Agenda

Public Meeting of the Trust Board

Date: On 03 May 2018 at 1.00pm – 4.00pm

Location: Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

Item	Subject	Presenter	Time	Action	Format
1.	Patient Story	Director of Nursing	1.00pm	Discuss	Paper
Opening of the Meeting					
2.	Chair's Welcome	Chairman	1.30pm	Note	Verbal
3.	Quorum	Chairman		Note	Verbal
4.	Register of Interests	Chairman		Note	Paper
Meeting Administration					
5.	Minutes of the previous meeting held on 18 January 2018	Chairman	1.35pm	Approve	Paper
6.	Matters Arising/Action Log	Chairman		Note	Paper
Main Business					
7.	Chair's Report	Chairman	1.40pm	Note	Verbal
8.	Chief Executive's Report	Chief Executive	1.45pm	Note	Paper
9.	Strategy a) STP Update & Budget b) Trust Improvement Plan Better Best Brilliant	Chief Executive Deputy CEO/Executive Director of HR & OD	1.50pm	Note Discussion	Paper Paper
10.	Quality a) IQPR b) Research and Development Report c) Mortality Report: Responding to deaths	Director of Nursing & Medical Director Medical Director	2.05pm	Discussion Discussion Note	Paper Paper Paper

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11.	Performance a) Finance Report b) Control Total Update c) Communications Report	Director of Finance & Business Services Director of Communications	2.15pm	Discussion Discussion Discussion	Paper Verbal Paper
12.	Governance a) Corporate Governance b) Board Assurance Framework c) NHSI Self-Assessment (Licence Conditions) d) Emergency Preparedness, Resilience and Response Annual Report e) IG and General Data Protection Regulations (GDPR) Report	Trust Secretary: Director of Corporate Compliance and Legal Services / Director of Finance & Business Services	2.45pm	Assurance Assurance Discussion Discussion Discussion	Paper Paper Paper Paper Paper
13.	People a) Workforce Report b) Gender Pay Gap Report c) Staff Survey Presentation	Director of Operational HR	3.00pm	Assurance	Paper
For Approval					

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14.	Membership Strategy	Trust Secretary: Director of Corporate Compliance and Legal Services	3.30pm		
Reports from Board Committees					
15.	Quality Assurance Committee Report	QAC Chair	3.35pm	Assurance	Paper
16.	Integrated Audit Committee Report	IAC Chair	3.40pm	Assurance	Paper
17.	Finance Committee Report	FC Chair	3.45pm	Assurance	Paper
For Noting					
18.	Council of Governors' Update	Governor Representative	3.50pm	Discussion	Verbal
19.	Any other business	Chairman		Note	Verbal
20.	Questions from members of the public	Chairman		Discussion	Verbal
Close of Meeting					
	Date and time of next meeting: 5 July 2018 Boardroom, Post Graduate Centre, Medway NHS Foundation Trust				

NHS
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MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Jon Billings Non-Executive Director	• Director of Fenestra Consulting Limited • Associate of Healthskills Limited • Associate of FMLM Solutions • Chair of the Medway NHS Foundation Trust Quality Assurance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
2.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Chair of the Medway NHS Foundation Trust Charitable Funds Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	Stephen Clark Chair	• Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Access Bank UK Limited – Non Executive Director • Chairman Advisory Council- Brook Street Equity Partner LLP • Chairman of the Medway NHS Foundation Trust • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	James Devine Director of HR & OD	• Member of the London Board for the Healthcare People Management Association • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
5.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
6.	Diana Hamilton-Fairley Medical Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
7.	Anthony Moore Non-Executive Director	• Chair of the Medway NHS Foundation Trust Finance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
8.	Joanne Palmer Non-Executive Director	• Director of Lloyds Bank (Fountainbridge 1) Limited • Director of Lloyds Bank (Fountainbridge 2) Limited • Director of Lloyds Halifax Premises Limited • Director of Lloyds Gresham Nominee1 Limited • Director of Lloyds Gresham Nominee 2 Limited • Director of Lloyds Commercial Properties Limited

		• Director of Lloyds Bank Properties Limited • Director of Lloyds Commercial Property Investments Limited • Director of Lloyds Target Corporate Services Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust • Trustee of the Sisi & Savita Charitable Trust • Director of Mark Spragg Limited • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
11.	Tracey Cotterill Director of Finance and Business Services	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
12.	Adrian Ward Non-Executive Director	• Trustee of the Bella Moss Foundation • Director of Award Veterinary Sciences Limited • Chair of NMC Fitness to Practice Panel • Member of the RCVS Preliminary Investigation Committee • Member of the BSAVA Scientific Committee • Member of the Medway NHS Foundation Trust Quality Assurance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds

Meeting in Public

NHS Medway NHS Foundation Trust

Board of Directors Meeting in Public on 18/01/2018 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive	LD
	Mrs J Palmer	Non-Executive Director	JP
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mr T Moore	Non-Executive Director	TM
	Mr M Spragg	Non-Executive Director	MS
	Dr D Hamilton-Fairley	Medical Director	DHF
	Mrs T Cotterill	Director of Finance and Business Services	TC
	Mr J Devine	Director of HR and OD and Director of Improvement	JD
	Mrs K Rule	Director of Nursing	KR
Attendees:	Ms G Alexander	Director of Communications	GA
	Ms D King	Governor Board Representative	DK
	Mr C Bradley	2020 (item 9b only)	CB
	Ms S Bennett	Patient (presentation only)	SB
	Mr J Lowell	Director of Clinical Operations	JL
	Mrs A Meadows	Assistant Trust Secretary (minute taker)	AM
	Dr D Sulch	Deputy Medical Director for Unplanned Integrated Care	DS
	Mr K Hunt	Liaison	KH
Apologies:	Mr A Ward	Non-Executive Director	AW
	Ms S Murphy	Trust Secretary and Director of Corporate Governance and Legal	SMM
	Mr B Stevens	Director of Clinical Operations	BS

1. Patient Story

1.1 SB attended to provide detailed account of her positive experience at the Birth Place. SB was very grateful to members of staff who cared for her and allayed her fears during child birth. The Board was grateful to SB for sharing such a personal account of her delivery and for such positive feedback of the care provided.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 Apologies for absence were noted as stated above.

2.3 DHF introduced DS who had just joined the Trust as Deputy Medical Director for Unplanned Integrated Care and will also be leading on clinical effectiveness and research programmes. DHF noted that DS is an expert in Stroke and would help in improving the Trust's stroke pathways.

2.4 JD introduced KH from Liaison and noted that the Trust had been working with Liaison on improving the booking systems and the cost base for medical locums in particular.

3. Quorum

3.1 It was confirmed that the meeting was quorate.

4. Register of Interests

4.1 This was noted.

5. Minutes of the Previous Meeting

5.1 The minutes of the previous public meeting were **APPROVED** as a true and accurate record of the matters discussed.

6. Matters Arising and Action Log

6.1 The Board of Directors **RECEIVED** the Action Log

6.2 0392, 0393 and 0394 – It was agreed that these actions should be closed
0395 – It was noted that Deloitte would be coming to assist with the risk statement
0396 – It was noted that the action should be left open - JD to follow up

7. Chair's Report

7.1 SC noted that in the depth of winter, the Trust had faced the same challenges as elsewhere; high levels of attendance, with some very unwell patients. However staff did their best to minimise waits, maintain flow and ensure patients were discharged in a timely way. SC thanked staff for the hard work they do on behalf of the Trust. SC noted ED improvements and thanked LD and the team for their support.

7.2 SC noted there is now flu in the community and there has been a sharp rise in the number of cases nationally. Whilst the Trust's vaccination rate (64 per cent) is a little higher than the national average (59 per cent currently) SC emphasised that this is not as high as the Trust would like and urged everyone who has not had the vaccination to do so especially the frontline staff and all other staff who care for patients.

7.3 .SC noted that the Trust is moving forward in its improvement programme and extended thanks to all members of staff. SC provided updates on the community services review and stakeholder engagement.

7.4 SC made reference to the yellow names badges (Hello, My Name Is…) worn by staff and noted that these are now worn in many countries around the world. SC noted that Chris Pointon was a speaker at a clinicians' Grand Round educational session last week where he impressed on the audience that the patient-centred care that the Trust aspires to means always treating patients with respect, and addressing them as individuals.

8. Chief Executive's Report

8.1 The report was taken as read.

9. Strategy

9a) Sustainability and Transformation Partnership (STP) Update

9.1 DHF highlighted the current STP activities in Medway and the rest of Kent. DHF noted that the development of the clinical strategy, a key piece of work in relation to the future provision of healthcare, is now moving forward.

9.2 In relation to the Stroke Review, DHF noted that consultation on stroke services will take place over the coming months following a long period of review and engagement. The five options going out for consultation are to go live soon and MFT features in three out of five. It was noted that the consultation process is to last between ten to twelve weeks. DHF noted a recent positive meeting where DHF, LD and an officer from the Council had a discussed the consultation sharing the same view on how to respond to it.

9.3 DHF also noted that East Kent is to go out for consultation shortly on the configuration of their emergency services with more details to be provided in the near future on the potential of building a new hospital. Questions were taken. SC thanked DHF.

9b) Trust Improvement Plan

9.4 JD noted the monthly report around the improvement programme and explained that the report focuses on delivery sprint.

9.5 JD mentioned that 16 schemes were identified to bring about financial or efficiency gains focussing on three primary areas; theatres, pre-assessment and radiology.

9.6 It was noted that the report includes the governance process ad timescale being walked through around these particular projects. JD noted that the schemes are led by programmes in the new structure with 2020 helping to improve capabilities.

9.7 CB briefed Board on sustainability noting that the 2020 contract ends in March. CB noted that hand over would ensure work could continue effectively. The vision in the next three months is to develop a plan to run improvement and pass on capabilities.

9.8 JD noted that the aim of the sprints is to improve efficiency and assured Board that work will continue to do so. JD noted that there are a number of work streams but the Executives have decided to focus on 6 streams which will help deliver the other ones.

9.9 Following a query raised by JB in relation to the radiology project and how this could be calibrated, it was confirmed that the Trust has external support to do this work, benchmarking was required to understand how to achieve the national average. Guy's and St. Thomas' Hospital was used as a benchmark and the Trust is also learning from other organisations. TC added that the Trust is looking at a holistic radiology strategy and how it fits into the estates strategy.

9.10 TM made reference to the contract with 2020 which is coming to an end and advised that progress made so far should be measured.

ACTION: KPI on each area 2020 has worked on to be presented to Board to assess progress in March.

10 Quality

10a) IQPR

10.1 The report was taken as read. The Board was asked to note the IQPR for November performance.

10.2 KR made reference to an infection control case reported in November and noted the processes in place for stronger antimicrobial stewardship.

10.3 KR noted that two never events were reported in November. KR explained that the first case is being closely monitored after an initial investigation while the second has been fully investigated with safety alerts immediately circulated before investigations commenced. KR provided assurances that the Trust will continue to monitor safety and quality indicators closely although it has been a really busy period. All escalation areas were open which resulted in additional pressure on staffing. Processes put in place to meet with the high demands of the period were noted.

10.4 KR noted mixed sex accommodation breaches reduced in November but there is a significant increase now due to higher demand. However, patient safety is priority this period following the guidance issued. JL noted that due to the extreme pressure in November/December in ED, the four hour target was a challenge but the Trust coped at 90.45% performance in November. The four hour target issue was linked directly to flow.

10.5 JL noted that with colleagues from across the sector nationally having similar pressure, the period experienced the highest level of escalation. The escalation ward was opened on the 27 of December.

10.6 It was noted that there was focus on delayed transfer of care rate which resulted in more progress compared to past years and one of the best in the country. Other pieces of work being considered are evening calls, executive presence almost 24 hours daily, etc. It was noted that these are well received.

10.7 It was noted that RTT performance slightly decreased to 81.76% from 83.32 %. Four specialties have back logs with Dermatology constituting the highest. The factors responsible were explained and assurances provided that action plans are being prepared to address the back log. It was noted that 52 weeks target went down by 7 - a good trajectory. It was noted that Diagnostics deteriorated slightly.

10.8 It was noted that the Trust is compliant with all the cancer standards. Work has taken place on the trajectory previously set. The support and funding from NHSI was noted. There are daily huddles with discussion around cancer

pathways for individual patients. The cancer improvement plan is also being worked on. Questions were taken.

10.9 JB suggested that debrief on quality and safety could be reported through the quality assurance committee rather than come to Board.

10.10 SC noted Kent wide activities and advised the Trust to bench mark itself with the IQPR reflecting this.

10b) Mortality Report

10.11 The report was taken as read. DHF noted the first edition of the new national framework for NHS Trusts - 'National Guidance on Learning from Deaths' and explained that the focus of the new framework is on the quality of care received by patients (whether or not death is avoidable), improving governance processes around patient death and ensuring the families/carers of patients who have died in care are properly involved at every stage.

10.12 It was noted that the new framework includes new board leadership roles, a new system of 'case record reviews', quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this.

10.13 The Board was asked to note the updated Learning from Deaths Dashboard for Q1 and Q2 which is a national dashboard that has been developed. DHF noted that the revised dashboard is a significant step forward as to how death is investigated. DHF advised that this will be brought to Board quarterly in line with the national requirement.

10.14 DHF noted that the revised Responding to Deaths Policy within the report which incorporates the NHSI/RCP updates was for noting and advised that this would be the Trust's Policy on Mortality.

10.15 The Board **APPROVED** the revised Responding to Deaths Policy as the Trust's Mortality Policy.

10.16 DHF thanked the team.

10c) Annual Report on Safe Working Hours

10.17 DHF noted the annual requirement to provide a report in compliance with the new Junior Doctor contract to the Trust Board. The Board was asked to note the progress made between August 2016 and August 2017 in introducing the new contract. The Board was assured that reporting and management systems that enable compliance with the contract have been implemented. The Board noted that appropriate controls and processes are in place to deliver safe working hours for Junior Doctors.

10.18 It was noted that the report included the number of exception reports, fines levied and issues that have arisen in the introduction of the system. However, all rotas have been adjusted to meet the requirements of the new contract and Junior Doctors have an opportunity to feedback which is taken seriously. It was noted that their training needs were protected. DHF advised that it is important for Board to know the role of the appointed Guardian of Safe Working Hours.

10.19 DHF noted that there is a significantly high level of interaction between the Senior and Junior Doctors. DHF commented that Junior Doctors work very hard and they have also been very flexible. DHF added that there are very few exception reports considering the level of work being done and the number of extra hours they put in. DHF thanked the Junior Doctors and the Human

Resources team. DHF noted that the report would be received quarterly in future.

