split by RCN & HCA). Arrow indicates sum of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 80	15 %
Staff Turnover (%)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE). Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	15 %
Staff Turnover (Medical)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Medical Staff. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
Staff Turnover (Nursing)	"% Staff leaving & joining the Trust against Whole Time Equivalent (WTE) for Nurses. Metric excludes Dr's in training. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <10	
Staffing Level Difficulties	Any incident related to Staffing Levels Difficulties		1 %
Total Staff In Post (FundEst)	Count of total funded establishment staff		1 %
Vacancy (%)	"% Vacant positions against Whole Time Equivalent (WTE). Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months."	>= 0 & <7	15 %

Staffing	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	
Training	Appraisal Rate (%)	Number of staff with appraisal in date as a % of total number of staff. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months.	>= 85	50 %
	Corporate Induction (%)	% of people who have undertaken a Corporate Induction	>= 95	
	Major Incident Training (%)	% of people who have undertaken Major Incident Training	>= 95	
	Statutory Training (%)	"The percentage of staff that have completed Statutory training courses, this data is split out by training course. Arrow indicates average of last 12 months data (as shown in graph) together with variance (shown in direction of arrow and %) against the previous 12 months. "	>= 85	50 %
Use of Resources	Capital position £m	Capital spend. The graph shows the capital spend for each month - the year to date is shown in the arrow.	>= 0	
	Cash borrowings £m	Cash borrowings. The graph shows the monthly cash borrowings with the year to date total within the arrow.	>= 0	
	CIPS £m	Cost Improvement Programmes (CIPs): Graph shows monthly delivery of savings. The arrow shows the cumulative year to date position with the % change against the previous month.	>= 0	
	Clinical Productivity: Outpatient	Clinical Productivity graph: outpatient sessions v plan		
	Independent Sector £k	Independent Sector (Cost of Secondary Commissioning of mandatory services) The graph shows the Independent Sector (cost of secondary commissioning of mandatory services) cost per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	
	Additional sessions £k	Additional sessions (Waiting List Payments) The graph shows the additional sessions (waiting list payments) pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	
	Agency Spend £m	Agency and Medical/StaffFlow Locum spend by month YTD. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	
	Clinical Productivity: Theatres	Clinical Productivity graph: theatre sessions v plan.		
	Payroll Pay £m	Payroll Pay (Permanent+Overtime+Bank). The graph shows the total pay per month for a rolling 12 months. The arrow shows latest monthly figure together with % variance against the last month reported.	>= 0	

Data Assurance Stars

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

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

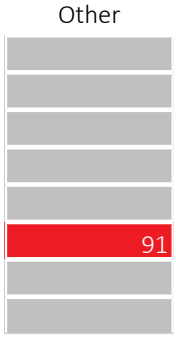
 Data captured on electronic system with direct feed, data has an assured process, data is validated/reconciled

East Kent Hospitals University NHS Foundation Trust

Human Resources Heatmap

	Clinical	Corporate	Finance & Perform	HR	Qual Safety & Ops	Specialist	Strat Dev & Cap Plan	Surgical	Urgent & Long Term
Agency %	12.6	2.3	5.8	6.4	2.3	20.6	39.3	33.3	77.8
Appraisal Rate (%)	78.4	68.4	75.4	84.6	68.1	79.6	60.7	84.4	67.0
Employed vs Temporary Staff (%)	90.1	89.6	89.8	91.3	86.9	90.5	88.8	93.1	80.8
Sickness (%)	4.9	2.8	2.5	3.4	5.5	5.0	4.2	4.8	4.7
Staff Turnover (%)	14.4	12.3	12.5	15.5	10.3	12.0	9.3	13.9	17.6
Statutory Training (%)	93					92		93	91
Total Staff In Post (SiP)	1502	87	134	122	120	1395	279	1774	1630
Vacancy (%)	18.1	13.3	10.2	11.0	13.1	9.6	11.2	6.9	19.2

Apdx.


Other
91

NHS
East Kent Hospitals University
NHS Foundation Trust

Patient Safety Heatmap - SEPTEMBER 2018

KEY

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

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	C. Diff Infections (Post 72h)	Number of Cardiac Arrests	Cases of MRSA (per month)	Number of Complaints	Number of Compliments	Aware of Nurse in each shift %	Privacy for discussions with	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
K&C - KENT & CANTERBURY HOSPITAL																		
Specialist																		
KBRA - BRABOURNE	100.0	0	0	0	0	0	0	0	50	100	100	38	100	0.0	96.0	88	100	13
MARL - MARLOWE WARD	90.9	1	6	0	0	0	0	0	33	50	33	42	100	0.0	88.9	94	91	8
Surgical																		
CLKE - CLARKE WARD	96.4	4	2	0	0	0	0	4	100	50	50	15	98	2.0	90.7	102	98	7
KENT - KENT WARD	100.0	3	7	0	0	0	0	0	NULL	NULL	NULL	9	100	0.0	94.3	93	94	8
KITU - INTENSIVE CARE UNIT	100.0	1	0	0	0	0	0	58	N/A	N/A	N/A	N/A	N/A	N/A	88.2	85	81	23
Urgent & Long Term																		
HARB - HARBLEDOWN WARD	100.0	1	8	0	0	0	0	76	33	50	50	43	100	0.0	78.1	84	122	5
INV - INVICTA WARD	100.0	0	10	0	0	0	1	0	100	100	100	38	100	0.0	94.2	91	111	6
KING - KINGSTON WARD	100.0	0	13	0	0	0	0	0	33	33	33	36	100	0.0	87.1	86	109	5
KNRU - EAST KENT NEURO REHAB	NULL	0	3	0	0	0	0	0	100	100	100	60	100	0.0	NULL	81	101	5
MTMC - MOUNT/MCMASTER WARD	100.0	1	5	0	0	0	0	0	NULL	NULL	NULL	15	100	0.0	92.3	82	111	5
TREB - TREBLE WARD	100.0	0	3	0	0	0	0	0	50	50	50	44	100	0.0	90.5	89	94	7
QEQM - QUEEN ELIZABETH QUEEN MOTHER HOSPITAL																		
Specialist																		
BIR - BIRCHINGTON WARD	100.0	1	0	1	0	0	0	3	NULL	NULL	NULL	28	100	0.0	94.1	82	125	6
KIN - QEQM KINGSGATE (MOTHERS)	100.0	0	1	0	1	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	84.8	81	90	18
QSCB - SPECIAL CARE BABY UNIT	100.0	0	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	90.3	94	92	14
RAI - RAINBOW WARD	100.0	0	0	0	0	0	0	0	N/A	N/A	N/A	5	100	0.0	90.6	91	92	12
Surgical																		
BIS - BISHOPSTONE WARD	93.3	1	0	0	0	0	1	108	33	50	33	81	98	0.0	76.8	76	84	6
CSF - CHEERFUL SPARROWS FEMALE	100.0	1	3	0	0	0	1	1	50	50	100	39	100	0.0	91.6	102	130	6
CSM - CHEERFUL SPARROWS MALE	100.0	1	1	0	0	0	0	2	33	50	50	27	100	0.0	86.6	112	138	6

Apdx.

KEY

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

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	C. Diff Infections (Post 72h)	Number of Cardiac Arrests	Cases of MRSA (per month)	Number of Complaints	Number of Compliments	Aware of Nurse in each shift %	Privacy for discussions with	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
QITU - INTENSIVE CARE UNIT	100.0	2	0	0	0	0	0	46	N/A	N/A	N/A	N/A	N/A	N/A	87.2	82	113	24
SB - SEA BATHING WARD	100.0	0	0	0	0	0	0	2	50	33	50	16	100	0.0	93.5	N/A	N/A	6
Urgent & Long Term																		
DEAL - DEAL WARD	100.0	1	6	0	0	0	1	0	50	100	100	5	100	0.0	93.0	98	112	5
FRD - FORDWICH WARD STROKE UNIT	100.0	0	4	0	0	0	1	0	50	50	100	32	100	0.0	81.3	91	113	7
MW - MINSTER WARD	100.0	1	5	1	0	0	0	0	33	50	33	16	100	0.0	55.7	92	102	7
QCCU - CCU	100.0	0	2	0	3	0	0	1	50	50	50	76	100	0.0	77.7	81	110	24
QX - QUEX WARD	100.0	1	7	0	0	0	1	0	100	NULL	100	46	97	2.7	NULL	97	105	5
SAN - SANDWICH BAY WARD	100.0	1	2	0	0	0	0	1	NULL	NULL	NULL	52	100	0.0	98.6	132	133	6
SAU - ST AUGUSTINES WARD	100.0	0	2	0	0	0	0	0	NULL	NULL	NULL	N/A	N/A	N/A	92.1	105	110	5
STM - ST MARGARETS WARD	95.0	0	3	0	0	0	0	19	33	33	33	44	100	0.0	75.3	98	99	5
WHH - WILLIAM HARVEY HOSPITAL																		
Specialist																		
FF - WHH FOLKSTONE WARD (MOTHERS)	100.0	0	0	0	1	0	1	0	33	50	50	N/A	N/A	N/A	89.0	93	91	32
KEN - KENNINGTON WARD	100.0	0	0	0	0	0	0	1	50	33	50	0	NULL	NULL	73.5	88	125	6
PAD - PADUA	100.0	0	0	0	0	0	0	0	N/A	N/A	N/A	0	NULL	NULL	83.4	88	89	6
SCBU - THOMAS HOBBES NEONATAL UNIT	100.0	0	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	101.3	94	92	10
Surgical																		
ITU - WHH ITU	100.0	4	1	0	0	0	0	36	N/A	N/A	N/A	N/A	N/A	N/A	99.2	84	83	28
KA2 - KINGS A2	95.0	0	2	0	0	0	0	191	33	33	50	62	91	0.0	106.8	105	104	6
KB - KINGS B	96.3	1	4	1	0	0	0	197	33	33	50	54	93	2.3	94.3	105	109	5
KC - KINGS C1	96.2	3	0	0	0	0	0	149	50	50	33	44	95	4.5	74.9	101	98	6
KC2 - KINGS C2	100.0	0	4	0	0	0	1	0	33	33	33	33	98	0.0	65.6	79	88	6
KDF - KINGS D FEMALE	94.4	6	2	0	0	0	0	286	33	33	50	43	100	0.0	101.0	N/A	N/A	N/A
KDM - KINGS D MALE	100.0	7	3	0	0	0	1	0	50	33	50	34	96	0.0	N/A	107	105	7
RW - ROTARY WARD	100.0	0	0	0	0	0	0	61	33	33	33	56	97	0.0	94.1	107	97	9
Urgent & Long Term																		
CCU - DGH CORONARY CARE UNIT	100.0	0	0	0	0	0	0	0	100	NULL	100	71	100	0.0	NULL	N/A	N/A	N/A
CJ2 - CAMBRIDGE J2	97.1	1	0	0	0	0	0	1	33	50	25	0	NULL	NULL	80.5	101	146	7
CK - CAMBRIDGE K	100.0	2	3	0	0	0	0	0	50	50	50	43	94	0.0	49.7	86	85	6
CL - CAMBRIDGE L REHABILITATION	100.0	0	3	0	0	1	0	1	33	33	33	51	93	3.4	77.8	83	118	6

Apdx.

KEY

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

	Harm Free Care: New Harms (%)	All Pressure Damage: Cat 2	Falls: Total	C. Diff Infections (Post 72h)	Number of Cardiac Arrests	Cases of MRSA (per month)	Number of Complaints	Number of Compliments	Aware of Nurse in each shift %	Privacy for discussions with	Discuss Worries with Nurses %	FFT: Response Rate (%)	FFT: Recommend (%)	FFT: Not Recommend (%)	Employed vs Temporary Staff (%)	Shifts Filled - Day (%)	Shifts Filled - Night (%)	Care Hours Per Patient Day (CHPPD)
CM1 - CAMBRIDGE M1 SHORT STAY	100.0	0	2	0	0	0	1	0	50	50	50	0	NULL	NULL	33.5	N/A	N/A	N/A
CM2 - CAMBRIDGE M2	100.0	2	7	0	0	0	1	0	50	50	100	29	100	0.0	99.4	101	85	6
OXF - OXFORD	100.0	2	4	0	0	0	0	0	50	50	100	38	92	8.3	98.1	108	118	8
RST1 - RICHARD STEVENS 1 STROKE UNIT	100.0	5	6	0	0	0	0	0	33	50	50	34	96	0.0	92.5	86	113	7
WBAR - BARTHOLOMEW WARD WHH	NULL	0	0	0	1	0	0	0	33	50	50	74	100	0.0	NULL	88	100	13
WCDM - WHH CDU MIXED	NULL	0	0	0	0	0	0	0	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	NULL	N/A

REPORT TO:	**BOARD OF DIRECTORS (BoD)**
DATE:	**1 NOVEMBER 2018**
SUBJECT:	**FULL CORPORATE/HIGHEST MITIGATED STRATEGIC RISKS REPORT**
BOARD SPONSOR:	**CHIEF NURSE AND DIRECTOR OF QUALITY**
PAPER AUTHOR:	**DEPUTY DIRECTOR OF RISK, GOVERNANCE AND PATIENT SAFETY**
PURPOSE:	**DISCUSSION**
APPENDICES:	**APPENDIX 1: CORPORATE RISK REGISTER (BY RESIDUAL RISK RANKING) DATED 23 OCTOBER 2018** **APPENDIX 2: HIGHEST MITIGATED STRATEGIC RISKS DATED 23 OCTOBER 2018**

BACKGROUND AND EXECUTIVE SUMMARY

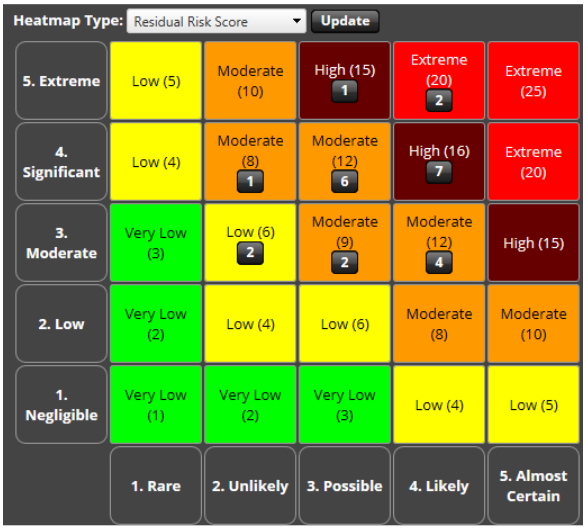
This report provides the Board of Directors with an update of the Full Corporate/Highest Mitigated Strategic Risks at 23 October 2018. The risks rated as "high" post mitigation (residual) on the Strategic and the Full Corporate Risk Register was last reviewed by the Board on 6 September 2018. The highest mitigated risks on the Strategic and Corporate Risk Registers was last reviewed by the Integrated Audit and Governance Committee (IAGC) on 16 October 2018. The highest mitigated Quality risks were last reviewed and discussed at the Quality Committee on 23 October 2018.