10.20 SC acknowledged the good development in relation to the new Junior Doctor contract.

11 Performance

11a) Finance Report

11.1 The report which summarised the Month 8 year to date was taken as read. TC in providing highlights stated that in Month performance was reported as a deficit of £5.7m which was slightly adverse to plan. TC explained that at the time (November 2017), forecast outturn was aligned to plan but a number of risks were raised.

11.2 TC noted the factors responsible for the adverse variance one of which was the unresolved contractual issue between the Trust and the main CCG around over-performance. TC explained that there is a gap between the contract value and the planned income in the Trust.

11.3 TC noted that cash remains an issue in the Trust partly because of performance against the income plan.

11.4 It was noted that the Trust is working very hard on financial recovery. The radiology project, theatres and pharmacy were noted as the main transformational projects being worked on. It was noted that work is also ongoing around facilities, catering and a range of areas as part of the recovery plan and to expedite the transformational schemes which will enable the Trust to improve its efficiency.

11.5 It was noted that the Trust maintains a high debt position with the CCG as the biggest debtor. There is a resultant cash issue but assurance was provided that the Trust is working with its regulators to try and expedite some payments as it is required to pay creditors. TC noted that additional income of £4m was received from the Department of Health. However, that did not last long considering the Trust's run rate spend of about £30m monthly.

11.6 TC noted that it has been heard from colleagues, there will be a reduction in the elective activity as a result of winter pressures. TC noted that this will cause a reduction in income as the Trust beds are occupied by increased emergency admissions and that this activity generates less income for the Trust. TC advised that an estimate of the impact of the lost income will be incorporated in the M9 forecast outturn.

11.7 SC noted that the Trust hopes to resolve the debtor issue with the CCG as part of the resolution of the contract issues. Following a query raised by DK around savings including stationery savings, TC noted that the Executives agreed on a range of controls to try and reduce expenditure. TC advised that there is a need to encourage a change in culture within the Trust with regard to expenditure, and considering the need for items. The issue of Carillion was raised by DK and TC confirmed that the Trust does not use Carillion but there is a small debtor balance.

11b) Communication Report

11.8 The Board noted the report. GA commented that it had been one of the busiest times for the team and there is a risk of overloading staff, patients and

the public with messages. The team is trying to do some streamlining in this regard whilst ensuring clarity of message.

11.9 GA noted that in relation to Staff, a whole range of things are going on with an internal staff survey review underway. GA noted the highly successful face to face staff briefing in December. With such encouraging attendance, GA advised that the team will be doing more of that as it brings messages closer to staff particularly around flow and finance.

11.10 GA noted that the Trust is working more effectively with its partner organisations.

11.11 In relation to financial recovery, GA noted that a full communications and engagement plan had been produced to support the Trust's financial recovery.

11.12 GA noted the good coverage over the Christmas period which gave the Trust an opportunity to raise the profile of charitable funds.

11.13 The forthcoming Unconference around building a brilliant Medway was noted together with the ongoing preparation towards this. GA noted the success around the new app for staff – @MFT (to support training, updates, HR, and useful information) with a commendable number of downloads and visits.

11.14 In relation to Media, GA provided updates including the breast screening, campaign with very good coverage on this. The team is now considering the same for organ donation.

11.15 In relation to community engagement, GA noted tremendous progress made in this area and advised that community engagement activity is now focused on five areas.

11.5 There has been engagement with the medical youth council, raising awareness of organ donation, engagement with local schools, ethnic minority community connections have been made to talk to a group on breast screening. GA noted that significant work is going on with positive feedback.

11.6 SC made reference to the ongoing work to improve features on fire safety and noted that the team would be working with communications on this. SC thanked GA.

11.7 Following a query raised by JB, GA noted that the communications team intends to engage with potential user communities such as the business community and incorporate other audiences also.

12 People

Workforce Report

12.1 The Board noted the report.

12.2 JD noted the metric around sickness and staff turnover and stated that HR Business Partners will work with all existing information sources, system-wide knowledge, staff survey results and in conjunction with outputs from the January unconference and culture workstreams, with the aim to implement a service-specific retention plan through quarter 4 17/18 and quarter 1 18/19.

12.3 On Nurse Recruitment, JD noted that the HR team continues to work with KR's team with 200 nurses recruited in the last few months. JD explained that with there has been an increased turnover rate. However, the retention project will launch in a week so as to improve retention across the organisation starting with nursing.

12.4 JD noted that the organisation has increased the percentage of pay bill spent on substantive staff with a decrease in agency usage and bank usage as part of the financial recovery plan. JD noted more of the organisation's cost is on

substantive pay rather than agency and bank adding that this will continue although spend may increase in December due to increased winter pressure and the opening of escalation wards.

12.5 JD referred to the forthcoming Unconference and noted that the facilitator will engage the audience rather than have them sit and listen only. It was also noted that the new quarterly Staff Survey which is different to the NHS Staff Survey will soon be launched.

12.6 JD provided an update on Equality Delivery System (EDS2) noting that the work is back on track to be concluded by March 2018. Finally JD made reference to the story about unite the union and theatre staff noting that the dispute is around working patterns. JD stated that the rota has been reviewed and since the beginning of November, the Trust has been working with the union and ACAS. JD noted that there is a need to move forward around working patterns with staff. JD commented the meetings have been harmonious in the spirit of conversation. Questions were taken.

13 Corporate Safeguarding Policy

13.1 The Corporate Safeguarding Policy was re-presented to Board for approval. The Board had earlier advised that minor adjustment be made so as to make the policy clearer in terms of frontline work and how the Board will be assured that the policy is compliant with statutory requirements and so fit for purpose.

13.2 KR noted that the revised version is now clearer noting the legal requirement to work with partnership agencies.

13.3 The Board **APPROVED** the Corporate Safeguarding Policy

13.4 The Board agreed that all policies for Board approval should be accompanied with front sheets. JD advised that the metric around when policies should be brought would be discussed with SM.

Action- JD to discuss the metric around when policies should be brought for Board approval with SM

14 Corporate Consent Policy

14.1 DHF noted that this is consent in relation to treatment or procedure as required by CQC.

14.2 Discussion ensued; it was suggested that the policy should state why consent is important and that this could be applied to policies generally.

14.3 The Board **APPROVED** the Corporate Consent Policy.

15. Corporate Estate and Facilities Policy

15.1 TC noted that there has been an annual review of the policy which is now presented for Board approval.

15.2 TC noted that the policy is far reaching and covers all the Estates' functions. TC confirmed that the policy is fit for purpose and provides information on levels of accountability and responsibility, implementation of specific policies and procedures, benchmarking and measurement of performance, and reporting mechanisms, in order to provide assurance to Board.

15.3 TC noted that the policy makes provision for annual estates report to Board. TC also noted that the policy refers to the Carter Model Hospital and requires a plan which the new Director of Estates will take forward. In relation to the Annual Compliance Statement, TC noted that the compliance reporting on the

estates function is in place, but more work was required on the facilities elements. In terms of the CQC control mechanisms, TC noted that the Health and Safety Committee meets regularly and is monitoring this.

15.4 The Board **APPROVED** the Corporate Estate and Facilities Policy.

16 Quality Assurance Committee (QAC) Report

16.1 The report was taken as read. JB noted the matters for highlighting which included the internally triggered review into stroke mortality. JB noted that the audit was undertaken by the Trust without being prompted by external bodies and noted that this is an example of a growing quality and safety culture.

16.2 JB also noted that QAC received a report on performance against Medicines Management Checklist and advised that a strong message in relation to compliance was taken back. JB noted that QAC would focus on workforce with a view to considering how the risks associated with this could be mitigated.

17 Integrated Audit Committee (IAC) Report

17.1 MS asked the Board to note the key issues report from IAC.

18 Council of Governors' Update

18.1 DK as Governor Board Representative raised the following queries:

- ED Re-development - What is the estimated open time?
  The estimated open time for phase one is March 2018 and the completed build is October 2018.
- When is CQC coming?
  KR confirmed that an information request came in recently from CQC which will give the Commission an insight as to areas of focus. KR noted that the CQC will write to the Trust giving two to three months' notice of their visit to the Trust.

19. AOB

19.1 SC noted that the next Council of Governors (CoG) was scheduled to be held on Monday, 22 January 2018.

20. Questions from members of the public

20.1 There were no members of the public.

The next Public Board will be held on Thursday, 1 March 2018. Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust

The meeting closed at 3.06pm.

Stephen Clark: Date:
Chair

PUBLIC BOARD ACTION LOG
ITEM 06

NHS Medway NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB - 0395	03/11/17	16.1	Risk Appetite Statement to be represented for approval at a subsequent meeting	Acting Deputy Director of Corporate Governance	18-02-18- Work in progress- Deloitte invited to advise	Open
PUB - 0396	03/11/17	20.1	BS to meet with DK and another Governor separately on patient notes and provide feedback to Board.	Director of Clinical Operations – Co-ordinated Surgical	18-02-18 – JD to follow up	Open
PUB- 0397	18/01/18	9.10	KPI on each area 2020 has worked on to be presented to Board to assess progress in March	Deputy CEO/Executive Director of HR and OD	Action completed – See update paper	Closed
PUB- 0398	18/01/18	13.4	JD to discuss the metric around when corporate policies should be brought for Board approval with SM	Deputy CEO/Executive Director of HR and OD and Trust Secretary		Open

Chief Executive's Report – April 2018

This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.

The Board is asked to note the content of this report.

In and around Medway

CQC

As you will be aware we are currently in the middle of our CQC Inspection. There is a change to the inspection regime this year, as it is now split in to three core parts; on 10 and 11 April 2018, we had the Core Services inspection (which will also include at least one unannounced inspection); on 30 April 2018, the Use of Resources Assessment will take place; with the final part, the Well-led review, taking place on 2 and 3 May 2018 – the latter two parts largely include Board members. Although we haven't yet received the CQC's feedback from the core inspection, they did tell us that staff were welcoming and friendly and I anticipate that the Trust will receive the final report sometime in June.

In the run up to the Core Services inspection on 10 and 11 April 2018, the CQC held a number of staff focus groups and drop-in sessions which were well attended. A handbook was also created for staff and everyone was invited to attend a staff briefing where they were shown the presentation that was going to be delivered to the CQC and made comments and suggestions on how to improve the presentation.

A CQC assurance group was also established, which is chaired by Jon Billings, to lead on the operational preparations for the CQC Inspections.

The CQC will be observing both the Private and Public Board Meetings as part of the Well Led review.

Performance Trajectories

NHS England has produced the annual planning guidance for 2018/19. Notably the guidance states that Trusts will be expected to meet 90 per cent of ED patients being seen, treated and admitted or discharged within four hours by September 2018, returning to 95 per cent by March 2019.

On the referral to treatment standard, the expectation is that the waiting list should not be any higher in March 2019 than in March 2018, alongside the expectation to halve the number of patients waiting 52 weeks in the same period.

Given the pressures we are under we have submitted plans to NHS Improvement for agreement that our constitutional targets will be met within the following timeframes.

Target	Trajectory for March	Actual for March	Timescale to meet standard
4 hour	85.84%	82.5%	October 2018
RTT	92%	81.90%	October 2018
Cancer	85%	85.1%	January 2018
Diagnostics	99%	96.8%	March 2019

Performance – Emergency Department four-hour target

The Trust remains under pressure with continued high numbers of presentations to our Emergency Department.

The front door streaming model continues – that is the redirection of suitable patients to primary care – and we have recently been awarded £1million to further develop the model and undertake some capital works to ensure that the environment for MedOCC is improved. In addition we also received funding to develop an area suitable for mental health patients awaiting admission.

The current phase of the Emergency Department capital build is almost at completion. The handover to the Trust is scheduled for May with the final phase due to be completed by June 2018, but the contractors have had some difficulty with the availability of specialist skilled labourers and therefore, there may be some need for additional time to handover on these elements.

We continue to have a focus on patient flow to improve patient experience throughout the hospital. In March we undertook a further MADE – which stands for Multi Agency Discharge Event.

Fifty-five per cent of the Trust's patients are what are known as 'stranded' patients, which are those that have stayed in hospital for more than seven days, and 16 per cent are 'super-stranded', patients who have been with us for more than three weeks. Our rates for stranded and super-stranded patients are about three times as high as they should be – which means a high number of our patients are staying a lot longer in hospital than we would expect them to. However the Trust continues to be one of the best performers in regards to Delayed Transfers of Care with all agencies working together to ensure patients with complex needs are cared for in the right setting.

We will continue to focus on flow in order for our four hour target to be achieved.

Elective and day case activity

As you will recall, trusts were instructed to pause elective activity during January to help alleviate pressure at the busiest time. We resumed surgical operations at the beginning of February, however given the pressures to flow and then late snow we have reviewed our ability to achieve the target and as a result will introduce changes in May that will enable further activity to be undertaken.

Achievement of this standard is an indicator of both efficiency and responsiveness of care for our patients, and it is imperative that we return to a full elective programme as soon as possible.

It is proposed that we “ring fence” Sunderland day-case centre and remove the area as recognised escalation. The purpose of this is to maximise utilisation of the surgical bed base and increase productivity within surgery. he unit will operate as a full 23-hour stay facility Monday-Friday and then fully close the unit each Saturdays at 1pm and re-open Monday mornings.

We will return to full operating from Wednesday 9 May 2018 to turn around RTT within the earliest possible timeframe. The Directorate and Programme leadership will monitor electives on a day by day basis to ensure patients follow correct pathways and that patient flow is maintained throughout the Trust

Our financial position

As reported at the last Board meeting, our financial challenge is great, and you will hear in the financial report that we ended the financial year with a larger deficit than originally planned and we have submitted to NHS Improvement a planned deficit position which will be extremely challenging for the Trust to achieve for 2018/19. This will be presented in more detail within the finance report.

The Trust has been through an Expert Determination Process on a range of issues where the CCG has challenged the Trust on their reported activity. Of the seven items that went to Expert Determination, four were found in favour of the Trust for 2017/18, but the largest item related to the change in pathway for non-elective admissions, and this was unfavourable to the Trust, but with clear guidance for resolution in 2018/19.

Our deficit is significant and long-standing, and in order to return the hospital to a sustainable position we need to transform services, tackle overspending on pay, and work closely with commissioners and other partners to provide services the community needs within the available budget.

We know that this may mean some very difficult decisions need to be made, but we will not compromise on patient care and our recently agreed quality strategy provides a way that we can reach financial sustainability without compromising quality of care,

We need to continue to focus on our own efficiency through our Better, Best, Brilliant programme, and it is also important that we receive the right level of income for the services we provide. We will continue to work closely with commissioners and other partners as this is not just about the hospital but about the healthcare system across Medway and Swale.

Children’s Community Health Services

Medway Council and Medway CCG have been awarded the contract to provide Children’s Community Health services to Medway Community Healthcare (MCH) following a recent procurement exercise.