The internal audit report on divisional risk management was presented to the IAGC at the October meeting and the actions identified will be under the auspices of the new Care Groups to implement; this will be the focus for the year ahead.

During the period under review, progress notes have been added for majority of the actions in the Principal risks report. Reminders have been sent to action owners from whom the remaining updates are required.

Current Risk Register Heat Map (by Residual risk score)

Corporate Risks (25)



Strategic Risks (7)

Key Changes to the Strategic and Corporate Risk Registers

Strategic Risk Register

1 There were no changes to the residual or target risk scores in the period under review. Some actions have been completed and no additional strategic risks added.

Corporate Risk Register

Changes to residual risk scores

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

Risk Ref.	Risk Title	Residual Score Sept 18	Residual Score Oct 18	Direction of travel	Target Score
CRR 16	Poor complaints management *The residual risk score has been increased to reflect the number of long delays in complaint management and staff shortages.*	**9 Moderate**	**12 Moderate**		**9 Moderate**
CRR 39	Delays in Radiological reporting *This risk is now mitigated and is due for removal from the CRR following approval at CEMG*	**12 Moderate**	**8 Moderate**		**4 Low**
CRR 40	Lack of robust antenatal and new-born screening programmes *The residual risk reduced as the likelihood as lessened. More focus has resulted in increased reporting. No harm to date. Risk will remain another month due to PHE focus and QA due October 18.*	**9 Moderate**	**6 Low**		**6 Low**

Three target scores have been changed. The target score for CRR 41 - Failure to manage Patients with challenging behaviour (Dementia and other mental health challenges) has decreased from 9 (moderate) to 6 (low). CRR 31 - Exposure to Cyber Security Attacks target score has increased from 2 (very low) to 3 (very low). CRR 39 - Delays in Radiological reporting has decreased from 6 (low) to 4 (low).

Risks approved for closure on the Corporate Risk Register (October 2018 Clinical Executive Management Group (CEMG))

3 There were no risks proposed for closure.

New Corporate Risks approved by the Clinical Executive Management Group (October 2018)

4 There were no new risks approved by the CMEG for inclusion onto the Corporate Risk Register.

Risks approved for merging on the Corporate Risk Register

5 There were no risks proposed for merging by CMEG.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	The attached risk registers reflects the corporate risks and the highest mitigated strategic risks facing the Trust and the mitigating actions in place.
LINKS TO STRATEGIC OBJECTIVES:	The corporate and strategic risks align to all of the four Strategic Priorities: **Patients:** Help all patients take control of their own health. **People:** Identify, recruit, educate and develop talented staff. **Provision:** Provide the services people need and do it well. **Partnership:** Work with other people and other organisations to give patients the best care.
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	This paper provides an update on the full corporate risks and the highest mitigated strategic risks for the Trust.
RESOURCE IMPLICATIONS:	None specifically identified other than identified in the Risk Register.
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	The Risk Group and the Clinical Executive Management Group reviews any new corporate risks and the scoring of the existing risks. The IAGC review the Corporate Risks and the Board Assurance Framework.

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

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors are invited to:

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

Corporate Risk Register Report (By Residual Risk Ranking)

Report Date	23 Oct 2018
Comparison Date	In the past 30 Day(s)

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 19	Delays in the cancer pathway of over 100 days **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Elizabeth Mount **Last Updated:** 09 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** There are now 15 patients waiting over 104 days, a reduction from 31 patients last month. 10 of these 15 actually have cancer, 3 had treatment in September and 3 were planned for October, 4 are awaiting decision to treat outpatient OPAs	24 Apr 2016	**Cause** * Diagnostic delays predominantly in the colorectal and prostate cancer pathways (access to endoscopy and MRI diagnostics) * Lack of outpatient capacity * Lack of treatment capacity **Effect** * Possible harm to Patients * Reputational damage * Regulatory concerns *Loss of STF	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Cancer 62 day treatment recovery plan **Control Owner:** Elizabeth Mount	Limited	I = 5 L = 4 Extreme (20)	Complete accredited training for surgeons undertaking endoscopy **Person Responsible:** Nicholas Goodger **To be implemented by:** 31 Oct 2018	High	**22 Oct 2018** QEQMH surgeons signed off (x3) WHH surgeons signed off (x3)	I = 5 L = 2 Moderate (10)
						Diagnostic capacity is reviewed at the KPI meeting and also within the Clinical Support Divisions **Control Owner:** Elizabeth Mount	Limited		Urology team to implement improvement action plan. **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Oct 2018	High	**09 Oct 2018** The waiting times are reducing as the plan is invoked.	
						Increased endoscopy resource achieved through outsourcing using an agency contract which will run for 1 year whilst internal resource is being created **Control Owner:** Lisa Neal	Adequate		Implement cancer 62 treatment recovery plan **Person Responsible:** Elizabeth Mount **To be implemented by:** 25 Dec 2018	High	**09 Oct 2018** Good progress is being made and the standard compliance is improving.	
						Process outlined for clinicians to complete initial screening of pathway delays **Control Owner:** Lee Martin	Adequate					
						The pathway for the cancer of unknown primary is through the upper GI MDT with onward referral to the relevant MDT if the primary becomes known **Control Owner:** Elizabeth Mount	Adequate					
						Tracking system in place with an updated position disseminated weekly. **Control Owner:** Lee Martin	Adequate					
						Use of Datix incident reporting for all delayed cancer patients to improve visibility of patient affected. **Control Owner:** Helen Goodwin	Adequate					
						WHH endoscopy unit JAG accredited **Control Owner:** Lisa Neal	Substantial					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 28	Lack of timely recognition of serious illness in patients presenting to the Emergency Departments **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Syed Gilani **Last Updated:** 09 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** With the improvement in middle grade recruitment there has been an improved percentage of patients seen within 1 hour and critically introduction of 2 hourly rounding	06 Jul 2016	**Cause** * Delay in assessment and evaluation of patients due to overcrowding in the Emergency Departments and lack of flow through the Emergency Care Pathway *Increased and unplanned local demand for emergency services that the Trust is unable to meet with the resources and infrastructure available *Over time the demography, comorbidity and acuity of ED attendees has changed, together with the rise in number of attendees, resulting in an increased requirement for conversion to admission *Inability to recruit into consultant and middle grade posts *Lack of availability of GP at the front door *Failure of the NHS 111 to provide appropriate advice * Surge resilience plans do not meet unprecedented demand * Lack of robust escalation plans * Failure to respond appropriately to the Operational Pressure Escalation Framework **Effect** * Poor Patient experience * Harm to Patients * Difficulties with staff recruitment and problems with staff retention * Breach of licence (Contract Performance Notice) * Regulatory concerns * Failure to retain STF funding * Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	A&E improvement Plan in place with work streams for Admission Avoidance, A&E Streaming, Improved Flow, Discharges and Workforce **Control Owner:** Lee Martin	Limited	I = 5 L = 4 Extreme (20)	Introduction and Evaluation of a Surgical Emergency unit at QEQM **Person Responsible:** Christine Hudson **To be implemented by:** 31 Oct 2018	High	**09 Oct 2018** The team continue to work out of the Physio gym at QE. Plans are afoot with regard to the substantive SEAU as part of the emergency floor developments.	I = 4 L = 3 Moderate (12)
						Accident and Emergency Delivery Board in place **Control Owner:** Susan Acott	Limited		Recruitment of acute physicians and specialty doctors establishment **Person Responsible:** Syed Gilani **To be implemented by:** 31 Dec 2018	High	**22 Oct 2018** Further advert for ED consultants is currently live, 1 applicant to date	
						Acute Medical Model in place **Control Owner:** Anil Verma	Limited					
						Daily intensive review/bed matching for emergency admissions not placed at time of review **Control Owner:** Lee Martin	Adequate		Resolution of over-crowding within the A&E departments leading to improved flow, improvement in ambulance handover and time to first clinician review metrics **Person Responsible:** Syed Gilani **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Monitored weekly at the ED Steering Group and daily through the ERP. Focus at the moment is on reducing the number of superstranded.	
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Lee Martin	Limited					
						Increased acute medical bed capacity through moving the cardiology ward to the Arundel suite as part of creating a cardiology inpatient area including CCU and general cardiology beds. Vacated space becomes an acute medical area **Control Owner:** Lesley White	Adequate		Create medical assessment areas as part of the emergency floor at both QEQMH and WHH **Person Responsible:** Tara Laybourne **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Plans are on track with both acute sites going live in October and November.	
						Increased opening hours of the surgical emergency assessment unit **Control Owner:** Christine Hudson	Adequate					
						Interim Hospital Directors in place at WHH and QEQM to support a greater site focus **Control Owner:** Lee Martin	Limited					
						Internal PMO service in place to manage the delivery of the A&E Improvement Plan **Control Owner:** Lee Martin	Adequate					
						Introduction of Bristol safety checklist in the EDs **Control Owner:** Elisa Steele	Adequate					
						Primary care service in place at QEQMH and WHH for a minimum of 6 hours per day, **Control Owner:** Anil Verma	Adequate					
						Review of Emergency Care Pathway and revised Improvement Plan **Control Owner:** Lee Martin	Adequate					
						SAFER bundle in place at K & CH **Control Owner:** Jonathan Purday	Limited					
						SAFER bundle in place at WHH **Control Owner:** Jonathan Purday	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						SAFER bundle in place in QEQM **Control Owner:** Paul Stevens	Limited					
						Single Health Resilience Early Warning Database (SHREWD) has been revised . It is expected that when the Trust is under pressure the system will respond with agreed actions **Control Owner:** Lee Martin	Limited					
						Weekly site based meetings in place designed to improve ownership of the emergency care pathway and reduce overcrowding in the emergency department **Control Owner:** Anil Verma	Adequate					
CRR 48	Challenges in embedding a mature and developed Patient safety culture across Obstetrics and Maternity **Risk Owner:** Sally Smith **Delegated Risk Owner:** Elhussein Rfidah **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and updated.	07 Feb 2017	**Cause** *Reports from both the Royal College of Obstetrics and Gynaecology (RCOG) and the Local Supervisory Authority (LSA) identified gaps in regulatory compliance and also other areas for improvement in maternity services *Recurrent incident themes *Difficulty in gaining engagement among some teams *Delays in prioritising quality transformation and education work streams *Low mandatory training figures *Failure to comply with policies/procedures **Effect** *Poor patient outcomes (potential harm to both pregnant women in our care and neonates) *Increased complaints/claims *Regulatory concerns *Reputational damage *Adverse effect on staff professional development * Never Event in maternity within past 12 months.	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Contract monitoring is in place bi-monthly with the CCGs. This provides assurance and progress against the plans and dashboard. **Control Owner:** Sharon Curtis	Adequate	I = 4 L = 4 High (16)	Deliver the actions and learning from the recent Never Event **Person Responsible:** Ursula Marsh **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** PLan is on track with no further NEs.	I = 3 L = 2 Low (6)
						Maternity Services Patient Safety Plan is in place and being implemented and monitored by the Division and Executive and CCGs. **Control Owner:** Sharon Curtis	Adequate		Ensure mandatory training is prioritised and staff undertake the required training **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Continuation of delivery of the training. New actions have been agreed as part of the CQC Plan.	
						Monthly performance meetings are in place as well as support meetings by the Executive Team. **Control Owner:** Sally Smith	Adequate		Produce and implement a transformation programme for Maternity which incorporates the outstanding actions from the existing action plans (including the RCOG Action Plan). **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2020	High	**09 Oct 2018** Plan is on track and is progressing well.	
						Never Event Action Plan is in place **Control Owner:** Ursula Marsh	Limited					
						Support in place from the Service Improvement Team, Dr Ciaran Crowe leading transformation and the Executive team. **Control Owner:** Sally Smith	Adequate					
						The RCOG and LSA Combined Action Plan in place **Control Owner:** Graham Ross	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 61	Failure to achieve the A&E Improvement Plan and evidence sustained improvements to the Emergency Care Pathway **Risk Owner:** Lee Martin **Delegated Risk Owner:** Lesley White **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions updated and risk reviewed.	18 Oct 2017	**Cause** *12 month delivery plan in place across east Kent. Concerns that there may be possible delays in delivery of the plan and that improvements may not be sustained due to: *Lack of ownership and engagement from Divisions *Conflicting priorities - operational pressures *Lack of appropriate bed base to support current capacity/ flow *Lack of capacity to deliver / implement and sustain change *Estate work delays *Inability to recruit to consultant and middle grade posts *Inability to resource the plan (finance) *Failure to engage external partners *Poor change management - inconsistent messages *Winter pressures and severity of flu **Effect** *Poor patient outcomes *Breach of licence (Contract Performance Notice) *Regulatory concerns *Reputational damage *Financial loss (circa £9.9m)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	2020 in place to focus on length of stay and supporting bed occupancy **Control Owner:** Lee Martin	Adequate	I = 4 L = 4 High (16)	Development of a pilot elective orthopaedic service at the K&C site. **Person Responsible:** Christine Hudson **To be implemented by:** 31 Dec 2018	Not Set	**22 Oct 2018** The new Theatres have arrived at K&C and are being installed.	I = 4 L = 3 Moderate (12)
						A&E Delivery Board in place **Control Owner:** Lee Martin	Adequate					
						A&E Improvement Director in place to support the delivery of the A&E Improvement Plan **Control Owner:** Lee Martin	Adequate		Recruitment of acute physicians and specialty doctors establishment **Person Responsible:** Richard Kingston **To be implemented by:** 31 Jan 2019	High	**09 Oct 2018** Successful middle grade recruitment - the plan continues to be effected.	
						Delivery plan in place with clear milestones **Control Owner:** Lee Martin	Adequate					
						Interim Hospital Directors in place at WHH and QEQM to support a greater site focus **Control Owner:** Lee Martin	Limited		Continue to deliver the actions to improve and sustain ED performance through the weekly meetings chaired by the COO. **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	Not Set	**22 Oct 2018** This action replaces the previous similar action but has moved to the COO to chair. Weekly reports are reviewed and new improvement actions agreed. Current focus is on the super stranded and stranded metrics to effect a step change.	
						Internal PMO service in place to manage the delivery of the A&E Improvement Plan **Control Owner:** Lee Martin	Adequate					
						Operational meetings in place **Control Owner:** Lee Martin	Limited					
						Programme management documentation (including risk log) developed **Control Owner:** Lee Martin	Limited					
						Robust Communications Strategy in place **Control Owner:** Natalie Yost	Adequate					
						Service Improvement Team in place **Control Owner:** Sarah Maycock	Adequate					
						Single oversight meetings in place **Control Owner:** Lee Martin	Limited					
						Trajectory in place identified by scheme and the monitoring of metrics that have been identified by NHSI **Control Owner:** Lee Martin	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 3	Inability to respond in a timely way to changing levels of demand for elective services **Risk Owner:** Lee Martin **Delegated Risk Owner:** Christine Hudson **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Job plan action shave been removed as the new round will commence in due course and the actions sit in another area.	05 Feb 2016	**Cause** * There is a increased and unplanned local demand for elective services that the Trust is unable to meet with the resources and infrastructure available. *Poor demand management. * Inability to recruit into Consultant and middle grade posts. *Lack of availability of Consultants due to sickness *Delays in information about Health/Screening campaigns *Backlog rollover from previous years *Demand from CCG's higher than agreed BP *No mechanism to sufficiently influence CCGs to improve pathways/tiers of care * Inpatient activity (DC, inpatients) not meeting BP * Failure to access our own surgical remit for the usage of beds for surgical patients/Emergency medical outliers in surgical beds *Failure to complete job planning *Referral management mechanisms in CCGs have resulted in a higher conversion rate to Surgery *Equipment failure leading to cancellations *Theatre unavailability **Effect** * Fail to meet RTT Standard * Harm to Patients * Breach of licence * Regulatory concerns * Reputational damage *Failure to retain STP Funding *Poor patient outcomes *Financial loss due to outsourcing of activities to the independent sector)	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Additional theatre lists in place **Control Owner:** Christine Hudson	Adequate	I = 4 L = 4 High (16)	A review of elective and trauma Orthopaedic capacity is being undertaken so that response to change in demand can be met. If funding is available this would include a pilot for orthopaedics which will increase emergency medical capacity on the WHH and QEQM sites as well as providing increased elective capacity across the Trust. **Person Responsible:** Christine Hudson **To be implemented by:** 31 Jan 2019	High	**09 Oct 2018** Plans are progressing with the move funded and staff being recruited.	I = 3 L = 2 Low (6)
						Annual business plan in place **Control Owner:** Lee Martin	Adequate					
						Daily intensive review/bed matching in place for elective admissions **Control Owner:** Lee Martin	Adequate					
						Demand and capacity reviewed and monitored in all areas outlined in the Operating Framework **Control Owner:** Lee Martin	Adequate					
						Each speciality supports dedicated validation time **Control Owner:** Christine Hudson	Adequate		Chronological booking of patients. **Person Responsible:** Christine Hudson **To be implemented by:** 31 Mar 2019	Not Set	**22 Oct 2018** The number of patients waiting a long time are steadily reducing. Daily and weekly meetings are in place to ensure we remain on trajectory.	