The School Nursing Team left the Trust on 1 April 2018. The Trust thanked the School Nursing Team for all their hard work and commitment to providing a fantastic service to our local schools and community.

Staff remaining from the Children’s Community Health Services will TUPE over on 1 June 2018.

Leadership changes

Ben Stevens left the Trust on secondment to Brighton and Sussex University Hospitals NHS Trust at the end of February 2018 and Benn Best has taken over as Director of Clinical Operations for Planned Care on an interim basis. Interviews for a substantive replacement took place in March and I am delighted to announce that Gurjit Mahil will be joining us on 18 June. Gurjit is coming to us from Whittington Health NHS Trust and I am very excited to have her join the team.

As you know, Gary Lupton had been appointed as the new Directors of Estates and Facilities and has now officially started with us, having joined the Trust from East Kent Hospitals University NHS Trust.

Recent achievements and celebrating our staff

I am delighted to say we have seen the number of successes continue here at Medway. We've had a significant presence in the BMJ awards this year, with our breast screening team, our perinatal mental health service and our hip fracture pathway all finalists in their award categories. In the HSJ Patient Safety Awards our surgical bereavement service is also a finalist in their category.
We were delighted to welcome Rehman Chishti MP for Gillingham and Rainham to the Trust recently to meet a number of staff who he had nominated for the NHS70 Parliamentary Aware. These awards have been set up to enable MPs to nominate health heroes in their constituency to mark the 70th anniversary of the NHS.

I was also thrilled to hear that the Friends of Medway got the overall prize in the 2018 Pride in Medway awards. The continuing support and dedication of the Friends to the work of the hospital is deeply appreciated by me and everyone at the Trust, so it is great that they are also getting the recognition they deserve from the wider community.

Our Human Resources and Organisational Development Team recently won HR Team of the Year at the Kent Chartered Institute of Personnel Development's annual awards, and are currently finalists in the Employee Benefits Awards for Best Financial Wellbeing Strategy and our Deputy Chief Executive James Devine is a finalist for HR Director of the Year. The winners will be announced on 7 June.

Beyond Medway

Kent and Medway Stroke Consultation

The consultation for stroke services closed on the 20 April. The Trust had implemented a campaign to raise awareness of the consultation and ensure people had enough information to respond to the survey. The Trust also submitted a response to the consultation and Medway and Swale postcodes had the highest response rate. The level of engagement we have achieved locally have been the result of a high profile, consistent communications campaign, engagement with and support from local politicians for an hyper acute stroke unit, and strong representation by clinicians and members of the Board at the engagement events.

The next stage is for the responses to be collated and combined with the evaluation criteria that was used to determine the five options. A meeting of the Joint Clinical Commissioning Groups Committee will meet to make the final recommendation. Each CCG will have two votes, our neighbouring CCGs have been included so there are 20 voting members

(includes East Sussex and Bexley). The recommendation will then go to the Joint Health Oversight and Scrutiny Committee before the final decision is made public.

New Medical School for Kent and Medway

It has recently been announced that a new medical school is to be located in Kent and Medway. It will be the county's first ever medical school, bringing together the existing centres of excellence in health and medical education provided by Canterbury Christ Church University, the University of Kent and local healthcare organisations, to offer a new model of patient-focused medical education.

Trainee doctors at the school will work across all the sites in Kent and Medway and in primary care (such as GP practices) from the very beginning of their training.

Roundtable discussions with Secretary of State

Trust Chief Executives and STP leads have been invited to join a roundtable hosted by the Secretary of State for Health and Social Care to discuss NHS priorities and reform in light of the Prime Minister's recent commitment to developing a long-term plan and multi-year funding settlement. There is further ministerially-led engagement with other parts of the health and social care system, including with clinicians, patients and carers planned. I will attend the roundtable on the 15 May and provide an update at the next Board meeting.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018

Agenda item 9ai

Title of Report	**Sustainability and Transformation Partnership update**
Prepared By:	Glynis Alexander
Lead Director	Lesley Dwyer, Chief Executive
Committees or Groups who have considered this report	NA
Executive Summary	This report provides an update on current activity in the STP in Medway and the rest of Kent.
Resource Implications	NA
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA
Improvement Plan Implication	The Improvement Plan is aligned with the STP
Quality Impact Assessment	NA
Recommendation	The Board is asked to note the report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The Kent and Medway STP is progressing in a number of areas, both strategically in terms of delivery models, but also in relation to proposed service changes.

1.2 There has been a good deal of work carried out towards developing a clinical strategy.

1.3 The consultation on stroke services across the county has now ended.

2 CLINICAL STRATEGY – QUALITY OF LIFE, QUALITY OF CARE

2.1 The Clinical and Professional Board has developed the vision statement for the Clinical Strategy, which has been approved by the STP Programme Board.

2.2 The strategy has a framework for the development of clinical pathways based on best national and international evidence with workshops of stakeholders including patient and public representation.

2.3 The first pathway for urgent and emergency care has been developed and is now going to the delivery boards for approval and then to the Local Accident and Emergency Delivery Boards for implementation.

2.4 The priorities for the Clinical and Professional Board for future pathway development are:

- Cancer
- Local Care – including primary care
- Children and Adolescent Services
- Mental Health

3 ACUTE STROKE SERVICES

3.1 The public consultation on the future of urgent stroke services in Kent and Medway closed on 20 April.

3.2 The Trust has implemented a campaign to raise awareness of the consultation and ensure people had enough information to respond to the survey.

3.3 The Medway and Swale postcodes had a high response rate. The level of engagement we have achieved locally has been the result of a high profile, consistent communications campaign, engagement with and support from local politicians for a hyper acute stroke unit, and strong representation by clinicians and members of the Board at the engagement events.

3.4 The next stage is for the responses to be collated and combined with the evaluation criteria used to determine the five options.

3.5 The Joint Clinical Commissioning Groups Committee will meet to make the final recommendation. Each CCG will have two votes. Neighbouring CCGs have been included so there are 20 voting members (including one from East Sussex and Bexley).

3.6 The recommendation will then go to the Joint Health Oversight and Scrutiny Committee before the final decision is announced.

4 VASCULAR SERVICES

4.1 MFT remains committed to the development of a vascular network.

4.2 Over the last three years we have been in discussion with East Kent University NHS Foundation Trust and the evaluation for the siting of the arterial centre (where all in-patient vascular surgery including emergency surgery would be performed) had concluded this should be on the Ashford site which is an emergency centre with similar services to ours.

4.3 The recent changes in the options for the Major Emergency Centre in East Kent to include a new build on the Kent and Canterbury site have had a major impact on the timeline for the capital changes needed on the William Harvey Site and it is unlikely that any investment will be made on that site until the consultation on the two options is complete.

4.4 A decision is required whether to continue to provide the service on both the Kent and Canterbury site and at Medway or create the arterial centre on one site as an interim measure. Kent and Canterbury does not have an Accident and Emergency Centre and therefore does not provide the co-located services that are recommended.

4.5 We are now therefore going through the evaluation criteria again to put forward a recommendation for an interim arterial centre on one of the two sites.

5 PATHOLOGY SERVICES

5.1 A review of pathology services delivered across Kent and Medway is currently underway.

5.2 This is being undertaken by all four acute hospitals working together as part of the national requirement to form a pathology network. It is also aligned to the STP through the productivity workstream.

5.3 The overarching aim is to deliver a service for Kent and Medway that provides a high-quality service for patients, is streamlined and efficient, and provides best value for money.

5.4 Potential options have been scoped, with the next step being to consider the evaluation criteria, refine and shortlist.

6 CAPITAL FUNDING

6.1 The NHS in Kent and Medway is to receive up to £19.5million of funding to invest in projects to improve healthcare.

6.2 Five projects in Kent and Medway will receive funding which will enable local NHS services across the county to grow and improve and to become more joined up including a significant investment in Kent and Medway's programme to develop out of hospital care services.

6.3 Medway NHS Foundation Trust will receive up to £1million to create an Urgent Treatment Centre at the front entrance of Medway Maritime Hospital, directing patients to the most appropriate service.

7 NEW MEDICAL SCHOOL FOR KENT AND MEDWAY

7.1 A new medical school has been announced for Kent and Medway.

7.2 It will be an essential boost for improving health and care for the people of Kent and Medway, as well as encouraging local people into health and care careers.

7.3 It will be the county's first ever medical school, bringing together the existing centres of excellence in health and medical education provided by the two universities, and local healthcare organisations, to offer a new model of patient-focused medical education.

8 NEW ACCOUNTABLE OFFICER FOR KENT AND MEDWAY CCGs

8.1 Glenn Douglas has been appointed Accountable Officer across seven Clinical Commissioning Groups in the area.

8.2 The new shared leadership approach will strengthen how CCGs work together, driving service improvements and channelling resources to where they are needed – front line services.

Report to the Board of Directors

9 NEW SHARED CARE RECORD FOR KENT AND MEDWAY

9.1 The Shared Care Record will be a new electronic system which will bring together key information about individuals requiring care into one place.

9.2 Using existing point of care systems within the NHS, Kent County Council and Medway Council, it will provide an up-to-date overview of any patient and their history. This will enable health and social care staff to make the best decisions with patients about their care.

9.3 The Business Services Centre, part of Kent County Council, is working on behalf of the STP to develop the system requirements and prepare to procure the system.

Report to the Board of Directors

Board Date: 03/05/2018

Agenda item 9aii

Title of Report	**STP Funding**
Prepared By:	Tracey Cotterill – Director of Finance & Business Services
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee – 26th April 2018
Executive Summary	This report outlines the proposed budget for the Kent and Medway STP for 2018/19 and the financial contribution requested from MFT. The Total proposed budget for 2018/19 is £6,710k The Trust is being asked to contribute £396k which equates to 6% of the total.
Resource Implications	
Risk and Assurance	There is a national expectation for all NHS bodies to engage with the STPs for the purpose of improving the provision of increasing demand for care within the finances available. If the Trust does not contribute to the STP it will not be engaged in the discussions and not able to participate in debate and decisions on behalf of the Medway and Swale population.
Legal Implications/Regulatory Requirements	
Improvement Plan Implication	The productivity workstreams are designed to deliver efficiency savings to the participating organisations. Whilst the Trust may pursue many of those efficiencies independently, there is a recognition that a larger body will generate further incremental benefit.
Quality Impact	

Report to the Board of Directors

Assessment				
Recommendation	To consider approval of the funding request.			
Purpose and Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☐	☐	☐

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 This report outlines the proposed budget for the Kent and Medway STP for 2018/19 and the financial contribution requested from MFT.

1.2 The Total proposed budget for 2018/19 is £6,710k

1.3 The Trust is being asked to contribute £396k which equates to 6% of the total.

2 RETURN ON INVESTMENT

2.1 There are a number of workstreams supporting improved productivity and enhancing procurement savings opportunities through economies of scale and joint review covering a wider scope.

2.2 Appendix 1 details the high level deliverables that the STP is focusing on in 2018/19.

2.3 Appendix 2 shows the schedule of savings that the Trust has within its CIP programme that is being supported by the productivity workstreams.

2.4 The Finance Directors Group and the Programme Board monitor performance against the deliverables and progress of the productivity workstreams

3 CONCLUSION & RECOMMENDATION

3.1 The Trust has incorporated many of the savings opportunities within its own CIP schemes, but the STP will provide additional bandwidth to deliver some of those schemes as well as incrementally improving the level of savings available through scale.

3.2 It is recommended that the Board approve the contribution to the STP in line with national guidance and to enable the Trust to continue to participate in the various programmes

Report to the Board of Directors

Appendix 1 – STP Deliverables for 2018/19

Area	18/19 deliverables
System Transformation	• Single AO and senior management implemented for the Kent and Medway CCGs (7 of 8) • Roll out joint committee for decision making responsibilities for delegated CCG functions/responsibilities • Development of strategic commissioner end state with a clearly defined local and strategic offer, including transferring any functions from NHSE/I
Clinical Strategy	• Implement UEC model through the LAEDBs • Support Cancer, Mental Health, Prevention and Paediatrics to develop programmes utilising the care model framework • Establish programmes in specialised services and primary care
Mental Health	• 80% of all MH 5YFV targets achieved (across access and waiting times; clinical standards and patient outcomes; and expansion of MH services) • Six new examples of integration of (secondary care) mental health in Local Care, Urgent and Emergency Care and Acute Hospital services • One public mental health and wellbeing campaign and evaluation framework implemented
Prevention	• Further develop and deliver business cases for obesity and smoking • Embed prevention within key clinical priorities and pathways, particularly stroke and mental health, but also diabetes and lung cancer • Delivery of prevention through Local Care
Workforce	• Develop a workforce strategy aligned to the clinical strategy • Develop Kent and Medway medical school plan
Digital	• Procure and deliver the Kent Care Record • Support the procurement of 111 services, including digital online 111 services
Estates	• Develop and submit an estates workbook to NHSE/I to access STP capital • Development of an estates strategy to identify savings

Report to the Board of Directors

Appendix 2 – Savings Opportunities for MFT supported by Productivity Workstreams

STP Scheme	STP Working Group	Total
Anti Embolism	Supplies and Services	10,000
Continence	Supplies and Services	20,000
Enteral Feeds	Supplies and Services	956
Negative Pressure Wound Therapy	Supplies and Services	10,000
Radiology Consumables and Reporting	Supplies and Services	50,000
Wound care	Supplies and Services	60,000
Re-usable sharps bins	Supplies and Services	6,500
Orthotics - basic insoles	Supplies and Services	10,000
Collaborative Bank	Temp Staffing	187,500
Medical Locum Break Glass	Temp Staffing	1,265,852
Nusing and Midwifery Rates	Temp Staffing	562,880
Send-aways	Pathology	66,500
Biosimilars	Medicines	750,882
		3,001,070

NHS Medway NHS Foundation Trust

Performance Report to the Trust Board (public)

Committee Date: 03/05/2018 **Agenda item** 9b

Title of Report	**Transformation Assurance Group – Update Paper**
Prepared By:	James Devine, Deputy CEO & Executive Director of HR&OD
Lead Director	James Devine, Deputy CEO & Executive Director of HR&OD
Committees or Groups who have considered this report	• Transformation Assurance Group • Executive Team
Executive Summary	Over the past twelve months, the Trust has been working with 2020 Consulting on specific aspects of the Better, Best, Brilliant improvement programme. As planned, their work with the Trust came to an end in March 2018, with the aim of building an internal transformation team leading in to 2018/19. With effect from April 2018, our new transformation team will take over the work of 2020. Their work will continue to focus on the better, best, brilliant programme, and build upon the same project methodologies to improve capability across the organisation. In order to provide greater oversight of the transformation programme, a Trust Board sub-group was established; namely, the transformation assurance group. This is led by the Chairman. In terms of progress, a series of schemes have been identified to work toward achieving the financial requirements for 2018/19; with initial discussions having taken place with proposed partner organisations to support these transformation programmes.
Resource Implications	
Risk and Assurance	Risk of non-delivery will impact upon the financial recovery programme
Legal Implications/Regulatory Requirements	Non-delivery of the financial recovery could lead to regulatory action in the form of financial special measures.

Improvement Plan Implication	This work spans across the entire better, best, brilliant improvement programme
Quality Impact Assessment	All schemes under the programme go through an initial QiA process. These are then reviewed by the Medical Director, and/or Director of Nursing.
Recommendation	The Board are asked to note the content of this report; acknowledging that future updates will provide further detail in terms of progress
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

1 BACKGROUND

Over the past twelve months, the Trust has been working with 2020 Consulting on specific aspects of the Better, Best, Brilliant improvement programme. As planned, their work with the Trust came to an end in March 2018, with the aim of building an internal transformation team leading in to 2018/19.

In March 2018, a detailed report was provided to the Trust Board which showed the work undertaken over the previous twelve months by 2020, and the impact of the improvements made.

With effect from April 2018, our new transformation team will take over the work of 2020. Their work will continue to focus on the better, best, brilliant programme, and build upon the same project methodologies to improve capability across the organisation.

This report provides an update on the work of the transformation team to date.

2 TRANSFORMATION TEAM

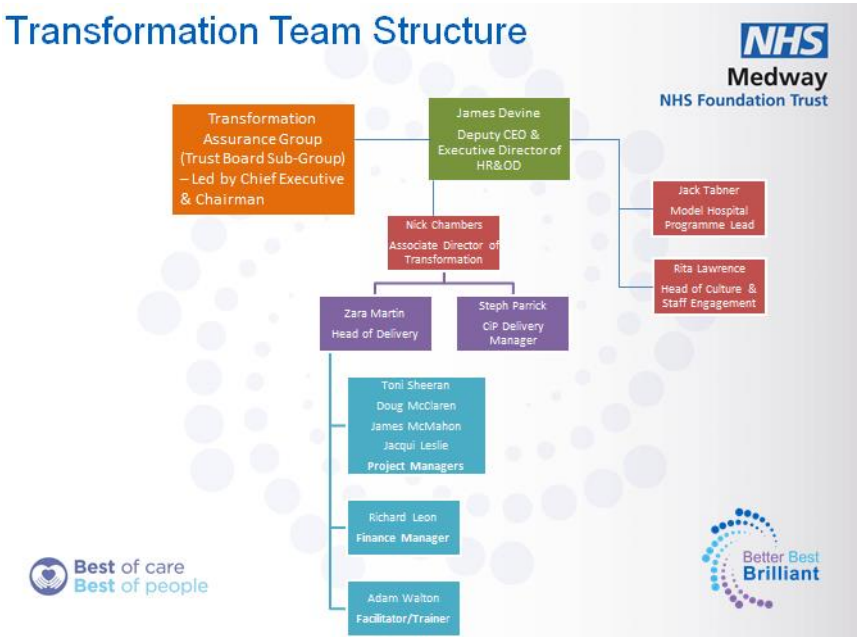
The new transformation team structure will report to the Deputy Chief Executive, with the work programmes reporting through to the transformation assurance group; which is led by the Chairman.

The team will continue to work on the thirteen workstreams under the BBB programme, and work alongside leaders across the hospital to improve processes, systems and lead improvement projects.

In addition, the transformation team will work with clinical and non-clinical teams to realise the efficiencies detailed within the model hospital. This programme identifies inefficiencies across specialties and corporate areas, and provides a benchmark amongst peer groups. This data is then used to improve efficiency, reduce variation and make better use of resources.

For sake of clarity, the term ‘transformation’ replaces schemes previously referred to as ‘cost improvement’ as we believe that transformation is about directly improving patient care/safety and pathways, whilst balancing the need to reduce variation and unwarranted costs.

The structure of the team is below:



3 TRANSFORMATION ASSURANCE GROUP

In order to provide greater oversight of the financial challenge during 2018/19, the programme of works will be overseen by a Trust Board sub-group; namely, the transformation assurance group.

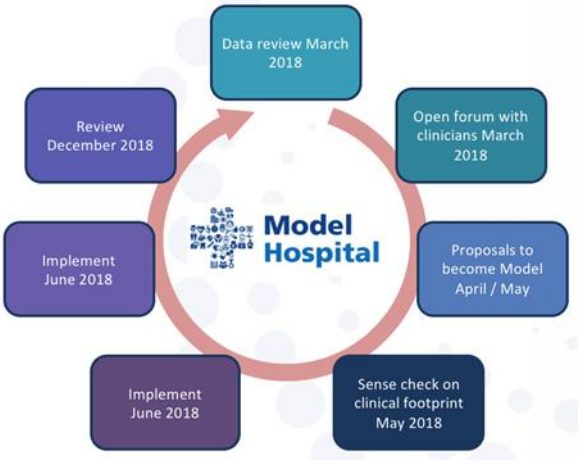
This group will be led by the Chairman of the Trust, and its aim being to assist the Trust Board in fulfilling its responsibilities through monitoring the establishment and delivery of detailed transformation plans and cost improvement programmes. In addition to monitoring progress, the Group will provide guidance on priorities and will have responsibility for providing all the necessary executive support to ensure objectives are reached and the programme succeeds.

To date, the group has met three times.

4 MODEL HOSPITAL

As stated above, much of the work over the next twelve months will focus on the model hospital. Over the past four weeks, we have been sharing the data by the top twenty four specialities where the data represents most efficiency gains. The aim being that during April and May, we review the data and propose changes to existing service models, and implement during Q1 and Q2 of 2018/19.

The graphic below shows the process we are undertaking, and the timescale. It is important to note that this will be an iterative process; as and when the model hospital data is updated (in some cases, the data is the latest; in other specialities it is extracted from 2015/16), we will again review areas of inefficiency.



5 ADDITIONAL SCHEMES

Unsurprisingly, many of the additional schemes that feature as part of the 2018/19 transformation work are related to pay. During 2017/18, we made significant progress on reducing our reliance on agency workers, and increasing the number of substantive staff we employ.

That said, we must continue to get greater grip and control on our expenditure and ensure that we manage our financial resource within existing financial budgets.

We will also work, where required, with external partners to being expertise to particular projects.

6 NEXT STEPS

The Trust Board are asked to note the content of this update report.

Further updates on progress of the transformation programs will be reported to the transformation assurance group, and to the Trust Board.

-End

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018 Agenda item

10a

Title of Report	**Integrated Quality Performance Dashboard - Update**
Prepared By:	Associate Director of Business Intelligence
Lead Director	Executive Team
Committees or Groups who have considered this report	Draft to Quality Improvement Committee and Quality Assurance Committee
Executive Summary	To inform Board Members in the form of a flash report of March's performance across all functions and key performance indicators. A full report will be presented to the next Board. Key points are: • The Trust did not achieve the **four hour ED target** for March and performance has slightly decreased from 82.63% in February to 82.49% in March. • There was one **12 hour breach** in March. • **HSMR** data reported in this month's IQPR is for the period from January 2017 to December 2017. This is currently 107.6, which is within expected range. • This month saw a 78.8% increase in the number of **Mixed Sex Accommodation** breaches, which totalled 202 in March. An IT system has been launched to support the wards in accurately recording and reviewing MSA breaches. • **RTT** performance has slightly increased to 79.82% from 80.48%. This is below the national standard of 92%, as well as the agreed 90% trajectory. • All **Cancer targets** have been achieved in February. The 2-week wait symptomatic breast performance has increased by 7.61% to 97.22%. The 62-day GP performance was achieved in February, although

Report to the Board of Directors

	performance has decreased by 6.23% to 85.12%. The 62-day screening standard was also achieved in February, and this has improved by 14.83% to 91.30%. • There was a 17.6% decrease in the number of **falls** in March (61) compared to February (74). • 89 complaints were reported in the month, an increase from February's 82. There was one complaint returner in March.
Resource Implications	N/A
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Improvement Plan Implication	Supports the Improvement Programme in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report as appropriate
Recommendation	N/A
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

NHS Medway NHS Foundation Trust

Integrated Quality and Performance Report

April 2018

Please note the data included in this report relates to **March** performance. Executive updates are now included within this report.

Best of care
Best of people

Contents

Legend					
↑↓	Performance has improved since the previous month.	↑↓	Performance has deteriorated since the previous month.	↔	Performance has not changed since the previous month.

Best of care
Best of people

10633 Patients visited our ED , which is a **16.56% increase** on the previous month, with **82.49%** seen within 4 hours, compared to 82.63% . **1927** Patients were admitted, with a slight **decrease** in conversion rate of **18.12%** compared to 18.71% in February.

There were **5450** total patient admissions in March, and **5470** patients were discharged.

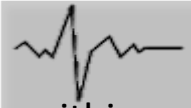
Bed Occupancy **decreased** by **5.29%** in March to **90.30%**.

3205 patients arrived at ED via ambulance which is an **8.35% decrease** on last month.

31.9% Of ambulance patients were seen in under 15 minutes.

March's Story....

379 Babies were delivered in the month of March (32 more than February) with Emergency C-Section rate with an **increase** of **3.37%** from the previous month to **21.84%.**



HSMR is **107.6** and within expected parameters (101.5 – 113.9) compared to 107.03 as reported in February.

85% of staff have had an appraisal compared to **83%** in February.

34436 Patients attended an outpatient appointment with **9.38%** DNA rate which is a decrease of **0.10%** on last month.

There were **61** total falls in March, compared to **74** in February.

RTT Overall Incomplete Pathways for March was **79.82%** which decreased by **0.66%** on previous month. This is below the Trust improvement trajectory. The Trust also reported **1 x 52** week waiters which remained the same compared to February.

31 day subsequent treatment surgery cancer target was achieved at **100.00%** in February (reported one month in arrears).

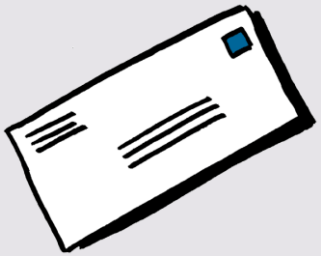
2 Week Wait symptomatic breast was above the target of **93%** in February with performance of **97.22%** - increased by 7.61%.

2 Week Wait cancer performance for February was **97.76%** (reported one month in arrears) . This is a **0.91%** increase from January's performance.

March's Performance....

96.75% of patients waited under 6 weeks for diagnostic tests in the month of March, which has slightly decreased by **0.17%** since February's reported performance.

We received **89** complaints in March, increasing from those received in February by **7**. The number of complaint returners increased to **1** in March.



There were **202** Mixed Sex Accommodation breaches in March which is a **78.76%** decrease on February's performance.

Safe Page 10

Legend: Compliant with target; Breaching target

Infection Control

The trust target of CDAD cases for 2017-18 is no more than 20 cases, the Trust has reported 24 cases. There have been 24 post infection reviews undertaken with 13 cases considered unavoidable. 3 cases of level 3 lapses of care have been identified, these cases will incur a £10,000 fine per case. The trends and themes from these are similar to those from last year:

- Irrational antimicrobial prescribing / poor antimicrobial stewardship
- Timeliness of stool samples and incomplete risk assessment / Time to isolation.
- Delay in empirical treatment with metronidazole.
- Poor diagnoses with subsequent inappropriate antimicrobial therapy.

Other contributory factors include shortage of staff, use of locums and high occupancy rates.
Directorates have action plans in place to address learning from the post infection reviews, supported by the IPCT. However there is little assurance that actions have been effective in some areas. Actions plans are being reviewed and will be monitored at the recently established antimicrobial stewardship steering group.

Serious Incidents

As at 31st March 2018 there are a total of 114 open Serious Incidents (SIs)

- 72 subject to an active investigation
- 9 submitted for review at the CCG SI Closure Panel and referred back to the Trust for further information
- 33 awaiting review at a forthcoming CCG SI Closure Panel

In line with the NHSE SI Framework the Trust is required to submit 100% of all serious incident final reports to the CCG within 60 working days or initial reporting. Trust wide compliance for March 2018 is 20% against a YTD average of 24%. The Trust is in discussion with the CCG to agree a plan to review and close the SIs which have breached the 60 day reporting standard.

Duty of Candour
Monitoring and reporting of compliance with Duty of Candour is currently under review. The processes set out in the Trust policy are not well understood by some staff which has resulted in evidence of compliance being incorrectly logged. A validation exercise is being undertaken and the outcome will be reported to the executive team.

Pressure Ulcer Acquisition
One Grade 3 pressure ulcer acquisition was reported in March.
Patient acquired a stage 3 pressure ulcer to the Thoracic region of the spine 1.5cm x 1.5cm depth was superficial but due to anatomical location was categorised as a stage 3.

Tissue viability validated pressure Ulcer on the 7/3/18 patient RIP 11/3/18 – patient was acutely unwell and required non-invasive ventilation, patient was very undernourished and was under dietician and spent most of her time in bed.

RCA has been completed and high level investigation is being carried out through the use of the toolkit. Initial findings shows good practices around risk assessments being completed and that the patient was turned regularly.

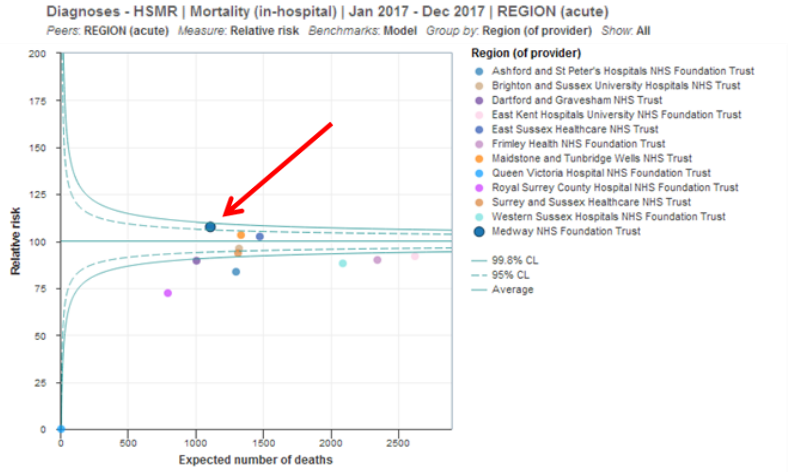
NICE Guidelines and Technology Appraisals
Since April 2017, 197 guidelines have been published by NICE. Of these, 180 (81%) have been reviewed, with 96 of these being deemed as applicable to the Trust.