						Elective demand - Continuing to alert CCG colleagues to excessive demand and collaborating with them to provide alternatives to referral e.g. advice and guidance **Control Owner:** Lee Martin	Adequate					
						Escalations of capacity for outpatients and theatres happen as required **Control Owner:** Christine Hudson	Limited					
						Inpatient bed requirements for Surgical division completed **Control Owner:** Christine Hudson	Adequate					
						Numerical table of residual gap analysis in terms of capacity reported to Finance & Performance Committee **Control Owner:** Lee Martin	Adequate					
						Regular review of Performance for RTT where improvement plans have not delivered the required results **Control Owner:** Christine Hudson	Adequate					
						RTT - Recovery trajectory in place **Control Owner:** Christine Hudson	Limited					
						Support from the National Intensive Support Team (National team) - training and capacity planning (demand management for etc **Control Owner:** Christine Hudson	Limited					
						The Surgical Division continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations **Control Owner:** Christine Hudson	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 59	Potential delays in new and follow-up patient appointments **Risk Owner:** Lee Martin **Delegated Risk Owner:** Julia Bournes **Last Updated:** 09 Oct 2018 **Latest Review Date:** 10 Oct 2018 **Latest Review By:** Julia Bournes **Latest Review Comments:** The electronic referral system paper switch off programme for new patients has been implemented on 1.10.18. with utilisation now over 80%. The paper referral backlog for new patients is reducing with a plan to clear by the end of December 2018. Follow up waiting lists have now been implemented for all specialties as part of the Alscripts PAS launch. Work to develop standard operating procedures for the waiting list ownership and management is underway.	06 Sep 2017	**Cause** *Lack of out-patient clinic capacity to meet the increased referral and follow-up demands *Lack of visibility of the quantum of issues for specialties that do not have partial booking process for follow-up appointments **Effect** *Potential for patient harm *Failure to meet national performance standards *Regulatory concerns *Financial loss - contract performance notice/fines *Reputational loss	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	Annual review of capacity and demand using Production Plans as part of the Business planning process **Control Owner:** Philip Cave	Adequate	I = 4 L = 4 High (16)	Divisions to use the follow-up framework to assess their follow-up gap **Person Responsible:** Christine Hudson **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** The improvement work continues to reduce backlog.	I = 4 L = 2 Moderate (8)
						Outpatient Improvement Programme in place **Control Owner:** Julie Barton	Limited		Senior review of current demand in each specialty, led by the Clinical Support Services Division and profiling of future demand with a trajectory to reduce the current backlog **Person Responsible:** Julia Bournes **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Update is awaited.	
						Process in place for data validation **Control Owner:** Lee Martin	Adequate		Develop and roll-out a framework for quantifying and clinically prioritising and treating high risk patients across all Specialties **Person Responsible:** Julia Bournes **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Validation work is in progress.	
						Regular reporting of number of patients in each speciality that are waiting longer to be seen than the specialty milestone **Control Owner:** Jackie Tapp	Adequate		Develop a plan to ensure efficiencies in all clinics (for specialties that have implemented partial booking) **Person Responsible:** Lee Martin **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Focused work continues with OPD.	
						Regular review of capacity and demand by specialty reported in performance meetings **Control Owner:** Lee Martin	Limited		Divisions to use the follow-up framework to assess their follow-up gap **Person Responsible:** Lesley White **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Backlog work continues as part of the improvement plan.	
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Christine Hudson	Limited		Implement tiers of care for agreed specialties **Person Responsible:** Lesley White **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Rheumatology has been implemented.	
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Elizabeth Mount	Limited		Divisions to use the follow-up framework to assess their follow-up gap **Person Responsible:** Elizabeth Mount **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** The backlog work continues as part of the improvement plan.	
						Specialty Production plans in place to meet the new patient gap **Control Owner:** Lesley White	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
									Support the Specialties to improve and transform their outpatient pathways via the Outpatient Improvement Programme **Person Responsible:** Julia Bournes **To be implemented by:** 31 Mar 2019	High	**02 Aug 2018** Programme progressing, will pick up pace following the introduction of ERS and PAS.	
CRR 44	Failure to meet the Referral to Treatment (RTT) Standard for the Trust **Risk Owner:** Lee Martin **Delegated Risk Owner:** Christine Hudson **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions updated and risk reviewed.	02 Feb 2017	**Cause** * Inability to provide enough activity to sustain waiting list sizes * Backlog rollover from previous years * Demand from CCG's higher than agreed BP * Inpatient activity (DC, inpatients) not meeting BP * Failure to access our own surgical remit for the usage of beds for surgical patients * Failure to complete job planning *Referral management mechanisms in CCGs have resulted in a higher conversion rate to Surgery *Failure to phase the seasonal plan in line with emergency demand *Continued Increase in Orthopaedic & General Surgery waiting list additions *Higher than planned demand within business plan resulting in no flexibility within capacity in key specialities such as Orthopaedics, Dermatology, Maxillo Facial and Gynaecology *Recruitment constraints in services such as Neurology an Dermatology, leading to long outpatient waits *General Surgery capacity for patients presenting with high BMI for benign disease (single handed surgeon) creating 52 week waits *Gynaecology capacity for named sub-specialty conditions resulting in 52 week waits *ENT surgical demand remains in excess of capacity in key subspecialties resulting in 52 week waits **Effect** *Poor patient outcomes *Financial loss due to outsourcing of activities to the independent sector) *Breach of licence (Contract Performance Notice) *Reputational damage *Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	A joint improvement plan is in place and supported by NHS Elect **Control Owner:** Christine Hudson	Limited	I = 4 L = 4 High (16)	Review of 1st appointment booking capacity and booking processes **Person Responsible:** Christine Hudson **To be implemented by:** 31 Oct 2018	High	**22 Oct 2018** Improvement actions are in place to deliver this and monitored at least weekly, and more often.	I = 4 L = 2 Moderate (8)
						Action plans in key specialties to ensure improved performance **Control Owner:** Christine Hudson	Limited		Increase theatre utilisation to 50 weeks per year **Person Responsible:** Christine Hudson **To be implemented by:** 31 Oct 2018	High	**22 Oct 2018** Plans are in place to deliver this action.	
						Escalations of capacity for outpatients and theatres happen as required **Control Owner:** Christine Hudson	Limited		Each Division is required to review the capacity and demand plan in line with RTT achievement and submit business cases for any additional capacity (if required)" **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Weekly meetings are in place to monitor the improvements that are reported monthly via the IPR.	
						Focused management of undated pathways waiting over 30 weeks and risks to 52 weeks, particularly within General Surgery, ENT and Gynaecology **Control Owner:** Christine Hudson	Adequate		Surgical Specialties to develop and implement action plans "Get it right first time" which will include meeting RTT **Person Responsible:** Christine Hudson **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** The programme continues with the national team and is reported through Quality Committee.	
						Improved Slot Utilisation – The Trust has developed operational datasets to locate and identify and fill unused slots **Control Owner:** Christine Hudson	Limited		Each Division is required to review the capacity and demand plan in line with RTT achievement and submit business cases for any additional capacity (if required)" **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Improvements are in place as per the plan and reported monthly in the IPR to Board.	
						Recovery trajectory in place **Control Owner:** Christine Hudson	Limited		Each Division is required to review the capacity and demand plan in line with RTT achievement and submit business cases for any additional capacity (if required) **Person Responsible:** Karina Greenan **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** RTT improvement work continues and is monitored and reported via the IPR to the Board of Directors.	
						Saturday working in new consultants contracts across the trust to improve utilisation of theatre capacity and increase capacity **Control Owner:** Christine Hudson	Adequate					
						The new Interactive Patient Tracking Technology is in place which allows real time recording of patient pathways and supports the operational teams in delivery **Control Owner:** Christine Hudson	Limited					
						The Surgical Division continues to deliver the cost improvement programmes for theatres (Capacity) including utilisation, dropped session review and cancellations **Control Owner:** Christine Hudson	Limited					
						Validation in place **Control Owner:** Louise Pallas	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 65	Risk of prosecution by the CQC for a breach of parts 20(2)(a) and 20(3) of the Duty of Candour regulation without first serving a Warning Notice **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 22 Oct 2018 **Latest Review Date:** 01 Oct 2018 **Latest Review By:** Jonathan Purday **Latest Review Comments:** The duty of candour compliance is now almost 100% in specialist and CSSD. UCLTC still has poor and disorganised duty of candour compliance. The new care group structure will allow a complete review of the governance structure - particularly within UCLTC (now split into acute & Specialist)	20 Feb 2018	**Cause** * Continued poor compliance with Duty of Candour * Delay or uncertainty regarding the severity of the incident reported contributes to lack of compliance * A lack of clarity regarding responsibility for completing the formal letters confirming the Duty of Candour conversation * Concerns regarding the 'right' time to fulfil requirements – this is more of a concern when there has been a delay in identifying the incident or completing the Duty of Candour conversation * Concerns that the patient or family questions cannot be answered immediately * Limited formal Duty of Candour training available * Low training attendance for Duty of Candour training **Effect** * Reputational damage * Missed opportunities to engage with patients and families regarding an adverse event leading to complaints and subsequent claims * Professional misconduct * Breach of contractual obligations to provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurs (a 'reportable patient safety incident' is one which could have or did result in moderate or severe harm or death). * Potential fines for non-compliance	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Appointment of Duty of Candour guardian with responsibility for overseeing Duty of Candour Trustwide **Control Owner:** Jonathan Purday	Limited	I = 4 L = 4 High (16)	Implement the Duty of Candour Action Plan **Person Responsible:** Nicholas Goodger **To be implemented by:** 31 Oct 2018	High	**09 Oct 2018** Surgery showing an improved and sustained position for initial and final DOC compliance.	I = 4 L = 2 Moderate (8)
						Circulation of Action Against Medical Accidents (AvMA) and NHS Resolution Duty of Candour Leaflets to Divisions and at Clinical Induction **Control Owner:** Melinda Brewer	Limited		Monthly challenge of divisional Duty of Candour performance at the executive performance meetings **Person Responsible:** Paul Stevens **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Monthly performance is showing an improved position in all areas with Surgery and Specialist areas having this improved performance sustained. Action date extended to provide further assurance in ED, UC and CSSD.	
						Compliance updates provided to the Patient Safety Board **Control Owner:** Melinda Brewer	Limited					
						Duty of Candour Action Plan in place for Urgent Care & LTC **Control Owner:** Anil Verma	Limited		Implement the Duty of Candour Action Plan **Person Responsible:** Richard Kingston **To be implemented by:** 29 Mar 2019	High	**09 Oct 2018** Performance is improved slightly but progress is not sustained.	
						Duty of Candour presentations provided at the QII Hubs **Control Owner:** Melinda Brewer	Limited					
						Duty of Candour training in place **Control Owner:** Melinda Brewer	Limited					
						Trust-specific Duty of Candour leaflets in place and disseminated to Governance teams **Control Owner:** Melinda Brewer	Adequate					
						Updated Datix Duty of Candour page. This page has been updated to enable easy and rapid completion of the Duty of Candour with links to patient information leaflets and to the Trust Duty of Candour webpage for further information **Control Owner:** Melinda Brewer	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 36	Inadequate Safeguarding training arrangements Trust-wide (adult and children) **Risk Owner:** Sally Smith **Delegated Risk Owner:** Carol Tilling **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk has been reviewed and the actions updated.	09 Sep 2016	**Cause** *Lack of access to current training data *Failure to prioritise training attendance * Lack of clarity as to what level of training people require (the staff themselves) **Effect** *Regulatory concerns *Legal challenge *Reputational loss *Failure to meet performance standard	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 5 Extreme (20)	Adult Safeguarding training delivered by e-Learning with face to face training every 3 years at level 2 (Adult) **Control Owner:** Helen Goodwin	Adequate	I = 4 L = 4 High (16)	A review of the training needs analysis **Person Responsible:** Carol Tilling **To be implemented by:** 31 Dec 2018	Not Set	**09 Oct 2018** This too will commence this month.	I = 3 L = 2 Low (6)
						Child Safeguarding training delivered by e-Learning with face to face training every 3 years at level 2 (Children) **Control Owner:** Carol Tilling	Adequate		Implement improvement plans for Children safeguarding training. **Person Responsible:** Carol Tilling **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** New actions have been agreed to meet this standard by the timeframe. Actions are included in the CQC Plan.	
						Improvement plans and trajectory in place (Adult) **Control Owner:** Sally Hyde	Adequate		A cleansing of ESR to ensure accurate reporting **Person Responsible:** Carol Tilling **To be implemented by:** 31 Dec 2018	Not Set	**09 Oct 2018** This will commence this month.	
						Improvement plans and trajectory in place (Children) **Control Owner:** Carol Tilling	Limited		Recruit additional staff to the team to help with training and also safeguarding activity. **Person Responsible:** Carol Tilling **To be implemented by:** 31 Jan 2019	Not Set	**09 Oct 2018** Business case has been approved and recruitment has commenced.	
						Monthly training sessions on all sites (Adult) **Control Owner:** Helen Goodwin	Limited		Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Elizabeth Mount **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Awaiting September data then will update.	
						Non compliant staff are known by name on a monthly basis and followed up. **Control Owner:** Sally Smith	Adequate		Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Heather Munro **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Awaiting September data then will update.	