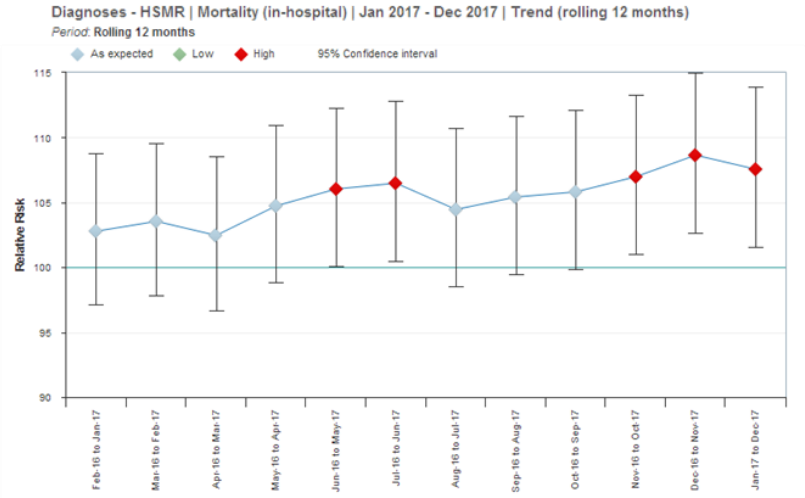
The statutory 90 day review requirement is for Technology Appraisals only. 90 Technology Appraisals have been published since April 2017; of these, 3 are updates of existing TAs. 77 (86%) have been assessed, with 44 (59%) being deemed as applicable and 31 (41%) are not applicable to the Trust. 37 (84%) have been implemented by the Trust. The remaining 6 TAs not assessed are all within the 90 day assessment timeframe.

Mortality

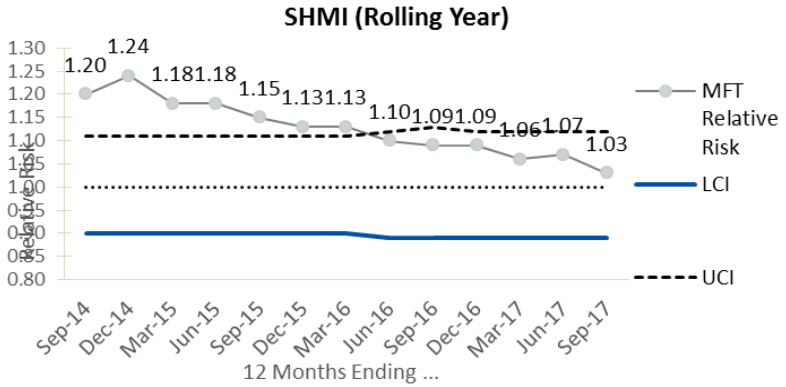
The HSMR for the period January 2017 – December 2017 is 107.6 (95% confidence interval 101.5 – 113.9). This represents an increase from the previous rolling 12 month value of 108.6 and is highlighted as high for the third consecutive month by Dr Foster.

Peer comparison shows that the Trust currently has the highest relative risk in the area, but is now within the 99.8% confidence limit.

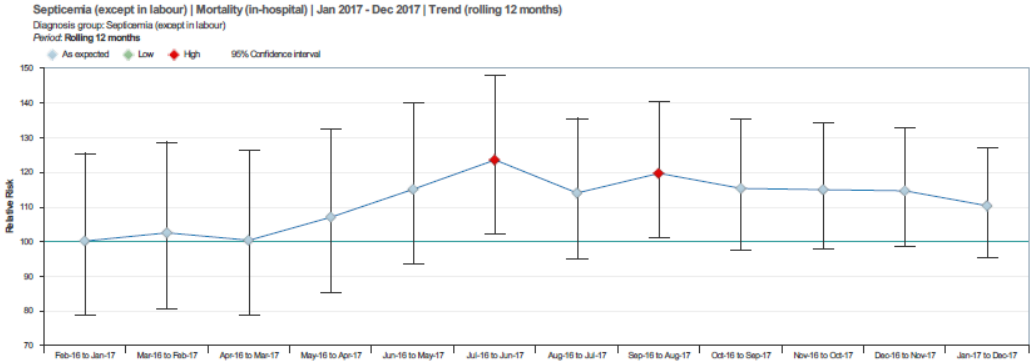




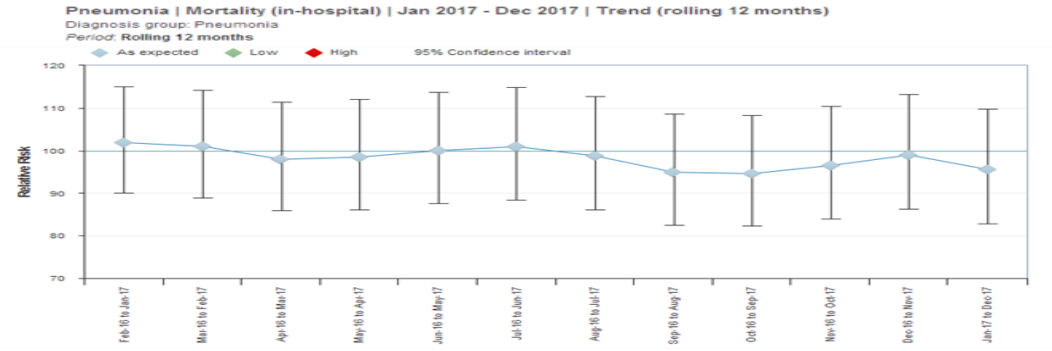
The latest Summary Hospital-level Mortality Indicator (SHMI) for the period October 2016 – September 2017 was published on 22 March 2018. The value has decreased slightly to **1.03** from 1.07 in the previous data update (for the period July 2016 – June 2017) and remains within the expected range.



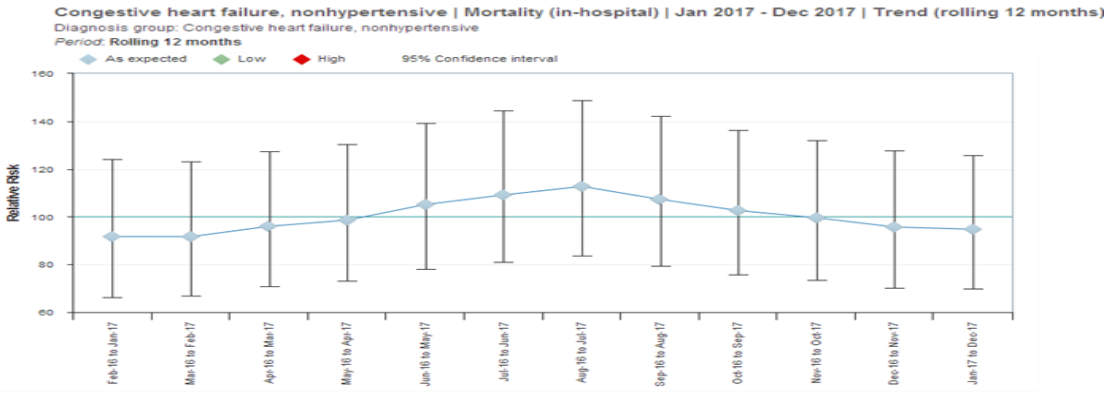
The HSMR for Septicaemia is currently **110.2** (95% confidence interval 95.2 – 127.0); this represents a slight decrease from 114.5 for December 2016 – November 2017. It is within the expected limits.



The HSMR for Pneumonia remains low at **95.6** (95% confidence interval 82.8 – 109.8), having fallen from 98.9 in the period December 2016 – November 2017, and is within expected limits.

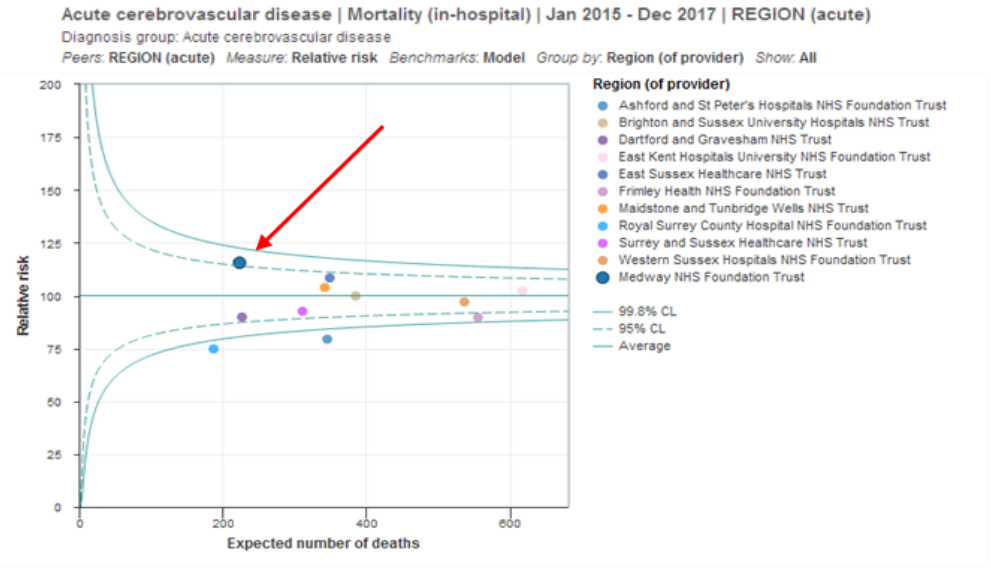


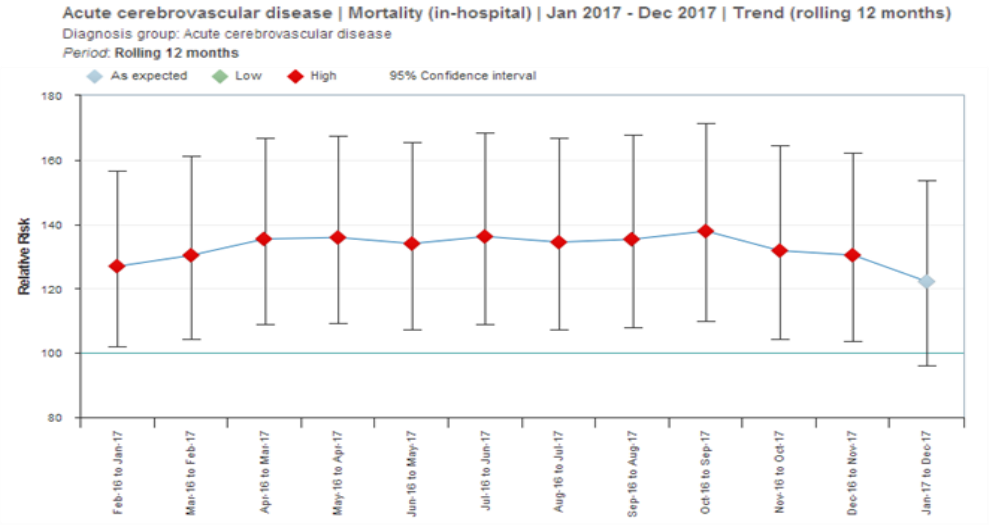
The HSMR for congestive heart failure has fallen again to **94.7** (95% confidence interval 69.8 – 125.6) and is within expected limits.



The HSMR for acute cerebrovascular disease is **122.2** (95% confidence interval 95.9 – 153.4) and is within normal limits for the first time since the period January – December 2016. The Trust will continue to review all stroke deaths until the HSMR has been within the expected range for three consecutive months.

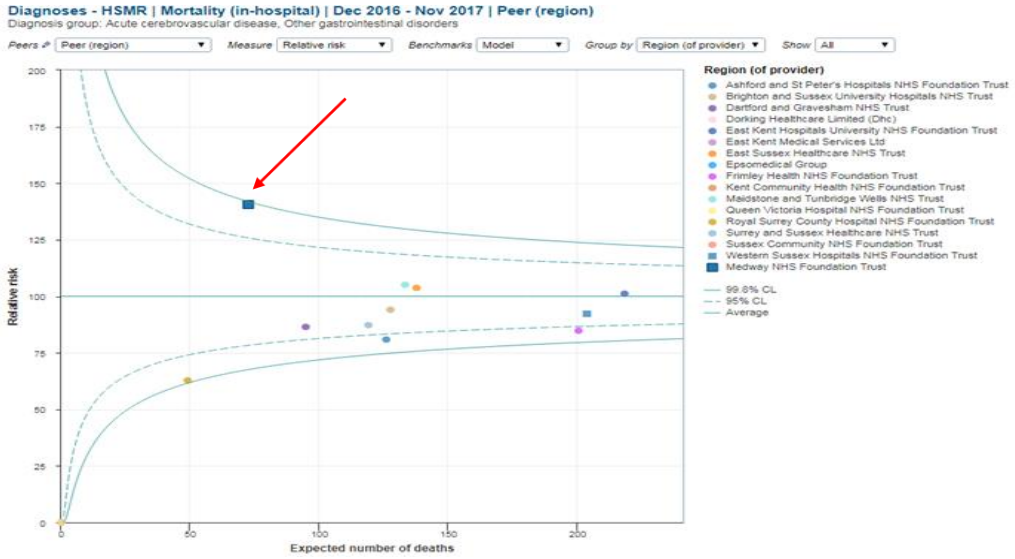
Peer comparison for acute cerebrovascular disease shows that Medway continues to have the highest relative risk in the area, but is now within the 99.8% confidence limit.

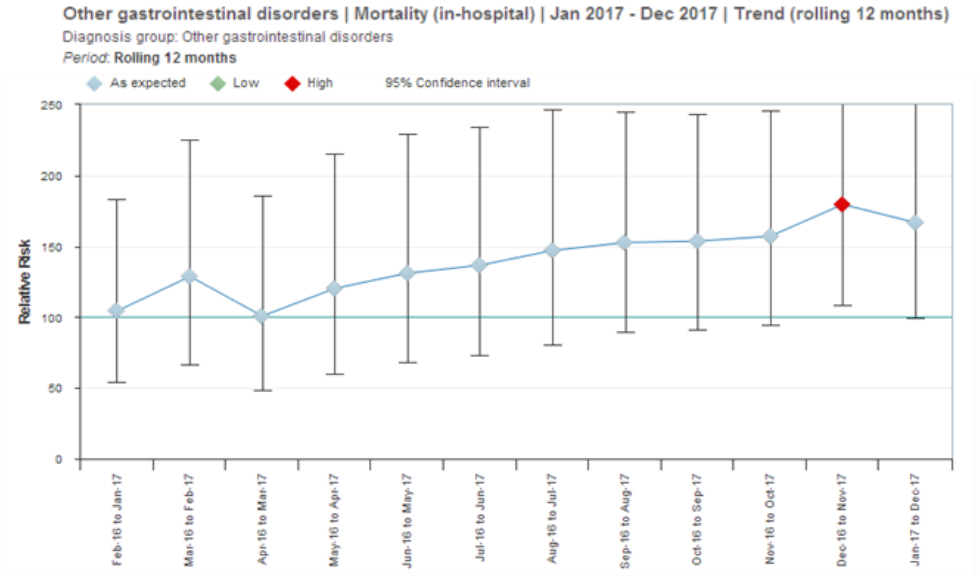




The relative risk for other gastrointestinal disorders has been recalibrated, and Medway is now only showing as an outlier for the period December 2016 – November 2017. This fits in with the preliminary review of cases, which suggests that the cause of death for the patients in this cohort was either malignancy or dementia in the majority of cases.

The data is correct at the time of compilation: Monday 03 April 2018.





Effective Page 23

CQUIN – The Trust is awaiting signed-off update. The CCG have yet to complete a review of the Trust submission for Q3, they will complete this alongside the review of the Trust's Q4 submission. This is likely to be undertaken in May / June 2018.

Caring Page 24

- **Mixed Sex Accommodation (MSA) Breaches**

The number of Mixed Sex Accommodation (MSA) breaches has increased. An IT System has been launched at the end of March to support ward teams to accurately record and evaluate MSA breaches using national guidance from NHSE. Figures are monitored regularly with weekly reports going to Deputy Directors of Nursing.

Responsive Page 25

- **RTT**

The RTT performance for March was 79.82%.

The Trust are working closely with out commissioners and our regulators to improve our constitutional RTT 18 week target. Each failing speciality has submitted a trajectory and an action plan which is being monitored on a weekly basis. At the meeting we investigate how each individual programme is managing their patients, we discuss long waiters, number of referrals, polling times, trajectories and corrective actions. We have reduced the number of long waits (52 weeks) significantly however due to prolonged winter pressures reducing the number of elective beds available we are only operating on urgent, long waits and cancer patients only.

Cancer

February performance against the Cancer Waiting Time Standards has improved on last month with compliant performance against all the standards. The 62 GP referral standard exceeded the trusts trajectory and was the second consecutive month where the trust met the standard.

● 2WW - The Trust is compliant for both GP 2 week wait and symptomatic breast standards in month.
There were 23 breaches in February across a number of tumour sites however only Children's was non-compliant.
Breaches were predominantly as a result of patients being unavailable for the first appointment, rescheduling booked appointments, prison availability and clinic changes. The Trust had 2 breaches for symptomatic breast due to a patient changing an appointment and prison availability.

● 31D – The Trust is compliant with the first definitive, subsequent drug and subsequent surgery treatments.
There was 1 patient breach in urology against the 31d first definitive standard, due to the patient being too unwell for the procedure.

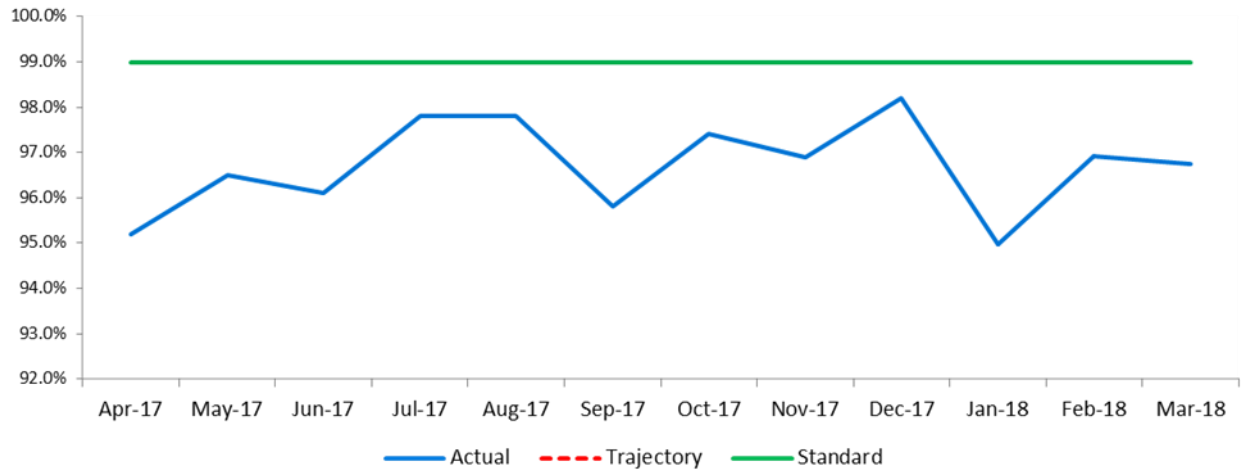
● 62D - The Trust is compliant with both the 62-day GP referral standard and 62 day screening standard.
The 62 GP standard performance was 85.12% which was above the improvement trajectory for a second consecutive month.
The shadow 38 day reporting performance is 85.25% ensuring the Trust is compliant against the 62 day GP standard.
There were 9 breaches against the GP 62 day referral standard. These are detailed as 1 Lower GI, 2 Lung, 2.5 Upper GI, 3.5 Urology patients.

Pathway breaches were varied due to complex pathways, diagnostic delays and patient choice.
There were 4 breaches over 104 days and 4 breaches between 62 and 76 days.
The trust is investing a great deal of energy in the development of cancer services and there is a tremendous clinically lead improvement programme currently underway. Additional Cancer Business Informatics and management support has also been implemented.

Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	84.7%	74.2%	80.0%	82.1%	80.1%	72.3%	74.0%	75.1%	84.8%	91.4%	85.1%	
Trajectory												84.9%
Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Diagnostics

Diagnostic performance remains below trajectory, with a slight deterioration of 0.2% in March 2018, due to staff sickness in principle area of Radiology.



Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Performance	4.8%	3.5%	3.9%	2.2%	2.2%	4.2%	2.6%	3.1%	1.8%	5.0%	3.1%	3.3%
Actual	95.2%	96.5%	96.1%	97.8%	97.8%	95.8%	97.4%	96.9%	98.2%	95.0%	96.9%	96.7%
Trajectory												
Standard	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

Further actions:

Weekly robust Diagnostic PTL Meeting, with focus on improvement actions is now operational.
Non-obstetric ultrasound: Insourcing from March 2018, with review of appointment timings and processes
Better utilisation of all imaging capacity and progression of business case for digitalisation of plain film which will modernise this part of the service and greatly improve patient experience and staff working lives.

ED

The Trust's performance against the national 4 hour standard for March was below trajectory at 82.49% for all types., which was a 3.53% deterioration on the prior months performance. March saw the second most attendances in a month in the last year, with 10633 in total.
Admitted 4 hour performance was 18.14% which is a marginal improvement on February's position .
The Non-admitted pathway was 85.41%, a decrease on February's 87.64%. Minors and Children's ED both performed above the national 98% target.

Performance below trajectory for March is primarily through lack of internal flow from the main bed base to discharge. The trust observed an average of 89, 4hour breaches each day, the majority of which are within Medicine and due to bed availability. (Fig 1)
The drivers for delay with discharge continue to be multifactorial and span the entire continuum both internal and external to the trust.

MFT remains consistently one of the top performers in the region for ambulance handover with 31.9% of offloads within 15 minutes, seeing the largest number of conveyances in the region (3214).

Following the winter pressures period the clinical operations improvement focus will be on the work streams that improve better discharge such as Red 2 Green and the SAFER care bundle . Visual management tools have been developed by the business intelligence team and will support the roll out of new programme of work to improve flow and lower bed occupancy.

A clinically led process review of the acute medical pathway has been undertaken in March and is informing further process redesign work to be mobilised as part of the BBB flow work that is currently underway.

Front door streaming of patients who are more appropriate to receive urgent care via a local primary care provider continues to achieve above the national 20% target. We however continue to work with sector partners to improve the patients offering in this space. The change in streaming protocol during December has had a sustained and positive impact for patients. As demonstrated in Fig 2 below.

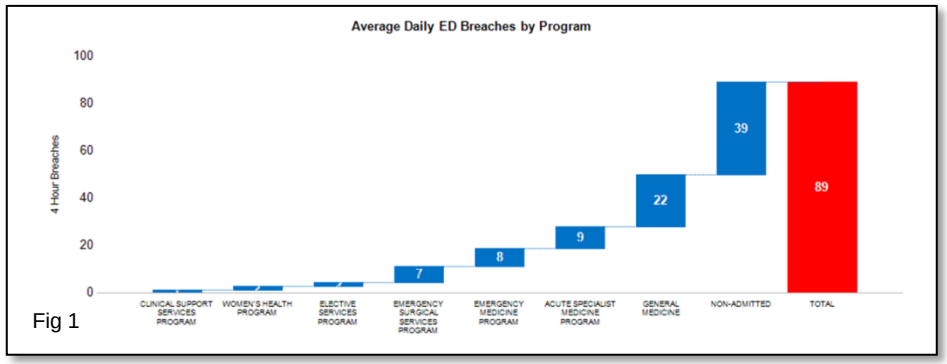


Fig 1

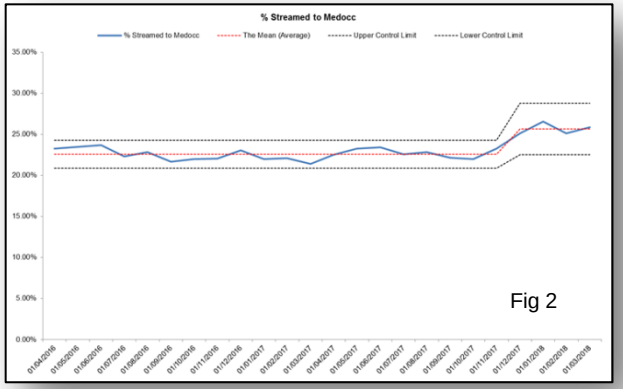


Fig 2

Voluntary turnover (across all staff groups) has decreased to 11.8% (-0.03%) and remains above the tolerance level of 8%; turnover, is expected to plateau over the next two months following the TUPE of pathology service. Sickness absence at 3.87% is slightly elevated however, remains largely static and below the tolerance of 4%. Ratios of long-term sickness to short-term sickness have both slightly increased over the winter period.

The year-end position of pay bill spent on substantive staff (80%) is significantly higher (+3%) than for 2016/17 (77%); agency usage for the financial year decreased by 11% from £40.5m to £17.4m, whilst bank usage increased by 8% from £8.4m to £25.3m. The Trust met its NHSI agency ceiling for 2017/18. Works to continue working with suppliers and clinical programmes to reduce agency expenditure are underway. In addition, the Trust continues to actively support staff moving from temporary to substantive posts.

Data Quality Validation Update

The Team are engaged in a variety of projects to improve systems with identified data quality issues:

Existing work projects:

- **Cancer PTL Open Pathways:** the DQ Team continues to support investigations into open cancer pathways on the Infoflex system pre 2015 period.

Further to completing the initial phase of the validation project in February 2018 (approx.6000 open pathways), the DQ Team have additionally investigated 1522 open cancer pathways on Infoflex. Data validation of these records has been generated since a modification of the Business Intelligence cancer reporting service, which will contribute to an accurate service level of reporting. The Cancer Information System fully supports monitoring of the pathways of suspected cancer patients from receipt of referral until discharge or diagnosis and then on to treatment.

- **Maternity Euroking Upgrade** – Working in conjunction with IT project team, BI and maternity team. Ensuring that data provided on monthly submission is accurate and ensuring new system when live will not impact data or patient care. Working on a maternity PTL with BI to improve patient care and department efficiency.

- **New to Follow Up Ratio** – Working with BI team to identify true new to follow up ratio specifically looking at cancer patients on long term follow up surveillance programmes.

- **DM01** – Working with services to ensure the data on the DM01 is clean and accurate, assisting with the data cleanse process.

Data Quality Training

RTT decision making training being delivered to all staff that have pathway management involvement/management responsibilities. In collaboration with the training team, the RTT guideline booklet has been redesigned and is available to all staff on the intranet.

Working with the imaging department and BI developing diagnostic DM01 training and a diagnostic PTL, with the aim of improving patient care and department efficiency.

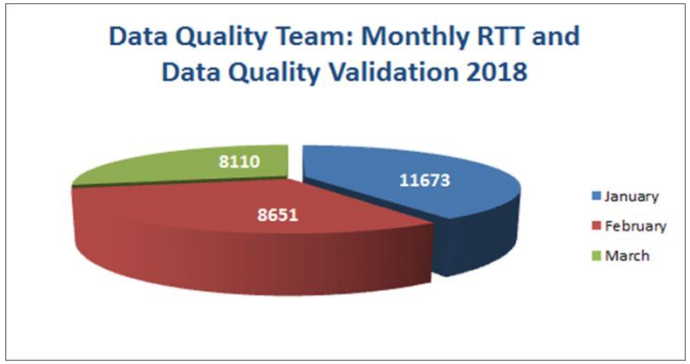
Other DQ Validation Work:

The team continue to validate multiple data quality issues related to patient records, identified through the Data Quality dashboard. The DQ team is actively assisting the directorates looking at their RTT data, analysing and identifying trends or errors that are occurring. Regular engagement with the relevant teams is on-going, providing training, advice and support with the common goal of achieving the 92% target.

The team work in collaboration with the BI team to look at the CCG challenges that are sent through, to ensure that the data provided is accurate. Working on collaborative approach with service teams to improve DQ by DQ co-ordinators working within the services to offer support and be a visual presence.

Quarterly DQ statistics

The chart below, gives a quarterly overview of combined RTT and DQ related validation of patient records across the clinical directorates that has been carried out by the DQ team between **Jan – Mar 2018**.



A quarterly breakdown of patient records that have been validated has been attributed to supporting RTT targets and other related data quality is shown below.