						Safeguarding Team in place **Control Owner:** Sally Smith	Adequate		Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Julie Barton **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Awaiting September data then will update.	
						Training needs analysis and Training Programme in place. Training support provided using QII Hubs (Adult) **Control Owner:** Helen Goodwin	Adequate		Divisions are required to prioritise safeguarding training and ensure staff are released to meet the 85% compliance standard. **Person Responsible:** Elisa Steele **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Awaiting September data then will update.	
						Training needs analysis in place at ward/department level (Children) **Control Owner:** Carol Tilling	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 51	Patient safety may be compromised as a result of the move of acute medicine, acute geriatric medicine and Stroke from the K&C site **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 01 Oct 2018 **Latest Review Date:** 01 Oct 2018 **Latest Review By:** Jonathan Purday **Latest Review Comments:** The continued safety of patients on the K & C site is continuously monitored. There have been a few inappropriate transfers but systems have been put in place to prevent recurrence. There has been no evidence that vascular or urology patients care has deteriorated following the move of medicine from the site.	11 Apr 2017	**Cause** *Temporary transfer of acute medicine, geriatric medicine and Stroke from the K&C site *On K&C site we may not have the right level of medical cover for all the specialties that remain on the site *Ambulance handover delays *Patients transferring between sites *Imbalance between substantive consultants and locum consultant posts leading to unsatisfactory trainee doctors education experience **Effect** *Potentially avoidable moderate or severe harm or death *Overcrowding at WHH & QEQM (negative bed position) *Reputational damage *Legal challenge *Regulatory concerns *Additional costs required for changes to services	AO1: Patients. Help patients take control of their own health	I = 5 L = 4 Extreme (20)	Increased proportion of patients treated through ambulatory care **Control Owner:** Jonathan Purday	Adequate	I = 5 L = 3 High (15)	Implementation of the East Kent Clinical Strategy through the STP process **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Public consultation is reliant on the pre-consultation business case (PCBC). Clinical Commissioning Groups now identified the timeline PCBC to be drafted by December 2018.	I = 5 L = 2 Moderate (10)
						Oversight group in place **Control Owner:** Lee Martin	Adequate					
						Patients return to the K&C site only once medically optimised **Control Owner:** Lee Martin	Adequate		Fully implement the acute medical model on WHH & QEQM sites **Person Responsible:** Richard Kingston **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Action changed to reflect new Care Group management structure and realistic target date. Risk re-opened due to potential risk associated with the move of elective orthopaedic surgery to K&C site.	
CRR 56	Inadequate critical care capacity **Risk Owner:** Sally Smith **Delegated Risk Owner:** Christine Hudson **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and actions updated.	02 Aug 2017	**Cause** *Significant growth in emergency demand nationally for critical care beds insufficient to meet acuity *More people surviving with comorbidities * Increased activity of the PPCI service in WHH - out of hospital cardiac arrests who require increased length of stay **Effect** *Potential harm to patients/patient safety concerns *Cancellations of elective surgery *Nursing patients outside the foot print of the Critical Care Unit, theatre recovery and ED *Increase in non-medical transfers between sites *Inability to recruit and retain medical and nursing staff *Delays in admitting patients *Financial loss - no funding if patients are not in a critical care beds *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Admissions, Discharge and Transfer policy in place **Control Owner:** Deborah Higgs	Limited	I = 3 L = 4 Moderate (12)	Deliver on the clinical strategy expand capacity for critical care to meet population needs. **Person Responsible:** Deborah Higgs **To be implemented by:** 31 Mar 2019	High	**22 Oct 2018** The business case is going to FPC in October.	I = 2 L = 3 Low (6)
						Capacity and demand is known **Control Owner:** Deborah Higgs	Limited					
						Movement of nursing staff across sites to support activity **Control Owner:** Deborah Higgs	Limited					
						The Critical Care Escalation plan (part of the Admission, Discharge and Transfer Policy) includes plans for a surge in demand for the 3 acute sites. **Control Owner:** Deborah Higgs	Limited					
						Utilise critical outreach team to care for patients outside of the critical care unit **Control Owner:** Deborah Higgs	Limited					
						Utilise skilled staff to ensure patient safety **Control Owner:** Deborah Higgs	Limited					
						Utilising extended recovery in a planned way for a period of 9 months. 5 key competencies will be developed to support recovery staff and both the ITU and theatre matrons will manage **Control Owner:** Jane Kirk-Smith	Adequate					
						Utilising extended recovery in a planned way for a period of 9 months. 5 key competencies will be developed to support recovery staff and both the ITU matron and theatre manager will manage **Control Owner:** Deirdre McFarlane	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 20	Failure to send timely information to GPs on their patients who have had an outpatient appointment **Risk Owner:** Lee Martin **Delegated Risk Owner:** Julie Barton **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and updates noted.	24 Apr 2016	**Cause** * Lack of knowledge of performance standards * Lack of consistent monitoring of performance standards * Gaps in administration workforce e.g. ENT **Effect** * Failure to meet performance standard * Patients ongoing care is delayed * Breach of licence (Contract Performance Notice) - financial penalty up to 10% of monthly income (circa £3.3m) * Reputational damage * Potential harm to Patients *Increased pressure on staff leading to low staff morale	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 3 L = 5 High (15)	Deep-dives carried out with corresponding action plans in place **Control Owner:** Julie Barton	Adequate	I = 3 L = 4 Moderate (12)	Implement Divisional GP Letter Action Plans **Person Responsible:** Elizabeth Mount **To be implemented by:** 30 Sep 2018	High	**22 Oct 2018** Update awaited although improvement is underway.	I = 3 L = 2 Low (6)
						Dual reporting in place **Control Owner:** Julia Bournes	Adequate		Implement Divisional GP Letter Action Plans **Person Responsible:** Karina Greenan **To be implemented by:** 30 Sep 2018	High	**22 Oct 2018** Update awaited for this month.	
						Performance standards for response times agreed and monitored against the standards **Control Owner:** Julie Barton	Adequate		Implement Divisional GP Letter Action Plans **Person Responsible:** Mark Dwyer **To be implemented by:** 30 Sep 2018	High	**22 Oct 2018** Improvement work is being implemented - actual status is awaited.	
						Process for Vacancy Panel approval in line with agreed priority in place **Control Owner:** Lee Martin	Adequate		Implement Divisional GP Letter Action Plans **Person Responsible:** Christine Hudson **To be implemented by:** 30 Sep 2018	High	**22 Oct 2018** Outsourced the typing in the Care Group so there is no delay.	
						Regular feedback from GPs highlighting concerns **Control Owner:** Julie Barton	Adequate		Roll-out OpenEyes system to enable letters to Ophthalmology Patients be produced in a timely manner **Person Responsible:** Andy Barker **To be implemented by:** 31 Oct 2018	High	**22 Oct 2018** T3 remains on track to deliver this action.	
						Trust-wide Administrative review to ensure design of new roles to focus on patients pathway (including ensuring correspondence are delivered in a timely way) has been implemented. **Control Owner:** Christine Hudson	Limited					
						Typing of letters outsourced to an external provider with clear turnaround targets **Control Owner:** Julie Barton	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 16	Poor complaints management **Risk Owner:** Sally Smith **Delegated Risk Owner:** Jane Christmas **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed. New action has been added around reviewing the processes.	24 Apr 2016	**Cause** -There is an increasing complexity in the scope and nature of concerns raised. - The processes in divisions and within the Patient Experience Team have resulted in delays across the whole pathway. - There is a gap in communication between the PET and the Care Group governance teams. - The Care Group teams do not always receive timely notification of written complaints. - Staff shortages are impacting on the management of complaints. **Effect** - The ability of the Trust to respond within the 30 days of receipt is not being met consistently. - The time-frame agreed with the complainant is often being met but the quality of the Trust's response is sometimes failing to meet expectation. - There are a number of returners and dissatisfaction - Reputational loss	AO1: Patients. Help patients take control of their own health	I = 3 L = 5 High (15)	Complaints Policy and Process in place **Control Owner:** Jane Christmas	Limited	I = 3 L = 4 Moderate (12)	Implementation of detailed action plan. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Dec 2018	Not Set	**22 Oct 2018** This month the team have been working on reducing the backlog. Monthly meetings are in place with the Care Group leads. Complaints are now shared with the Care Group Head of Nursing and not just the Governance leads to ensure adequate oversight at a senior level.	I = 3 L = 3 Moderate (9)
						Complaints team in place with staff based on the three main sites. **Control Owner:** Jane Christmas	Adequate					
						Detailed action plan in place monitored by the Complaints and Patient Feedback Group. **Control Owner:** Jane Christmas	Limited		Review of the complaints process and make recommendations. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Dec 2018	Not Set	**22 Oct 2018** A peer review of the complaints process has been arranged for 24th October with a neighbouring Trust. This will identify areas for streamlining and for improvement. New actions have been implemented to strengthen escalation and timeliness of responding to complaints. Monthly meetings with Care Groups to address complaints that have been open greater than 60 days. This backlog is reducing.	
						Process is in place to prevent data capture anomalies **Control Owner:** Jane Christmas	Adequate					
						Regular review of the complaint KPIs with Divisional leads **Control Owner:** Jane Christmas	Adequate					
						The Datix system is used to record complaints and Trust responses. This system can monitor agreed time scales and record satisfaction with the responses. **Control Owner:** Helen Goodwin	Adequate		A training programme needs to be developed and implemented for staff according to a training needs analysis. **Person Responsible:** Jane Christmas **To be implemented by:** 31 Mar 2019	Medium	**22 Oct 2018** Similar to last month the actions continue with Feedback Friday sessions are in place as well as 'It is good to talk' sessions. With the new Care Groups training and education will be given.	
						The PET provide support and specific training in the management of complaints to staff in all clinical and non-clinical divisions. **Control Owner:** Sally Smith	Limited					
						The Trust responds to its legal and professional duty of candour **Control Owner:** Paul Stevens	Limited					
						Web-based complaints management system in place **Control Owner:** Jane Christmas	Adequate					
CRR 46	Delays in signing off and implementing Consultant job plans **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Jonathan Purday **Last Updated:** 15 Aug 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** The divisional structure has now been replaced by the 7 Care Groups. At the time of switch to care groups 305 out of 392 job plans were fully signed off (77.8%). A further 56 job plans in progress (14%), 4 job plans are awaiting for 3rd sign off, 16 job plans are awaiting for 2nd sign off and 36 job plans are awaiting for 1st sign off.	02 Feb 2017	**Cause** Complexity of job planning not well understood Original timetable was not realistic Competing demands **Effect** *Potential mismatch between capacity and demand. *Potential Poor Patient outcomes *Reputational damage *Financial loss (Circa £840k) *Negative impact on clinical engagement	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 4 High (16)	Diary card templates are available for doctors to use to help inform and populate their job plans **Control Owner:** Paul Stevens	Adequate	I = 4 L = 3 Moderate (12)	**Person Responsible:** **To be implemented by:**			I = 3 L = 2 Low (6)
						Job planning policy in place **Control Owner:** Paul Stevens	Limited					
						Job Plans in place **Control Owner:** Sandra Le Blanc	Limited					
						Monthly compliance reports produced and distributed by the Medical Directors office **Control Owner:** Paul Stevens	Limited					
						Process in place for implementing pay changes as agreed by EMT and Management Board **Control Owner:** Sandra Le Blanc	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 41	Failure to manage Patients with challenging behaviour (Dementia and other mental health challenges) **Risk Owner:** Sally Smith **Delegated Risk Owner:** Sally Hyde **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and the actions have been updated.	07 Nov 2016	**Cause** *Increased number of long-stay Patients/delayed discharge *National shortage of Mental Health Nurses *Mental Health Liaison and Crisis teams are unable to recruit into their current vacancies and have relied on agency cover to maintain their rotas. *There is a national shortage of in-patient mental health beds **Effect** *Potential harm to Patients, Staff and Visitors *Patients with recognised mental health disorders may not be treated in a timely way. *There is an increasing number of calls to security and to SafeAssist Acute to manage challenging and violent behaviour. *Other patients are put at risk of harm from violent episodes. *Patients who require in-patient Mental Health Services are managed in acute facilities which are not fit for this purpose.	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	Agency RMN used **Control Owner:** Lee Martin	Adequate	I = 3 L = 4 Moderate (12)	Monitor compliance with the Smart tool usage through the Safeguarding & Dementia teams **Person Responsible:** Sally Hyde **To be implemented by:** 30 Nov 2018	High	**22 Oct 2018** The report has not been received yet, so this will be chased in November.	I = 3 L = 2 Low (6)
						Agreed SOP in place to order additional nursing staff when a mental health patient has attended or is admitted. RMN, then RN, then HCA if the others are not available **Control Owner:** Sally Smith	Adequate		Review of the policy and action cards to manage challenging behaviour in the clinical areas. **Person Responsible:** Sally Smith **To be implemented by:** 31 Dec 2018	Not Set	**22 Oct 2018** This action has yet to be completed but in progress.	
						Dementia friendly services, environment and specialist team **Control Owner:** Sally Smith	Adequate		Plans being formulated to ensure 24 hour cover across the Trust by 2020. Mental Health Commissioner locally is leading the commission intentions up to this date. **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	Not Set	**22 Oct 2018** Crisis guidance presented at the A&E Delivery Board with new standards being proposed for contract compliance and better care of the mentally unwell person. Regular meetings are in place.	
						Increase in cover arrangements for a 12 hour period across all 3 sites in place **Control Owner:** Lee Martin	Adequate		Implementation of the new guidance for caring for mental health patients in an acute hospital **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2019	Not Set	**22 Oct 2018** Scoping of what actions need to be taken is in progress. We are working closely with KPMT at all times.	