Data Quality Validation statistics		
Month	RTT Validation	DQ Validation
Jan	4089	6864
Feb	3730	4921
Mar	3648	4462

3. Safe

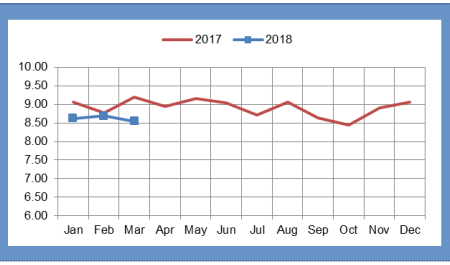
		Monthly Target	RAG Status	Trend Jan-18	Feb-18	Mar-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
1.1.3.2	NRLS Organisational Reporting Rate (6 monthly)		G	46.74 (national median 40.14)								
1.1.4	Never events	0	G	0.00	0.00	0.00	⇔	0.1				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	G	0.00%	0.00%	0.00%	⇔	0.0			✓	
1.1.5	Incidents resulting in death	0	R	8.00	2.00	5.00	↑	4.1				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.30	R	0.13	0.53	0.34	↓	0.31				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	1.21	1.83	1.37	↓	1.4				✓
1.1.10	Incidents with moderate or severe harm with duty of candour response	100%	R	3.4%	3.0%	6.7%	↑	0.1				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	G	13.00	4.00	8.00	↑	7.1				✓
1.1.15	Pressure ulcers (grade 3&4)	0	R	2.00	0.00	1.00	↑	0.9				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	G	0.19	0.08	0.07	↓	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	4.33	5.65	4.18	↓	5.0				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.13	0.15	0.07	↓	0.1				
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	⇔	0.0			✓	
1.1.21	% Duty of Candour with first letter	100%	R	0.0%	0.0%	0.0%	⇔				✓	
1.2.2	New VTEs - point prevalence in month	0.36%	R	0.21%	0.20%	1.02%	↑	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	16.7%	18.5%	21.8%	↑	18.8%				
1.3.1	MRSA screening of admissions	95%	G	84.6%	98.6%	96.3%	↓	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	0.00	1.00	0.00	↓	1			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	G	3.00	2.00	1.00	↓	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	107.6 (101.5-113.9)							✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	116.3 (104.1-129.5)							✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.03 (0.89-1.12)							✓	✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

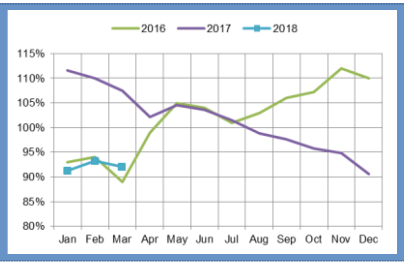
We have continued to see good performance remaining over the target of 8 for March.



Daily huddles are being undertaken to make sure wards are staffed correctly for patient safety.

Safe Staffing

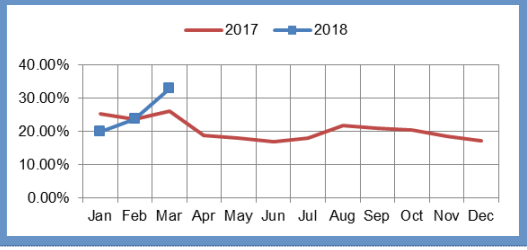
Safe staffing remain above target for March.



Staff issues are being risk assessed multiple time daily. Staff are redeployed when necessary to ensure wards are safely staffed.

Temporary Staffing

The Trust remains below target for Temporary Staffing.



The Trust is working to transfer staff from Agencies to the Trust's staffing bank, to reduce the Agency spend.

Best of care
Best of people

Staffing Levels – Nursing & Clinical Support Workers

		Day				Night				Day		Night		Internal KPIs
		Registered Staff		Care Staff		Registered Staff		Care Staff						
WARD	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	*Average fill rate - registered staff (%)*	*Average fill rate - care staff (%)*	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Overall fill rate
Bronte Ward	18	1597	1135	1135	1109	1093	1139	729	739	*71%*	*98%*	*104%*	*101%*	*91%*
Byron Ward	26	1664	993	2014	2002	1046	1013	1395	1416	*60%*	*99%*	*97%*	*101%*	*89%*
CCU	4	1072	778	0	8	713	717	0	12	*73%*		*100%*		*85%*
Dickens Ward	25	1890	1306	1547	1543	1364	1275	1336	1358	*69%*	*100%*	*93%*	*102%*	*89%*
Harvey Ward	24	1659	1115	1676	1593	1046	1228	1395	1496	*67%*	*95%*	*117%*	*107%*	*94%*
Keats Ward	27	1686	1114	1193	1508	1023	1148	1023	1236	*66%*	*126%*	*112%*	*121%*	*102%*
Lawrence Ward	19	1134	1139	899	952	698	763	698	722	*100%*	*106%*	*109%*	*103%*	*104%*
Milton Ward	27	1655	1076	2368	2202	1046	1253	2093	1973	*65%*	*93%*	*120%*	*94%*	*91%*
Nelson Ward	24	1658	1096	1231	1253	1023	1025	682	693	*66%*	*102%*	*100%*	*102%*	*89%*
Tennyson Ward	27	1652	934	2078	1875	1046	991	1395	1347	*57%*	*90%*	*95%*	*97%*	*83%*
Wakeley Ward	25	2044	1313	1603	1487	1395	1271	1395	1395	*64%*	*93%*	*91%*	*100%*	*85%*
Will Adams Ward	26	1676	931	1065	1848	1023	1035	1012	1672	*56%*	*174%*	*101%*	*165%*	*115%*
Arethusa Ward	27	1994	1295	1349	1552	1364	1331	1067	1365	*65%*	*115%*	*98%*	*128%*	*96%*
ICU	9	3862	2933	0	0	3476	2802	0	0	*76%*		*81%*		*78%*
Kingfisher SAU	14	2419	1676	0	12	1701	1605	0	0	*69%*		*94%*		*80%*
McCulloch Ward	29	2501	1418	1203	1757	1705	1643	1023	1410	*57%*	*146%*	*96%*	*138%*	*97%*
Medical HDU	6	1467	1118	356	348	1392	1218	0	173	*76%*	*98%*	*88%*		*89%*
Pembroke Ward	27	2256	1734	1527	1874	1705	1749	1364	1715	*77%*	*123%*	*103%*	*126%*	*103%*
Phoenix Ward	30	2486	1435	1620	1486	1705	1572	1374	1419	*58%*	*92%*	*92%*	*103%*	*82%*
SDCC	26	2659	1700	1426	1011	682	928	341	605	*64%*	*71%*	*136%*	*177%*	*83%*
Surgical HDU	10	2264	2163	389	356	2022	1936	0	0	*96%*	*91%*	*96%*		*95%*
Victory Ward	18	1485	833	1005	1016	1012	836	891	721	*56%*	*101%*	*83%*	*81%*	*78%*
Delivery Suite	15	2859	2855	742	712	2952	2936	432	349	*100%*	*96%*	*99%*	*81%*	*98%*
Dolphin (Paeds)	34	3167	3377	1215	922	2542	2913	357	322	*107%*	*76%*	*115%*	*90%*	*103%*
Kent Ward	24	1060	1063	426	426	720	720	660	660	*100%*	*100%*	*100%*	*100%*	*100%*
NICU	25	4191	3682	423	138	4278	3648	0	0	*88%*	*33%*	*85%*		*84%*
Ocelot Ward	12	902	727	530	786	732	755	372	636	*81%*	*148%*	*103%*	*171%*	*114%*
Pearl Ward	23	1103	1058	588	573	1116	1095	372	312	*96%*	*97%*	*98%*	*84%*	*96%*
The Birth Place	9	1087	1081	372	360	1104	1086	372	350	*99%*	*97%*	*98%*	*94%*	*98%*
Trust total	**610**	**57,145**	**43,072**	**29,979**	**30,706**	**42,724**	**41,628**	**21,776**	**24,093**	***75.4%***	***102.4%***	***97.4%***	***110.6%***	**92%**

Staffing Levels – Nursing & Clinical Support Workers

		Quality Metrics / Actual Incidents								Associate Chief Nurse (Divisonal) review		
WARD	Beds	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade 2 and above	Number of Falls with moderate to severe harm	Number of patient related medication errors - moderate to	Number of complaints relating to nursing care	Post 72 Hour CDIFF Acquisitions	MRSA Colonisations Post 48 hours	MRSA Bacteraemia Post 48 Hours	ACND rag rating	Assurance statement	Care Hours Per Patient Day Overall
Bronte Ward	18	0	1	0	0	2	0	1	0		senior sister worked clinically	7.65
Byron Ward	26	3	2	2	0	2	0	1	0		matron overeen saftey on the ward	6.83
CCU	4	0	1	0	0	0	0	0	0		senior sister worked clinically	11.91
Dickens Ward	25	0	1	0	0	1	0	0	0		senior sister worked clinically	7.91
Harvey Ward	24	7	0	0	0	1	0	0	0		matron overeen saftey on the ward	7.53
Keats Ward	27	3	1	1	0	2	0	1	0		matron overeen saftey on the ward	6.57
Lawrence Ward	19	0	0	0	0	0	0	0	0		safely staffed	6.78
Milton Ward	27	0	0	0	0	0	0	0	0		senior sister worked clinically	7.94
Nelson Ward	24	0	0	0	0	3	0	0	0		senior sister worked clinically	5.63
Tennyson Ward	27	0	0	0	0	0	0	0	0		matron overeen saftey on the ward	6.25
Wakeley Ward	25	0	1	0	0	2	0	0	0		senior sister worked clinically	7.37
Will Adams Ward	26	1	0	0	0	5	0	0	0		senior sister worked clinically	6.98
Arethusa Ward	27	0	1	0	0	1	0	0	0		A Matron is currently based on the ward to support staff and to ensure patients safety. Staffing is reviewed each shift and staff are moved from other areas, non-clinical facing staff work clinically and Ward Sisters and Matrons work clinically to provide patient care and maintain patient safety.	6.88
ICU	9	0	0	0	0	0	0	0	0		Staff rotate across all critical care areas to ensure patients safety is maintained. Often patients fit for ward based care remain on the unit due to operational pressures. When this occurs staffing levels are adjusted in accordance with patient requirement and reduced dependency. Staffing safe across all units.	22.14
Kingfisher SAU	14	0	0	0	0	3	0	0	0		Staffing is reviewed each shift and staff are moved from other areas, non-clinical facing staff work clinically and Ward Sisters and Matrons work clinically to provide patient care and maintain patient safety.	11.56
McCulloch Ward	29	1	0	0	0	2	0	0	0		A Matron is currently based on the ward to support staff and to ensure patients safety. Staffing is reviewed each shift and staff are moved from other areas, non-clinical facing staff work clinically and Ward Sisters and Matrons work clinically to provide patient care and maintain patient safety.	7.09
Medical HDU	6	0	0	0	0	1	0	0	0		Staff rotate across all critical care areas to ensure patients safety is maintained. Often patients fit for ward based care remain on the unit due to operational pressures. When this occurs staffing levels are adjusted in accordance with patient requirement and reduced dependency. Staffing safe across all units.	15.86
Pembroke Ward	27	0	0	0	1	1	0	0	0		Staffing is reviewed each shift and staff are moved from other areas, non-clinical facing staff work clinically and Ward Sisters and Matrons work clinically to provide patient care and maintain patient safety.	8.93
Phoenix Ward	30	0	0	0	0	3	1	0	0		Staffing is reviewed each shift and staff are moved from other areas, non-clinical facing staff work clinically and Ward Sisters and Matrons work clinically to provide patient care and maintain patient safety.	6.85
SDCC	26	0	0	0	0	6	0	0	0		Operational pressures and high demand for beds has led the ward to be used as an escalation ward to support the hospital. Additional temporary staff are used to maintain patient safety and ensure safe patient to nurse ratio.	6.17
Surgical HDU	10	0	0	0	0	1	0	0	0		Staff rotate across all critical care areas to ensure patients safety is maintained. Often patients fit for ward based care remain on the unit due to operational pressures. When this occurs staffing levels are adjusted in accordance with patient requirement and reduced dependency. Staffing safe across all units.	15.47
Victory Ward	18	0	1	0	0	1	0	0	0		Staffing is reviewed each shift and staff are moved from other areas, non-clinical facing staff work clinically and Ward Sisters and Matrons work clinically to provide patient care and maintain patient safety.	7.67
Delivery Suite	15	0	0	0	0	0	0	0	0		Staff moved from other areas in maternity	24.29
Dolphin (Paeds)	34	0	0	0	0	0	0	0	0			15.31
Kent Ward	24	0	0	0	0	1	0	0	0		Staff moved from other areas in maternity	7.88
NICU	25	0	0	0	0	1	0	0	0			10.71
Ocelot Ward	12	0	0	0	0	0	0	0	0		Support received from Trust nusring	8.32
Pearl Ward	23	0	0	0	0	1	0	0	0		Staff moved from other areas in maternity	6.68
The Birth Place	9	1	0	0	0	0	0	0	0		Staff moved from other areas in maternity	21.96
Trust total	**610**	**16**	**9**	**3**	**1**	**40**	**1**	**3**	**0**			

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend Dec-17	Jan-18	Mar-18	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	*8%*	G	27.20%	25.90%			26.32%		
1.5.3	Total Vacancies (WTE)	*TBC*		425.79	405.40			410.4		
1.5.4	Vacancy Rate (Band 5)	*TBC*		37.38%	39.32%			37.62%		
1.5.5	Vacancy Rate (Band 6)	*TBC*		20.61%	19.15%			21.29%		
1.5.6	Vacancy Rate (CSW)	*TBC*		16.42%	17.41%			17.54%		
1.5.7	Nursing Starters	*TBC*		16	23	7	↓	15.3		
1.5.8	Nursing Leavers	*TBC*		6	14	34	↑	16.5		
1.5.9	CSW Starters	*TBC*		6	7	7	↔	8.5		
1.5.10	CSW Leavers	*TBC*		4	6	13	↑	7.3		
1.5.11	Rolling annual turnover rate	*8%*	R	11.36%	11.81%	11.78%	↓	11.23%		
1.5.16	Safe Staffing	*94.00%*	R	91.2%	93.2%	92.0%	↓	95.2%		
1.5.17	CHPPD	*8.00*	G	8.62	8.69	8.55	↓	8.76		

Please note all indicators with a TBC target will be developed with a calculated baseline once 6 months of data is available.