						Nominated consultant psychiatrist cover for each site with Band 7 RMN and 5 x Band 6 support to cover 08:00 to 20:00 hours. **Control Owner:** Lee Martin	Adequate		CQC registration is being explored. **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2019	Not Set	**22 Oct 2018** Awaiting final guidance from the CQC following a detailed telephone meeting with the regulators. This action should be completed within November.	
						Psychiatric Liaison services to the EDs at QEQM will be 24 hours per day as well as 7 days per week. At WHH and the MIU at K&C the service remains the same. **Control Owner:** Sally Smith	Adequate					
						Regular escalation and meeting between the Trust COO and the COO of KMPT and the CCG is in place. **Control Owner:** Lee Martin	Adequate					
						Single point of access for referrals for emergency and urgent patients from 01 April 2016 with a separate crisis team covering this area. Arrangements for other patients, including self-referrals and existing patients set up though GPs and NHS111 **Control Owner:** Lee Martin	Adequate					
						Smart tool usage at Wards & Departments with Patients who display challenging behaviour **Control Owner:** Sally Hyde	Limited					
						Specialling Policy is in place **Control Owner:** Sally Smith	Adequate					
						Use of NHSP registered mental health nurses **Control Owner:** Sally Smith	Limited					
						Use of Safe Assist to maintain safety of Patients and Staff **Control Owner:** Fin Murray	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 34	Inadequate Health & Safety (H&S) systems embedded within the Divisions **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and actions updated with one action note to be re-entered.	09 Sep 2016	**Cause** * Failure to address H&S issues/incidents/themes within Divisions * Lack of appropriate H&S systems *Inconsistency in H&S processes **Effect** *Potential breach of H&S regulations which may result in penalty notices and significant fines *Harm to Staff *Reputational damage *Financial loss *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Annual H&S Toolkit Audit **Control Owner:** Elizabeth Shutler	Adequate	I = 4 L = 3 Moderate (12)	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	Not Set	**09 Oct 2018**	I = 4 L = 2 Moderate (8)
						Divisional deep-dives presented to IAGC by the Divisions **Control Owner:** Elizabeth Shutler	Limited					
						Divisional H&S Improvement Trajectory in place **Control Owner:** Fin Murray	Limited		Ensure the new Care Groups achieve compliance with the H&S training KPIs. **Person Responsible:** Rachael Westerman **To be implemented by:** 29 Mar 2019	Not Set	**09 Oct 2018** Quarterly stats being developed and shared with Care Groups.	
						Divisional H&S structures in place **Control Owner:** Fin Murray	Adequate					
						Divisional nominated H&S Link workers **Control Owner:** Fin Murray	Adequate					
						H&S KPIs reported to Board monthly via the IPR **Control Owner:** Fin Murray	Adequate		To improve attendance at committees, we are combining Site H&S meetings with Site Governance Meetings, chaired by the Site Director. **Person Responsible:** Rachael Westerman **To be implemented by:** 31 Mar 2019	Not Set	**21 Sep 2018** Pilot started at QEQM.	
						H&S module part of mandatory training for all staff **Control Owner:** Andrea Ashman	Adequate					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Julie Barton	Adequate					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Lesley White	Limited					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Elizabeth Mount	Adequate					
						H&S Risks are recorded on Local Risk Registers on 4Risk **Control Owner:** Christine Hudson	Limited					
						Oversight by Trust Board **Control Owner:** Elizabeth Shutler	Adequate					
						Site based H&S Committee in place **Control Owner:** Fin Murray	Adequate					
						Site based Health and Safety Teams in place **Control Owner:** Fin Murray	Adequate					
						Strategic H&S Committee in place **Control Owner:** Elizabeth Shutler	Adequate					
						Training programme in place **Control Owner:** Fin Murray	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 60	Potential negative impact during transition from paper health records to T3 (Transformation Through Technology) **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Lindsey Shorter **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions have been updated and reviewed.	10 Oct 2017	**Cause** *New Trust-wide clinical transformation programme (T3 Programme) that introduces new technology to replace paper health records. This includes ePrescribing; functionality to record the management and treatment of patients; functionality to manage and document patient activity through theatres; Order Comms (requests and results for pathology etc.) and Clinical documentation. *Lack of engagement between supplier and clinicians *Supplier fails to understand clinical requirements *Lack of capacity of the Programme and operational teams *Resistance to change **Effect** *Sub-optimal system with potential gaps and/or loss of Patient information leading to: *Potential harm to Patients *Regulatory concerns *Reputational damage *Financial loss *Failure to realise benefits	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Clinical and Technical leads in place **Control Owner:** Lindsey Shorter	Adequate	I = 4 L = 3 Moderate (12)	Agree timescale for the detailed plan and commercials. **Person Responsible:** Lindsey Shorter **To be implemented by:** 31 Oct 2018	High	**09 Oct 2018** Commercial discussions progressing with plan to complete by end October 2018.	I = 4 L = 3 Moderate (12)
						Clinical Safety Risk Management Strategy and Plan in place in line with NHS Digital Guidance **Control Owner:** Lindsey Shorter	Adequate					
						External Assurance Process in place for T3 **Control Owner:** Lindsey Shorter	Substantial		T3 Programme to be included in next years (commences July 18) RSM Tennon Audit Programme. **Person Responsible:** Lindsey Shorter **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Audit scope from RSM Tennon to be presented and agreed at T3 Programme Board on 15/10/18.	
						Governance structure in place for the T3 Programme. **Control Owner:** Lindsey Shorter	Adequate					
						Programme Director in post leading the T3 Programme **Control Owner:** Andy Barker	Adequate					
						Readiness of the Trust for the T3 Programme has been reviewed **Control Owner:** Richard Earland	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 58	Failure to embed Risk Management within the Divisions **Risk Owner:** Sally Smith **Delegated Risk Owner:** Helen Goodwin **Last Updated:** 22 Oct 2018 **Latest Review Date:** 12 Oct 2018 **Latest Review By:** Helen Goodwin **Latest Review Comments:** Internal audit report going to the October IAGC. There may be additional actions that arise with the change to Care Groups and resonsibilities	21 Aug 2017	**Cause** *The need for improved engagement from Divisions in the Trust Risk Management process; this is reflected in the failure to provide assurances on risks escalated to the Corporate Risk Register *Inconsistency in Risk Governance arrangements across Divisions *Ineffective risk management support structure at Divisional level *Poor usage of new risk system (4Risk) *Failure to prioritise risk management training *Lack of knowledge of risk management *Absence of risk registers in some Wards, Specialties and Departments **Effect** *Failure to deliver the Trust Strategic Priorities (4Ps - Patients, Provision, People, Partnerships) *Potential patient safety concerns *Financial loss *Regulatory concerns (This risk also links to the revised NHS Improvement Leadership and Improvement Capability Themes (Well-Led) within the Single Oversight Framework (SOF) where risk management is now specifically expressed) *Reputational damage *Legal challenge	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	4Risk face to face training completed for key staff **Control Owner:** Helen Goodwin	Adequate	I = 4 L = 3 Moderate (12)	A review of the 'Well Led' CQC domain with each Division to take place. **Person Responsible:** Sally Smith **To be implemented by:** 30 Nov 2018	High	**12 Oct 2018** Programme of reviews in place but the change in Care Group structures and new leadership teams may take more time to embed; target date for action therefore amended.	I = 4 L = 1 Low (4)
						4Risk Training resources in place (training videos, guidance and help manuals) **Control Owner:** Helen Goodwin	Adequate					
						Annual Risk Management Refresher Training/Workshop for Divisional Leaders **Control Owner:** Helen Goodwin	Limited		Revise the structure on 4Risk in line with revised organisational structures. **Person Responsible:** Helen Goodwin **To be implemented by:** 30 Nov 2018	Medium	**09 Oct 2018** New action added to revise the structure on 4Risk in line with the changes to care groups.	
						Annual Risk Maturity Assessment in place **Control Owner:** Helen Goodwin	Adequate		Care Groups to review their Risk Management Governance arrangements to ensure alignment with the Trust Risk Management Policy **Person Responsible:** Helen Goodwin **To be implemented by:** 30 Nov 2018	High	**22 Oct 2018** Care Group Governance structure currently being reviewed and strengthened as part of the bedding in of the new Care groups.	
						Dedicated Risk Management resource in place for the Trust (at Corporate level) **Control Owner:** Helen Goodwin	Limited					
						Divisional risk registers on the 4Risk system **Control Owner:** Helen Goodwin	Limited		Consider introducing the role of Divisional/Local Risk Champions in 2017/18 to support embedding Risk Management across Divisions **Person Responsible:** Helen Goodwin **To be implemented by:** 30 Dec 2018	High	**15 Aug 2018** THis is part of the internal audit actions	
						Local Risk Registers on the 4Risk system **Control Owner:** Helen Goodwin	Limited					
						Quarterly risk review meetings with Divisional Risk Owners **Control Owner:** Helen Goodwin	Adequate					
						Risk Management communicated to staff via various channels - including dedicated risk management page on Staff Zone, risk management blogs, bi-monthly 4Risk Drop-in sessions in QII Hubs at QE, WH and K&C **Control Owner:** Helen Goodwin	Adequate		Carry out and implement actions from Internal Audit review of Risk Management arrangements in Divisions when audit report is approved. **Person Responsible:** Helen Goodwin **To be implemented by:** 31 Mar 2019	High	**02 Aug 2018** This report has just been received and is being rolled out over teh remainder of the financial year.	
						Risk Management Governance arrangements in place at Risk Group, EPR, Management Board, Strategic H&S Committee, Divisional Governance Board, IAGC and Board **Control Owner:** Helen Goodwin	Limited					
						Risk Management Handbook in place that provides detailed guidance on the Trust Risk Management process **Control Owner:** Helen Goodwin	Adequate					
						Risk Management Strategy and Policy in place **Control Owner:** Helen Goodwin	Adequate					
						Trust Risk Leadership Behaviours in place **Control Owner:** Helen Goodwin	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 37	Potential negative impact of PAS system implementation on 18 weeks Referral to Treatment (RTT) **Risk Owner:** Lee Martin **Delegated Risk Owner:** Christine Hudson **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed and the action updated. Date changed as the team are still validating and gathering information from during this time.	04 Oct 2016	**Cause** *Potential reduction of clinics for outpatients for a three week period *Inability to accurately record timeliness from referral to treatment **Effect** *Potential harm to Patients *Reputational damage *Financial loss (circa £200k) *Regulatory concerns (linked to Trust License)	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	Detailed Information Database linking back to demand and capacity model that quantifies activity and the plans to bring the activity forward and any alternative provision if unable to do so **Control Owner:** Julia Bournes	Adequate	I = 4 L = 3 Moderate (12)	Implementation of Staff Training plan to ensure no disruption in activities during go-live period **Person Responsible:** Debbie Lowes **To be implemented by:** 30 Nov 2018	High	**22 Oct 2018** PAS now implemented and on going training is in progress for staff who still require it. Service disruption was minimal. The programme has been carefully managed on an hour by hour basis.	I = 4 L = 2 Moderate (8)
						Lessons learned/Advise received from other Trusts that have implemented PAS **Control Owner:** Julia Bournes	Adequate					
						Validation and closure of open out patient pathways , so that a reduced volume are transferred over to the new system - this will support delivery of RTT pathways and minimise time taken to validate. **Control Owner:** Lee Martin	Adequate					
CRR 47	Inability to prevent deterioration in the number of healthcare associated infection metrics **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Valerie Harmon **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions reviewed and updated and risk reviewed.	07 Feb 2017	**Cause** Lack of adherence to basic infection prevention control policies and procedures **Effect** * Increased exposure of Patients to Healthcare Associated Infections (HCAIs) such as MRSA, E.coli, C.difficile and Glycopeptide Resistant Enterococcus (GRE). *Potential hospital acquired water borne infection such as Legionella and Pseudomonas *Poor patient outcomes Increased hospital length of stay *Failure to meet targets *Financial loss - financial penalty *Regulatory concerns	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Back to basics campaign with a focus on hand hygiene rolled out **Control Owner:** Valerie Harmon	Adequate	I = 4 L = 3 Moderate (12)	Creation of a cross health economy collaborative to develop and implement bundles of care aimed at reducing the rate of E. coli bacteraemia both in hospital and in the community **Person Responsible:** Valerie Harmon **To be implemented by:** 25 Dec 2018	High	**22 Oct 2018** Collaboration and cross system working is in progress with peer review and support with the delivery of our plans.	I = 4 L = 2 Moderate (8)
						Dedicated Infection Prevention and Control Team (IP&CT) **Control Owner:** Paul Stevens	Adequate					
						Detailed annual programme of infection and prevention control in place **Control Owner:** Paul Stevens	Adequate		Check that the diarrhoea assessment tool is both understood and implemented correctly in the Trust inpatient areas **Person Responsible:** Valerie Harmon **To be implemented by:** 31 Dec 2018	High	**22 Oct 2018** The team are site based and work with the staff to ensure competence of the tool. Any non compliance is followed up.	
						Environmental cleaning audits in place **Control Owner:** Valerie Harmon	Adequate					
						Infection prevention and control action plan in place which encompasses reporting on indicators, mandatory training etc. **Control Owner:** Valerie Harmon	Adequate		Agree and implement an infection prevention and control action plan which encompasses reporting on indicators, mandatory training etc. **Person Responsible:** Valerie Harmon **To be implemented by:** 31 Mar 2019	High	**22 Oct 2018** The refreshed action plan will be reviewed at the CCG/NHSI Oversight meeting and the Trust IPC.	
						Water Safety Group terms of reference updated in line with the independent review recommendations and Health Technical Memorandum 04-01: Safe water in healthcare premises **Control Owner:** Finbarr Murray	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 13	Inability to fund an adequate asset replacement programme for high cost and high risk medical equipment approaching the end of their asset life **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** The one outstanding action has been implemented. Risk to be reviewed for next month in the light of this new control.	23 Feb 2016	**Cause** There has been a reduction in the capital allocation for replacement and updating of high cost essential clinical equipment. **Effect** Items of clinical equipment has reached the end of its asset life and requires increased maintenance and support in order to ensure that safety is maintained and reduce the likelihood of failure.	AO1: Patients. Help patients take control of their own health	I = 3 L = 4 Moderate (12)	Prioritised list of high cost medical equipment in place **Control Owner:** Fin Murray	Adequate	I = 3 L = 3 Moderate (9)	**Person Responsible:** **To be implemented by:**			I = 3 L = 2 Low (6)
						Prioritised list of replacement equipment for 2017/18 in place **Control Owner:** Sarah Charman	Adequate					
						Risk based approach to re-prioritising the capital programme in place **Control Owner:** Elizabeth Shutler	Adequate					
						The Medical Devices Group prioritises the replacement programme using a risk-based model outlined in the Medical Devices Policy. **Control Owner:** Elizabeth Shutler	Adequate					
						The Planned Preventive Maintenance Programme identifies and manages equipment used in the care of patients **Control Owner:** Julie Barton	Adequate					
						There is an annual capital allocation, under the auspices of the Medical Devices Group that make decisions on the priorities for purchase and replacement. **Control Owner:** Fin Murray	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 67	Sustained high level of Ambulance conveyance activity to the QEQM Hospital results in delayed treatment and an inability to stream patients safely **Risk Owner:** Lee Martin **Delegated Risk Owner:** Tara Laybourne **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Helen Goodwin **Latest Review Comments:** Aggregated RCA report sent to commissioners; awaiting feedback on actions identified.	03 May 2018	**Cause** *Ambulance activity over the past six months as regularly exceeded 100 ambulances conveying patients to the QEQMH. The forecast activity to the site has been set too high and without consultation with the Trust. Performance against this forecast appears to show the QEQM is below the level the department can manage safely and is inaccurate. * The estate and facility infrastructure of the ED at QEQMH in unable to meet the patient demand safely. * There has been an overall decrease in out of hours primary care services since 2016 **Effect** * There are too many patients within a crowded area with insufficient capacity to manage the most sick patients who require majors or resuscitation. * There has been statistically significant variation in activity over the past 7 months. * The ability to segregate paediatrics from the adult population is being affected adversely. * There has been a corresponding increase in activity since the out of hours primary care provision reduced	AO3: Provision: Provide the services needed and do it well	I = 3 L = 3 Moderate (9)	Performance reviewed at Board to Board and monthly performance meetings with Commissioners **Control Owner:** Lee Martin	Limited	I = 3 L = 3 Moderate (9)	Report all occasions where ambulance conveyance activity is >= to 100 per day as a SI and undertake an aggregated Root Cause Analysis in order to identify system wide actions. **Person Responsible:** Helen Goodwin **To be implemented by:** 01 Nov 2018	Low	**22 Oct 2018** One case reported during October. Improvements are being taken forward by SecAmb and reported at the monthly A&E Delivery Board for monitoring.	I = 3 L = 1 Very Low (3)
						Staff working within agreed policy, SOPs and clinical guidelines to manage patients safely **Control Owner:** Tara Laybourne	Limited					
						Systems wide, multi agency meetings with commissioners and regulators as part of the ED recovery programme **Control Owner:** Lee Martin	Limited		Explore the opportunity for emergency capital funding from NHSI to cover the potential re-building costs **Person Responsible:** Susan Acott **To be implemented by:** 31 Dec 2018	High	**22 Oct 2018** Observation Wards have been funded and in the process of being installed at WHH and QEQM.	
									Work with East Kent and North Kent commissioners to agree activity and reporting criteria **Person Responsible:** Tara Laybourne **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Awaiting feedback on aggregated RCA into ambulance activity; responsibility transferred to operational and Care Group management.	
									Review of Estate and Facilities and foot print of ED at QEQMH and identify opportunities to develop a plan for building work. **Person Responsible:** Finbarr Murray **To be implemented by:** 31 Dec 2018	High	**22 Oct 2018** New Vangard Theatres have arrived and the Observation Wards are being installed.	
CRR 39	Delays in Radiological reporting **Risk Owner:** Paul Stevens **Delegated Risk Owner:** Paul French **Last Updated:** 22 Oct 2018 **Latest Review Date:** 22 Oct 2018 **Latest Review By:** Paul Stevens **Latest Review Comments:** I believe that this risk has now been mitigated	04 Oct 2016	**Cause** *Increased demand *Lack of reporting capacity - Radiologist and Reporting Radiographers *Problems with PACS and RIS *Radiology have discovered 5581 images on the PACS system without any information on RIS. *Lack of scan capacity *Gaps in workforce (including staff turn over within Consultant Radiologist team) **Effect** *Failing to consistently meet 2WW and 18 week pathway access standards *Delays in Patients diagnosis and start of treatment *Potential harm to Patients *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 4 L = 4 High (16)	A number of weekday and weekend consultants are in place; and substantive radiologist in place. **Control Owner:** Paul French	Limited	I = 4 L = 2 Moderate (8)	Source substantive and fixed term radiologist **Person Responsible:** Paul French **To be implemented by:** 30 Nov 2018	High	**22 Oct 2018** New recruits have commenced with one more from overseas due to arrive.	I = 2 L = 2 Low (4)
						Additional outsourcing of reports. Increased allocation to existing providers and engagement with another company. **Control Owner:** Paul French	Limited					
						Ca pathway and urgent referrals are prioritised by CT/ MRI, **Control Owner:** Paul French	Limited					
						Reporting of CT & MRI capacity. Review of activity against reporting. **Control Owner:** Paul French	Limited					
						Seeking full time locum radiologists . In the interim adhoc at weekends and weekday **Control Owner:** Paul French	Adequate					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 40	Lack of robust antenatal and new-born screening programmes **Risk Owner:** Sally Smith **Delegated Risk Owner:** Ursula Marsh **Last Updated:** 02 Oct 2018 **Latest Review Date:** 02 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Residual risk reduced as the likelihood as lessened. More focus has resulted in increased reporting. No harm to date. Risk will remain another month due to PHE focus and QA due October 18.	07 Nov 2016	**Cause** *Lack of the awareness in the importance of offering haemoglobinopathy screening, the timeframes involved and the need to meet national standards. *Lack of tracking through the pregnancy adequately, including checking blood test results. *Lack of adequate follow up plan for women who have consented to screening and not had the blood test taken. *Discrepancy between documentation in hand held record and electronic records. *Obstetric ultrasound capacity utilisation is currently >95% *Lack of robust fail safe for the FASP screening program *NIPE Poor tracking of neonatal health care records *NIPE suspected congenital dislocation of the hips, lack of awareness within the radiology of the two week pathway. *New born blood spot screening programme, poor understanding of the national requirements within the acute hospital setting in particular NICU and SCBU. *Poor administration/process management and monitoring *PACS and RIS have further impacted on the First trimester and Fetal anomaly screening programmes **Effect** *Non-compliance with National Standards (haemoglobinopathy; chromosomal abnormalities (Down's or Edwards'/Patau's syndromes); Congenital dislocation of the hip; NIPE (newborn physical examinations); newborn blood spot and TB screening) *Potential harm to unborn and new born babies *Delay in diagnosis of foetal abnormality *Legal challenge *Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 3 L = 5 High (15)	ANNB screening, mandatory training and education regarding antenatal and newborn screening programmes is in place for midwives across the Trust. This is an annual session for midwives plus adhoc sessions as needed. **Control Owner:** Rachael Chapman	Adequate	I = 3 L = 2 Low (6)	Recommence tracking women through the fetal anomaly screening programme. **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Oct 2018	High	**28 Sep 2018** The tracking has been stopped temporarily due to reduced number of staff in the screening tea. The staffing level has now improved, the plan is to restart this by the mid October	I = 3 L = 2 Low (6)
						Antenatal and postnatal screening guidelines incorporating new standards are in place. **Control Owner:** Rachael Chapman	Limited		IDSP/SCT Provide and implement a central results 'log book' database that will ensure CMW are checking and following up results as per national standard **Person Responsible:** Rachael Chapman **To be implemented by:** 30 Nov 2018	High	**02 Oct 2018** Set up and ready to start. Go live November 18.	
						Antenatal Screening administrator in post **Control Owner:** Sharon Curtis	Limited		Request that the ANNB screen e-learning become mandatory for all MW and midwifery staff. **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Dec 2018	Not Set		
						Antenatal Screening Steering Group in place for all stakeholders of the Screening Programme **Control Owner:** Rachael Chapman	Limited		Explore the need for a dedicated 'failsafe' clerk, who will oversee the tracking of women through the programmes, monitor database, compliance and collate information for KPI's, in turn collating evidence that the Trust has a robust ANNB screening service. **Person Responsible:** Rachael Chapman **To be implemented by:** 31 Dec 2018	Medium	**28 Sep 2018** The job description of the current for the admin clerk is to be sent for job matching. She is currently band 2, data capture clerk, but working to maintain databases and failsafe.	
						Avoidable repeat pathway escalation in place to reduce error. **Control Owner:** Rachael Chapman	Limited		E3 to be updated to reflect national standards across all screening programmes, both in consenting of tests and recording of results for these tests. **Person Responsible:** Ciaran Crowe **To be implemented by:** 31 Dec 2018	High	**02 Oct 2018** Delays in IT support due to PAS implementation. Employing Cloud21 (IT experts) to focus on maternity IT projects.	
						Electronic referral system for US scan in place **Control Owner:** Rachael Chapman	Adequate		Implement workforce and recruitment plans to address staffing shortfalls in imaging and retention of skilled ultra-sonographers **Person Responsible:** Carolyn Wilson **To be implemented by:** 31 Mar 2019	High	**21 Sep 2018** Recruitment in place and an HEE course opportunity is being explored.	
						FASP - Daily review of demand, potential breaches and allocating appointments **Control Owner:** Vicki Fisk	Adequate					
						FASP - Escalation process in place to accommodate requests for first trimester scans when there is a late booking and to highlight women due to have scans within timelines **Control Owner:** Rachael Chapman	Limited					
						FASP - Fail safe tracking system for combined screening for chromosomal abnormalities (Down's or Edwards'/Patau's syndromes) **Control Owner:** Rachael Chapman	Limited					
						FASP - Monthly meetings held between Maternity and Ultrasound teams **Control Owner:** Rachael Chapman	Limited					
						FASP Tracking system commenced October 2017. **Control Owner:** Rachael Chapman	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						IDSP/SCT - Community midwives keep a form of log book to check screening results within the recommended period. **Control Owner:** Rachael Chapman	Adequate		Maternity Information Task and Finish Group to review the maternity pathway (including standardising the booking process) **Person Responsible:** Hannah Horne **To be implemented by:** 31 Mar 2019	High	**21 Sep 2018** Remains on track	
						Maternity Information Task and Finish Group in place to review the Maternity Pathway **Control Owner:** Rachael Chapman	Limited					
						Newborn blood spot. Nominated midwives, MCAs and nurses have been trained as 'blood spot champions'. **Control Owner:** Rachael Chapman	Limited					
						Newborn bloodspot, Fail safe tracking system for the New born blood spots screening programme (National/Local database) **Control Owner:** Rachael Chapman	Limited					
						NIPE Smart System in place (tracking fail safe system for new born examination and referral for any abnormalities including hips) **Control Owner:** Rachael Chapman	Limited					
						NIPE, 2 nominated person appointed to oversee the NIPE screening program. One midwife and one neonatologists **Control Owner:** Jeanett Salisbury	Adequate					
						NIPE, Tracking of babies who require referral for abnormalities of the heart, eyes, hips and testes following NIPE screening **Control Owner:** Rachael Chapman	Adequate					
						Screening guidelines in place and available to staff on SharePoint, Antenatal, Post-natal, Infectious diseases etc. **Control Owner:** Rachael Chapman	Limited					
						Short term planning in place to increase obstetric ultrasound capacity by introducing one appointment only for the nuchal/dating scan. **Control Owner:** Paul French	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
CRR 31	Exposure to Cyber Security Attacks **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Robert Nelson **Last Updated:** 21 Sep 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Robert Nelson **Latest Review Comments:** New action created to undertake additional penetration testing. Automatic patching now at 93%. Progress made with formation of Cyber Security Team (HR & Banding activity complete).	12 Aug 2016	**Cause** * External hacking *Staff non-compliance with internal processes * Unpatched or unsupported operating systems **Effect** * Loss to Trusts systems confidentiality and availability * Reputational damage * Potential financial and legislative penalties * Financial loss	AO3: Provision: Provide the services needed and do it well	I = 4 L = 3 Moderate (12)	Application Delivery Controllers with application firewall are in place **Control Owner:** Mark Williams	Adequate	I = 3 L = 2 Low (6)	Set up Cyber Team within IT to enhance monitoring and response **Person Responsible:** Mark Williams **To be implemented by:** 09 Nov 2018	Not Set	**09 Oct 2018** HR and banding panel have approved the role. Appointment process underway. Team composition will be identified and in place early November.	I = 3 L = 1 Very Low (3)
						Automatic patching is in place **Control Owner:** Sue Lang	Adequate					
						Cyber Essential Plus accreditation achieved **Control Owner:** Mark Williams	Substantial		In addition to our standard penetration testing, undertake an extended, external penetration test of two systems, one internally hosted and one cloud hosted. **Person Responsible:** Mark Williams **To be implemented by:** 29 Mar 2019	Not Set	**09 Oct 2018** New action created 9/10/2018	
						Cyber Essentials + accreditation certified on 18/4/2018 **Control Owner:** Mark Williams	Substantial					
						Home and Mobile working processes in place **Control Owner:** Robert Nelson	Adequate		Increase the proportion of successfully patched machines **Person Responsible:** Darryl Smith **To be implemented by:** 29 Mar 2019	High	**09 Oct 2018** Percentage success increasing (now 93%) further practical/tactical actions to improve this.	
						Incident management in place for reporting on cyber incidents **Control Owner:** Robert Nelson	Adequate					
						Information risk management regime in place **Control Owner:** Robert Nelson	Adequate					
						Information Sharing Agreements (ISAs) in place with some third parties for access to Trust information **Control Owner:** Michael Doherty	Adequate					
						IT Technical Security Assurance Group in Place **Control Owner:** Mark Williams	Adequate					
						Known SSSP documents have been moved to the electronic system **Control Owner:** Mark Williams	Adequate					
						Malware prevention in place **Control Owner:** Robert Nelson	Adequate					
						Management of user privileges in place **Control Owner:** Robert Nelson	Adequate					
						Migration of medical devices secure network overlay complete and in place **Control Owner:** David Attwell	Limited					
						Network Security in place (e.g. Boundaries, firewalls and internet gateways) **Control Owner:** Robert Nelson	Adequate					
						New network monitoring in place **Control Owner:** Mark Williams	Adequate					
						Ongoing monitoring in place taking into account previous security incidents and attacks and other factors **Control Owner:** Robert Nelson	Limited					

Corporate Risk Register Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Regular audits of electronic access to systems **Control Owner:** Michael Doherty	Adequate					
						Removable media controls in place **Control Owner:** Robert Nelson	Adequate					
						Secure configuration in place for IT systems **Control Owner:** Mark Williams	Adequate					
						Testing of the Disaster Recovery processes in place/complete **Control Owner:** Mark Williams	Adequate					
						User education and awareness in place for Staff **Control Owner:** Michael Doherty	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Report Date	23 Oct 2018
Comparison Date	In the past 30 Day(s)

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 2	Failure to maintain the quality and standards of patient care **Risk Owner:** Sally Smith **Delegated Risk Owner:** **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Additional control added. Risk reviewed.	20 Jan 2016	**Cause** *The Trust came out of Quality Special Measures early 2017 and needs to ensure the momentum for the improvement journey is sustained. * The withdrawal of the junior doctors in medicine from the K&C site and the level of uncertainty about where services will be delivered has added operational pressure across the Trust, in particular the WHH & QEQM sites. * A particularly difficult and challenging Winter compounded an already pressurised system. **Effect** - Loss of autonomy; - Impact on staff morale; - Increased operational pressure on the two acute sites; - Staff health and well being issues; - Staff retention issues; - Reputational damage; - Decline in pace and development of services; and - Regulatory concerns	AO1: Patients. Help patients take control of their own health	I = 5 L = 5 Extreme (25)	Agreed Improvement Plan in place with supporting Divisional plans. **Control Owner:** Sally Smith	Adequate	I = 5 L = 4 Extreme (20)	Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Public consultation is reliant on the pre-consultation business case (PCBC). Clinical Commissioning Groups now identified the timeline PCBC to be drafted by December.	I = 4 L = 2 Moderate (8)
						External Consultancy and NHSI/E support in delivering the improvement programme. **Control Owner:** Lee Martin	Adequate		Implementation of the system wide NHSI/NHSE/CQC - Safety Plan **Person Responsible:** Sally Smith **To be implemented by:** 31 Mar 2019	Not Set	**09 Oct 2018** Assurance received at the oversight meeting in September. Plan being delivered except 4 hour performance and Duty of Candour which are requiring closer monitoring and focus. The next meeting's focus will be Infection Control for October's meeting.	
						External help from Community Trust, social care, CCGs to deliver improvements in the emergency pathway. **Control Owner:** Lee Martin	Limited		Delivery of the emergency pathway improvement work. Actions as per CRR 28 & 61 **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	High	**09 Oct 2018** Weekly performance meetings continue. ED performance has plateaued with some days of challenged performance. Superstranded numbers are still higher than we would like. Conversations in place with partners. Waiting times in other pathways continue to improve.	
						Local improvement plan is in place meeting weekly to deliver an improvement plan. **Control Owner:** Lee Martin	Adequate		Implementation of the Quality Strategy **Person Responsible:** Sally Smith **To be implemented by:** 30 Apr 2019	High	**09 Oct 2018** Q1 report issued with actions mostly on track. Access targets registering red at end of Q1. Other metrics making good progress.	
						NHSI Improvement Director is working with the Trust. **Control Owner:** Sally Smith	Limited		Implementation of the new High Level Improvement plan **Person Responsible:** Sally Smith **To be implemented by:** 01 Sep 2020	High	**09 Oct 2018** The new high level plan has been sent to the CQC. A Board workshop is planned for the 1st November to discuss the wider improvement plan.	
						Quality Strategy is in place. **Control Owner:** Sally Smith	Limited					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 8	Inability to attract, recruit and retain high calibre staff (substantive) to the Trust **Risk Owner:** Sandra Le Blanc **Delegated Risk Owner:** Andrea Ashman **Last Updated:** 09 Oct 2018 **Latest Review Date:** 08 Oct 2018 **Latest Review By:** Andrea Ashman **Latest Review Comments:** Actions are on track for completion. Processes and time to hire metrics are improving.	23 Feb 2016	**Cause** * It is widely known that there is a national shortage of healthcare staff in specific occupational groups / specialities. * It is a highly competitive recruitment market for these hard to fill roles, * Potential negative impact of Brexit * The Trust progressing the work on its finances under the financial special measures regime, cultural issues identified in the CQC inspection * Proximity to London has impacted on the ability to attract and retain high calibre staff. * QE geographical location impacting on recruitment of staff *Increase in staff turnover due to retirement and voluntary resignation (exit interview suggests retirement accounts for 25% of turnover figures) *Uncertainty due to the STP plans *Increase in service demand *Potential negative impact that may arise from the publication of the Staff Survey Results. **Effect** * Potential negative impact on patient outcomes and experience *High agency spend - potential breach of NHSI agency cap * Financial loss * Reputational damage * Negative impact on staff health and wellbeing * Increase in stress levels and anxiety in key staff groups	AO2: People: Identify, recruit and develop talented staff	I = 5 L = 5 Extreme (25)	The Trust has a plan in place that supports the retention of the majority of newly qualified nursing staff locally. **Control Owner:** Sally Smith	Adequate	I = 5 L = 4 Extreme (20)	Develop and agree set of KPIs to measure the effectiveness of the People Strategy which will be reported regularly to the SWC **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Oct 2018	High	**09 Oct 2018** SWC has reviewed the KPIs at October's meetings. New actions have been set to continue to meet our standards. Progress is in place but some areas are slower to achieve and require additional support and actions.	I = 5 L = 2 Moderate (10)
						Divisional Great Place to Work Action Plans in place **Control Owner:** Jane Waters	Adequate					
						Hard to recruit plan in place and being implemented **Control Owner:** Andrea Ashman	Limited		Devise & work towards implementing revised recruitment process **Person Responsible:** Andrea Ashman **To be implemented by:** 31 Dec 2018	High	**08 Oct 2018** Revised AFC process being progressed. Weekly review of activity in place. fortnightly meeting with operations group to chase down activity and ensure revised processes are followed	
						implementation of retention plan as agreed with the Strategic Workforce Committee **Control Owner:** Andrea Ashman	Adequate					
						New People Strategy agreed by the Board incorporating attraction, retention, engagement and development of staff **Control Owner:** Sandra Le Blanc	Adequate		Revise and implement Divisional Great Place to Work Action Plans **Person Responsible:** Jane Waters **To be implemented by:** 29 Mar 2019	High	**09 Oct 2018** Listening into Action has been launched and the teams are agreed. Work is in progress to feedback quickly to staff and make evident that we have listened.	
						Occupation Health run a series of Mindfulness and Resilience and One to One Counselling (including active referrals) **Control Owner:** Emma Palmer	Adequate		Develop and implement a plan to recruit nurses from the UK and Europe **Person Responsible:** Louise Goldup **To be implemented by:** 29 Mar 2019	High	**09 Oct 2018** The plan is in place. The Board has approved the attract and retention initiatives. This is monitored monthly through the IPR.	
						Recruitment process in place **Control Owner:** Andrea Ashman	Limited		To produce and implement a People Strategy that focusses on attracting, developing, engaging and retaining staff. **Person Responsible:** Sandra Le Blanc **To be implemented by:** 01 Apr 2019	High	**09 Oct 2018** As per previous action - update received today at October's SWC. Some additional actions agreed to ensure we retain our staff and recruit the people we need as we expand for Winter.	
						Staff Performance Appraisals in place **Control Owner:** Jane Waters	Substantial					
						Training plans in place in each division / corporate area that supports staff development. **Control Owner:** Andrea Ashman	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 5	Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime **Risk Owner:** Philip Cave **Delegated Risk Owner:** David Baines **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk actions updated and the risk score has been reviewed.	20 Jan 2016	**Cause** Due to: * Failure to reduce the run rate * Poor planning * Poor recurrent CIP delivery (See Risk Ref. 1037) * Inability to collect income due * Poor cash management * Operational pressures relating to Emergency Care, High Agency usage *Failure to deliver RTT, A&E and cancer targets (See CRR 28) * Political climate (Brexit) and price inflation *Inability to deliver the planned levels of activity and collect the planned levels of income *Workforce pressures including inability to recruit (See SRR 9) *Lack of capacity of Finance and PSO staff *Lack of capacity and capability to deliver operational and financial performance (See SRR 12) *Inability to secure external support for key projects *Demand from CCGs higher or lower than annual plan *Failure to secure all the contractual income due from commissioners (See Risk Ref. 101) *Failure to deliver the CQUIN programme (See CRR 53) *Financial Special Measures governance not embedded *Additional costs of reconfiguring services across sites due to temporary move of acute medicine, acute geriatric medicine and Stroke from the K&C site(See CRR 51) *Negative impact of the new PAS and EMR implementation (See CRR 37) *Inability to resource the Trust's A&E improvement plan (estimated at £9.5 million) **Effect** Resulting in * Potential breaches to the Trust's Monitor licence * Adverse impact on the Trust's ability to deliver all of its services * Impact on ability to deliver the longer term clinical strategy * Poor reputation * Impact on organisational form	AO3: Provision: Provide the services needed and do it well	I = 5 L = 5 Extreme (25)	Cash Committee in place **Control Owner:** Philip Cave	Substantial	I = 5 L = 4 Extreme (20)	"Developing the Finance Team - Still Underpowered?" presented to FPC July 2016 setting out how the Leadership Development Programme would be deployed to support financial staff improvement **Person Responsible:** Philip Cave **To be implemented by:** 31 Oct 2018	High	**09 Oct 2018** PMO business case is being progressed. Awaiting final outcome.	I = 5 L = 3 High (15)
						Clinical engagement in delivery of CIPs requiring Clinical Practice changes **Control Owner:** Paul Stevens	Limited					
						Cost Improvement Plan targets in place with workstream in support **Control Owner:** Philip Cave	Adequate		Develop the Cost Improvement Plan for 2018/19 **Person Responsible:** Philip Cave **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** CIPs progressing well. There remains a shortfall which is also being worked on.	
						Divisional Vacancy Control Panel in place **Control Owner:** Philip Cave	Adequate					
						Financial Improvement Committee in place **Control Owner:** Philip Cave	Adequate		Design and implement training for clinicians **Person Responsible:** Elisa Llewellyn **To be implemented by:** 31 Mar 2019	Medium	**09 Oct 2018** The new Care Group structure has commenced and the leadership teams are in place. Training is being developed for implementation over the next few months.	
						Financial Improvement Director in place to provide support **Control Owner:** Susan Acott	Substantial					
						Financial Improvement Oversight Group (FIOG) in place to review key metrics **Control Owner:** Philip Cave	Adequate					
						Financial Recovery Plan in place **Control Owner:** Philip Cave	Substantial					
						Fortnightly confirm and challenge meetings with the Divisions (including Corporate) **Control Owner:** Philip Cave	Adequate					
						Monthly Financial Special Measures (FSM) review meetings with NHSI **Control Owner:** Philip Cave	Substantial					
						New approach to developing CIPs in place **Control Owner:** Philip Cave	Substantial					
						Payment by results infrastructure (coding and data quality) **Control Owner:** Philip Cave	Adequate					
						Process in place for responding to commissioner challenge of activity and cost date **Control Owner:** Philip Cave	Adequate					
						Production planning in place to ensure projection of activity plans in order to take remedial action if required **Control Owner:** Philip Cave	Adequate					
						Programme Support Office (PSO) in place with clear targets, milestones, grip & control and accountability to deliver the CIP **Control Owner:** Philip Cave	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Regular reporting on the Trust's Financial position to the Trust Board and senior management team (including ensuring the impact of any financial decisions on safety, quality, patient experience and performance targets is recognised and understood). **Control Owner:** Philip Cave	Adequate					
						Robust plans in place for the delivery of operational performance targets **Control Owner:** Lee Martin	Limited					
						Signed MoU in place that provides greater clarity on specific areas of agreement which were previously disputed **Control Owner:** Philip Cave	Adequate					
						Workforce and Agency Control Group in place **Control Owner:** Sandra Le Blanc	Adequate					
SRR 10	Non-delivery of a timely Sustainability and Transformation Plan that can be resourced **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Nicky Bentley **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Actions updated. Risk reviewed.	01 Jun 2016	**Cause** - STP timescales slip due to national management of the process - Parliamentary timing may not be conducive to timely implementation - Lack of CCG leadership **Effect** - Delay to EKHUFT clinical strategy - Poor patient care - Emergency transfer of services will become necessary - Enforcement actions - Trust's provider licence (finance)	AO4: Partnership: Work with other people and other organisations to give patients the best care	I = 5 L = 4 Extreme (20)	Clinical standards reviewed **Control Owner:** Elizabeth Shutler	Substantial	I = 5 L = 4 Extreme (20)	Produce Financial Plan linked to delivery of the STP **Person Responsible:** Philip Cave **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Public consultation is reliant on the pre-consultation business case (PCBC). Clinical Commissioning Groups now identified the timeline PCBC to be drafted by December.	I = 5 L = 2 Moderate (10)
						East Kent Programme Board in place which meets regularly to ensure delivery of an agreed plan **Control Owner:** Susan Acott	Limited		Presentation of the capital requirements to the NHSE Investment Committee as part of the Pre-consultation Business Case **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Public consultation is reliant on the pre-consultation business case (PCBC). Clinical Commissioning Groups now identified the timeline PCBC to be drafted by December 2018.	
						Internal Clinical Strategy Group in place **Control Owner:** Elizabeth Shutler	Adequate		Public consultation on the options in relation to the East Kent elements of the plan **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Public consultation does now not look likely until Summer 2019.	
						Kent and Medway STP Programme Board in place **Control Owner:** Elizabeth Shutler	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 16	Failure to maximise/sustain benefits realised and evidence improvements to services from transformational programmes **Risk Owner:** Susan Acott **Delegated Risk Owner:** Simon Hayward **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risks reviewed and updated.	27 Feb 2017	**Cause** * Lack of experience / capability in the particular area of change * Lack of capacity of those who need to lead and embed the change * Lack of resources to deliver / implement and sustain change * Trust's lack of appetite for change in some areas to be implemented *Unavailability of the space and physical resources to implement and embed improvements * Mechanism / governance structures for Transformation is not embedded. **Effect** * Inability to maintain safe, effective and caring services * Inability to deliver the transformation required to meet Trust objectives * Licence restrictions *Regulatory concerns * Reputational damage	AO3: Provision: Provide the services needed and do it well	I = 4 L = 5 Extreme (20)	Financial Improvement Director appointed by NHS Improvement following financial special measures. The FID brings vast experience in "turnaround" and has implemented a new methodology for identification and development of improvement programmes. Working alongside the Executive and Programme Support Office. **Control Owner:** Susan Acott	Substantial	I = 4 L = 4 High (16)	Agree a Transformation programme of work with clear owners and milestones that links to the Strategic Objectives **Person Responsible:** Simon Hayward **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** New TIG in place where finance, quality and improvement will align. Terms of reference are being finalised.	I = 4 L = 2 Moderate (8)
						Non-executive directors experience in finance and transformation provides additional input into plans / governance. Linked to individual work-streams to provide advice / challenge **Control Owner:** Susan Acott	Adequate		Approval for 2nd Phase of the Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** LiA is in place and progressing although the NHSI leadership development business case has not yet been approved by NHSI.	
						Phase 1 of Leadership & Development programme with EY & Plum in place **Control Owner:** Sandra Le Blanc	Adequate					
						Take learning from others – Strategic Development Team and Clinicians have gone on visits to other NHS and European / International hospitals **Control Owner:** Elizabeth Shutler	Adequate					
						Time limited implementation team in place for the Transformation Programme **Control Owner:** Simon Hayward	Adequate					
						Transformation and Financial governance architecture in place (including programme structure; reporting methodology and clinical and non-clinical engagement). **Control Owner:** Simon Hayward	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 4	Estate Condition - Unable to implement improvements in the Estate across the Trust to ensure long term quality of patient facilities **Risk Owner:** Elizabeth Shutler **Delegated Risk Owner:** Fin Murray **Last Updated:** 09 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** Risk reviewed.	20 Jan 2016	**Cause** - Backlog of work (£74million); - The financial constraint on capital funding; - The sheer volume and extent of work required **Effect** - Resulting in poor patient and staff experience - Adverse effects during extreme weather conditions (e.g. leaking roofs; burst pipes leading to water supply shortage; injury to staff/patients) - Potential breaches to health & safety standards and legislation - Inefficiencies and difficulties in moving forward with providing services of the future such as the Clinical Strategy	AO1: Patients. Help patients take control of their own health	I = 4 L = 5 Extreme (20)	An assessment of the maintenance required has been undertaken to understand the overall position **Control Owner:** Elizabeth Shutler	Adequate	I = 4 L = 4 High (16)	Develop pre-consultation Business Case for presentation to NHSE Investment Committee **Person Responsible:** Elizabeth Shutler **To be implemented by:** 30 Nov 2018	High	**09 Oct 2018** Clinical Commissioning Group timeline now identifies the Pre-Consultation Business Case (PCBC) to be drafted by December 2018.	I = 4 L = 2 Moderate (8)
						Interim Estates Strategy in place **Control Owner:** Fin Murray	Adequate					
						Prioritisation exercise for capital spend has been completed to ensure resources are used in the most effective / efficient way **Control Owner:** Elizabeth Shutler	Adequate		The Trust has engaged with NHSI to agree priorities to spend in 18/19 and 19/20. This is with a view to reduce the Trust Backlog position further. **Person Responsible:** Elizabeth Shutler **To be implemented by:** 31 Mar 2020	High	**09 Oct 2018** Senior Capital Lead is meeting with the Trust on 14 October to review the initial priorisation by site of backlog.	
						Prioritised Patients Environment Investment Committee (PEIC) action plan in place for 2017/18 **Control Owner:** Fin Murray	Adequate					
						Risk assessed condition survey carried out every 5 years (rolling interim plan every 18months) **Control Owner:** Fin Murray	Adequate					
						Statutory Compliance dashboard in place **Control Owner:** Fin Murray	Adequate					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
SRR 12	Insufficient capacity and capability of the leadership team (Executive and Care Group Clinical Directors) to develop and deliver key strategies and recovery plans **Risk Owner:** Susan Acott **Delegated Risk Owner:** Sandra Le Blanc **Last Updated:** 23 Oct 2018 **Latest Review Date:** 09 Oct 2018 **Latest Review By:** Sally Smith **Latest Review Comments:** One action closed and risk reviewed.	01 Jun 2016	**Cause** *The Trust is not meeting its constitutional standards *Large number of complex priorities that need to be delivered including the sustainability and transformation plan, A&E recovery plan, Financial Special Measures turnaround plan, Cost Improvement Plans as well as business as usual *The Trust is under the Financial Special Measures regime *Those tasked with delivery have focus diverted due to other urgent external matters *The move of acute medicine, acute geriatric medicine and Stroke from the K&C site *Governance structure fails to support the delivery of CIPs *Increased Patient activity in A&E during the winter period **Effect** * Inability to achieve strategic priorities * Failure to come out of Financial special measures * Further Regulation action/concerns * Reputational damage * Financial loss * Negative impact on patient safety / care / experience * Reduced staff morale * Failure to meet operational performance standards (RTT/A&E/Cancer) * Failure to meet regulatory requirements (CQC / NHSI, GMC and HEKSS)	AO2: People: Identify, recruit and develop talented staff	I = 4 L = 5 Extreme (20)	Business Partnering roles in place (Finance, HR & Information) together with support from central governance team. They are an integral part of the Divisional Leadership Team (Capacity) **Control Owner:** Lee Martin	Adequate	I = 3 L = 3 Moderate (9)	Development of senior, middle non-clinical leaders against the EKHUFT leadership framework **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** This is in development.	I = 3 L = 2 Low (6)
						Director of Finance in place with continuity in delivery of the FSM **Control Owner:** Susan Acott	Adequate		To finalise the Trust–wide leadership competency framework which will be the basis of a comprehensive diagnostic and structured development / assessment programme. **Person Responsible:** Jane Waters **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Discussed at SWC and development in progress. New JDs and structure implemented as of the 1st October.	
						Each Divisional Director is responsible for one of the national Performance Standards e.g. Cancer, ED, 18weeks (Capacity) **Control Owner:** Lee Martin	Limited		Design and deliver the Executive Development and Leadership Development Programme **Person Responsible:** Sandra Le Blanc **To be implemented by:** 31 Dec 2018	High	**09 Oct 2018** Plum are working with the Trust to develop the new Care group leadership and management development.	
						Executive Performance Reviews in place where delivery is challenged with EMT/DD meetings to support senior leadership team in prioritising and highlighting competing pressures (Capacity) **Control Owner:** Susan Acott	Adequate		Review of key action plans in line with capacity and capability (A&E Improvement Plan and Cancer) **Person Responsible:** Lee Martin **To be implemented by:** 31 Mar 2019	High	**02 Aug 2018** A comprehensive improvement action plan is being implemented, this includes agreed projects with community and CGG partners	
						Experienced COO appointed **Control Owner:** Sandra Le Blanc	Limited					
						Experienced Interim Chief Executive in place (experienced CEO in the NHS) **Control Owner:** Elizabeth Shutler	Adequate					
						External Consultancy Support (2020, Carnal Farrar, A&E Improvement Director, Financial Improvement Director) supporting Divisions and the Corporate Team to deliver transformation programmes (Capacity) **Control Owner:** Lee Martin	Adequate					
						Interim Hospital Directors in place at WHH and QEQM (Capacity) **Control Owner:** Lee Martin	Limited					
						Leadership Development Plans and targeted development plans for individuals in place (Capability) **Control Owner:** Sandra Le Blanc	Adequate					
						Leadership development programme in place for Clinical staff all professions (Capability) **Control Owner:** Sally Smith	Adequate					
						New clinician development programme (now into the 6th cohort) (Capability) **Control Owner:** Paul Stevens	Adequate					
						Outline Programme Plan in place for the Leadership Development Programme (Capability) **Control Owner:** Sandra Le Blanc	Limited					

Strategic Risks Report (By Residual Risk Ranking)

Risk Ref	Risk Title	Created Date	Cause & Effect	Strategic Priorities	Inherent Risk Score	Risk Control	Assurance Level	Residual Risk Score	Action Required	Action Priority	Progress Notes	Target Risk Score
						Recent appointment to two key posts in the Trust below Executive Director level (Capability) **Control Owner:** Sandra Le Blanc	Adequate					
						Substantive staff in place for Executive and Divisional Director positions (Capacity) **Control Owner:** Sandra Le Blanc	Adequate					
						Succession Plan in place for Executive Directors, Divisional Medical Directors, Divisional Directors and key posts to the organisation **Control Owner:** Sandra Le Blanc	Limited					
						Targeted resources into key CIP schemes in place e.g. patient flow, Cardiology (Capacity) **Control Owner:** Philip Cave	Limited					
						Transformation Programme in place (designed and resourced) (Capacity) **Control Owner:** Simon Hayward	Limited					