Commentary	Actions

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Jan-18	Feb-18	Mar-18	Movement	YTD avg	Data Quality	Carter	SDF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	*10%*	G	10.77%	10.53%	9.83%	↓	12%			✓	
2.5.4.1	Emergency Readmissions within 28 days Under 65	*10%*	G	9.72%	10.29%	8.74%	↓	10%			✓	
2.5.4.2	Emergency Readmissions within 28 days 65 +	*10%*	R	12.47%	11.01%	11.80%	↑	12%			✓	
2.6	Discharges before noon	25%	R	20.39%	21.78%	21.96%	↑	19%			✓	✓

5. Caring

		Monthly Target	RAG Status	Trend Jan-18	Feb-18	Mar-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	*83%*	G	87.0%	87.3%	86.6%	↓	88%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	76.6%	80.6%	74.7%	↓	82%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	100.0%	98.9%	98.2%	↓	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	159.00	113.00	202.00	↑	48.1			✓	
3.4.1	Number of Complaints	*45*	R	73.00	82.00	89.00	↑	67			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	44.4%				49%			✓	
3.4.3	Number of complaint returners	↓	R	1.00	0.00	1.00	↑	3.1			✓	

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

6. Responsive

		Monthly Target	Status	Trend						Alignment		
			Status	Jan-18	Feb-18	Mar-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CoLIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	80.41%	80.48%	79.82%	↓	82.14%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	3	1	1	↔	27				
4.2.3	A&E 4 hour target (all Types from Nov 2017)	95%	R	84.41%	82.63%	82.49%	↓	86.64%			✓	
4.3.1	Cancer – 2 week wait (1 month in arrears)	93%	G	96.85%	97.76%		↑	85.90%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	93%	G	89.61%	97.22%		↑	89.83%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	96%	G	98.56%	99.28%		↑	97.01%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	G	100.00%	100.00%		↔	97.11%				
4.3.5	Cancer – 31 day subsequent treatments - drug (1 month in arrears)	98%	G	100.00%	100.00%		↔	97.42%				
4.3.6	Cancer - 62 day consultant upgrade (1 month in arrears)	N/A		86.36%	71.05%		↓	73.93%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	G	91.35%	85.12%		↓	78%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	G	76.47%	91.30%		↑	86%			✓	
4.4.1	Diagnostic waits - under 6 weeks	99%	R	94.96%	96.92%	96.75%	↑	96%			✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Aug to Nov figures reported)	95%	R	51.00%	51.00%	51.00%	↔	56%				✓
4.6.1	Average elective Length of Stay	<5	G	2.66	2.78	3.30	↑	2.3				✓
4.6.2	Average non-elective Length of Stay	<5	R	6.59	6.47	7.21	↑	7.1				✓
4.6.6	Average occupancy	90%	R	94.66%	95.59%	90.30%	↓	95%				✓

Please note that indicators have been reduced since previous month to reflect the Single Oversight Framework and Quality Account

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Jan-18	Feb-18	Mar-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	*62%*	R		52.7%		↓	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	*79%*	R		66.6%		↓	70.7%			✓	
5.3.7	Rolling annual turnover rate	*8%*	R	11.4%	11.8%	11.8%	⇓				✓	
5.3.7.1	Executive Team Turnover Rate	*TBA*		0.0%	0.0%	0.0%	↔	3.8%			✓	
5.3.8	Overall Sickness rate	*4.0%*	G	3.81%	3.86%	3.87%	↑	3.8%				
5.3.9	Sickness rate – Short term	*3.0%*	G	1.83%	1.84%	1.87%	↑	1.9%			✓	
5.3.10	Sickness rate – Long term	*1.0%*	R	1.98%	2.02%	2.00%	⇓	1.9%			✓	
5.3.11	Temporary staff % of pay bill	*15%*	R	20.0%	23.7%	32.90%	↑	19.3%			✓	
5.3.14	Starters	*N/A*		41	53	42	↓	85.1				
5.3.15	Leavers	*N/A*		40	142	86	⇓	69.3				

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

8. Enablers

		Monthly Target	Status	Trend						Alignment		
			Status	Jan-18	Feb-18	Mar-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
7.2.1	APC – NHS number completeness (2 month in arrears)	*99%*	G	99.0%				98.9%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	*99%*	R	82.8%				93.4%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	*11*	R	215	153		⇩	144.6		✓		✓
7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	*0*	G	0	0		⇔	0.0				
7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	*99.25*	G	75	65		⇩	102.0		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	*1%*	G	0.4%	0.3%		⇩	0.5%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	*103.50*	G	6	11		⇧	3.86				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	*0.00*	R	2.00	5.00		⇧	2.14				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	*949*	R	2350	1985		⇩	1346.0		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	*50%*	G	100.0%	100.0%		⇔	100.0%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	*0.25*	G	0	0		⇔	1.6		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	*13.25*	G	2	0		⇩	0.7		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	*0.01*	G	0.01	0.00		⇔	1%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	*2*	G	0	0		⇔	3.0		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	*1.25*	G	0	0		⇔	0.3		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	*1.25*	G	0	0		⇔	2.9		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	*1*	G	0	0		⇔	1.1		✓		✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018 Agenda item

10b

Title of Report	Research & Development Annual Report for the period 1st April 2017 to 31st March 2018
Prepared By:	Dr Edyta McCallum
Lead Director	Dr Diana Hamilton-Fairley
Committees or Groups who have considered this report	• Clinical Effectiveness Group (20.04.18) • R&D and Innovation Governance Group (RI GG) (26.04.18)
Executive Summary	Report provides an outline of research activities for the period 1st April 2017 until 31st March 2018.
Resource Implications	N/A
Risk and Assurance	Section 4. Safety, provides an outline.
Legal Implications/Regulatory Requirements	N/A
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	Review and approval of document.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Research & Development Annual Report for the period 1st April 2017 to 31st March 2018

1. EXECUTIVE SUMMARY

1.1. Medway NHS Foundation Trust (MFT) is committed to research and innovation recognizing benefits these bring to patient care, general public health, education, staff retention and development of the Trust.

1.2. The report outlines progress and achievements over the last 12 months (1st April 2017 to 31st march 2018).

2. PERFORMANCE IN 2017/2018

2.1. In 2017/2018 there were a total of 111 research studies conducted at MFT.

Figure 1, Appendices, outlines the number of studies that MFT participated in over six years, from 1st April 2012 to 31st March 2018.

2.2 The 29% decrease in number of studies between 2016/2017 and 2017/2018 does not imply that research activity has declined. Studies vary in their intensity and in 2017/2018 there were fewer but more 'labor intensive' studies.

2.3 **Figures 2 and 3** (for oncology studies) and **Figures 4 and 5** (all other specialties) are a better reflection of study activity as these depict overall research activity, based on study weighting, per specialty, in 2017/2018 and proposed for 2018/2019.

2.4 Research in Reproductive Health, led by Professor Akolekar is by far most active. Two Band 7 midwives, funded by the NIHR support these activities.

2.5 For a third consecutive year, MFT was the highest at recruiting patients into clinical Trials in Kent, Surrey and Sussex (out of 20 member organisations).

2.6 5,313 patients participated in ethically approved research. Out of these 5,179 participated in research supported by the National Institute for Health Research (NIHR).

Figure 6 presents the annual recruitment target and the actual number of patients at MFT recruited into the NIHR adopted studies over six year period, from 1st April 2012 to 31st March 2018.

2.7 The Trust encourages research and innovation in all specialties.

Table 1 presents the number of studies in each specialty in the financial year 1st April 2017 until 31st March 2018.

2.8 In the period between 1st April 2017 and 31st March 2018 the Investigators at MFT published 90 articles.

MMH staff publications 2017-Re

MMH staff publications-2018-Re

3. FINANCES

3.1 Although the NIHR recruitment target was missed by 14%, based on overall research activity (weighting), the Trust qualified for a 5% increase in NIHR funding. In 2018/2019 additional £48K has been received.

Table 2 presents expected **core** funding allocations to all partners within Kent Surrey and Sussex in 2018/2019.

3.2 Throughout the year additional funding may be received (based on capacity) and so in 2017/2018, £88,266 has been allocated to the Trust, making the total NIHR funding in 2017/2018, £917,441.

3.3 MFT Investigators accumulated a total of £307K which must be reinvested in research related activities, Consultants PA's, etc. under supervision of the Research & Development and Innovation Governance Group (R&D IGG).

3.4 The Research Finance Standard Operating Procedure is currently reviewed by the Finance Director.

3.5 The Clinical Research Network Kent Surrey and Sussex (CRN KSS) audited the R&D and Finance Office for research related income and expenditure in March 2018. Although the report has not been finalized, the results are likely to be very positive.

4. SAFETY

4.1. All research carried out at the Trust must be in accordance with the principles set in UK policy framework for health and social care research and the Medicines for Human Use (Clinical Trials) Regulations 2004 and Amendment Regulations 2006.

4.2. Any research and/or innovation related incidences are reported to the Research & Development and Innovation Governance Group (R&D IGG) which in turn reports to the Clinical Effectiveness Group (CEG).

4.3. The R&D Department completes DATIX entry for serious adverse events related to research.

4.4. As DATIX is not designed to report R&D incidences and with recent implementation of research database EDGE, the system will be considered as a tool for future research related safety reporting.

4.5 Out of 30 incidences reported in 2017/2018, 17 were Serious Adverse Events (SAEs), but none of these were a result of research practice.

4.6. The patients involved suffer from critical illnesses and so the incidences are 'expected'.

4.7 Other reported incidences (13) relate to non-serious governance errors or operational issues such as flooding in Gate Lodge building where the delivery team are based.

4.8. The incidences are/were investigated and adequate measures put in place.

4.9 The R&D Office is in a process of reviewing the General Data Protection Regulation (GDPR) due to be implemented in May 2018 and its impact on research governance.

4.10 After initial discussions with Hill Dickinson, Health Research Authority (HRA), Clinical Research Network and other local Trusts, the impact appears to be minimal and no major concerns were identified thus far.

5. ACADEMIC COLLABORATIONS

5.1 Jointly funded post of Senior Research Officer (SRO) with the University of Greenwich (UoG) proved to be a success.

5.2 The SRO works 3 days at MFT and 2 days at UoG thus gaining experience in both academia and NHS research, which in turn supports collaborative projects.

5.3 The post has been such as success that the University of Kent (UoK) are looking for a similar collaboration. Currently Job Description is being finalised.

5.4 Submitted Grant Applications from October 2017 – present, include:

5.4.1 University of Greenwich Seedling fund: Dr Sanjay Suman (Consultant Geriatrician) and Professor Ian Swaine (University of Greenwich) – *The Development of an Exercise Ball for NHS Patients*. £4500 applied for in January 2018. Successful.

5.4.2 Bliss expression of Interest: Dr Ghada Ramadan (Consultant Neonatologist) and Professor Ian McLouglin (University of Kent) – *Developing a two-way Audiovisual System and Evaluating Effectiveness on Parental and Newborn Interaction in a Clinical Setting*. £118, 036 applied for in January 2018 (unsuccessful).

5.5 Funding applications in Progress:

5.5.1 NIHR Research for Patient Benefit pathway: Dr Shaumik Adhya (Consultant Cardiologist) & Professor Ian Swaine (University of Greenwich) – *Development of a dynamic-resistance exercise programme to improve physical function in heart failure patients with preserved ejection fraction (HF-PEF) – feasibility of a randomised controlled trial.*

5.5.2 NIHR Efficacy and Mechanism Evaluation pathway: Mr Henk Wegstapel (Principal Investigator at Medway NHS Foundation Trust), Mr Haithem Ali (Chief Investigator at Maidstone & Tunbridge Wells Trust) & Professor Ian Swaine (University of Greenwich) - *A pre-operative diet, exercise and psychological weight loss programme (GLIDE) for obese patients who are undergoing elective non-cancer general surgery under general anaesthetic: A Clinical Trial with Internal Pilot.*

5.5.3 Innovate UK Digital Health Technology Catalyst: Dr Ruiheng (Birmingham City University) & Medway NHS Foundation Trust – *Real-time Non-invasive Blood Glucose Monitoring System.*

5.5.4 Interreg 2 Seas Mers Zeeen project: Ecole Nationale Supérieure des Arts et Industries Textile (ENSAIT), Dr Ruiheng Wu (Birmingham City University)et al. & Medway NHS Foundation Trust – *Development of Adapted, Connected and Intelligent garments for Disabled people (ACID).*

5.5.5 [Funder TBC]: Dr Tara Rampal (Consultant Anaesthetist), Dr Manisha Shah (Consultant Anaesthetist), Mr Roberto Laza (Exercise Physiologist) & Dr Fernando (University of Greenwich) – *Effects of Combined Exercise With Hydrolysed Beef Protein Supplementation on Body Composition, Cardiopulmonary Capacity and Iron Status in Patients.*

5.6 New Non-portfolio Projects (non-academic)

5.6.1 Dr Kate MLoughlin (ED Consultant): Psychosocial Screening (HEEADSSS Screening) for Young People in the Acute Setting (preparing IRAS application).

5.6.2 Ms Caris Grimes (Consultant Colorectal Surgeon): *Analysis of NHS Litigation Authority Data Pertaining to Surgical Deaths* (awaiting REC favourable opinion).

5.6.3 Ms Caris Grimes (Consultant Colorectal Surgeon): *Inflammatory Bowel Disease: A Patient Survey* (Preparing IRAS application).

5.7 University Collaborative Events

5.7.1 The R&D Department held a research grand round on 9th March 2018 in collaboration with Canterbury Christchurch University, Institute of Medical Sciences (IMS). The event showcased the outstanding research and innovation work of three of our teaching consultants, Professors: Rahul Kanegaonkar, Annan Shetty, and Ranjit Akolekar.

5.7.2 Health Education England funded Integrated Clinical Academic Programme (ICAP) in collaboration with the University of Greenwich. Group sessions supported by MFT research staff.

6. Priorities for 2018/2019

6.1. With the Medical School being established at Kent and Medway in 2020, to evaluate the possibility of becoming Medway NHS Foundation **University** Trust.

6.2 Continue collaboration with the Clinical Research Network Kent Surrey and Sussex (CRN KSS) to increase funding and research activity.

6.3 In 2017/2018 two patients were engaged as Research Patient Ambassadors. The R&D Office will continue collaboration to improve patient engagement.

6.3. Ensure the General Data Protection Regulation (GDPR) is applied to research from May 2018.

6.4 Planned events:

6.4.1 International Clinical Trials Day will be celebrated by having a research stand at the Hempstead Valley shopping centre on 18th May 2018.

6.4.2 A 'joint study day' for the Integrated Clinical Academic Programme (ICAP) is planned for 28th June 2018 at the University of Greenwich, Medway Campus. The theme of the 'joint study day' is *Medical Innovation Translation* and will focus on the process of turning ideas into prototypes and testing them in a clinical setting. The event is open to all ICAP interns across Kent, Surrey, and will be hosted in collaboration with the University of Kent and University of Greenwich.

6.4.3 R&D will join the70th birthday celebrations of the NHS in July 2018.

6.4.4 'Medical Industry Event' on 17th July 2018 at the Canterbury Christ Church, Medway Campus in collaboration with Academic Health Science Network (AHSN) and local Industry to explore collaborative opportunities.

6.4.5 Research Grand Round on 14th September 2018 with the topic 'Plans for the Medical School and impact on the Trust'. Two main bidders for the school agreed to give presentations: Dr Peter Nicholls, Dean of Kent Health and Faculty of Sciences Director of Internationalisation at the University of Kent; Debra Teasdale, Dean of the Faculty of Health and Wellbeing at the Canterbury Christ Church University.

6.4.6 Research stands in front Trust foyer on 12th October 2018 and 8th February 2019.

APPENDICES

Figure 1. The no. of research studies (within MFT) between 1st April 2010/31st March 2011 and 1st April 2017/31st March 2018.

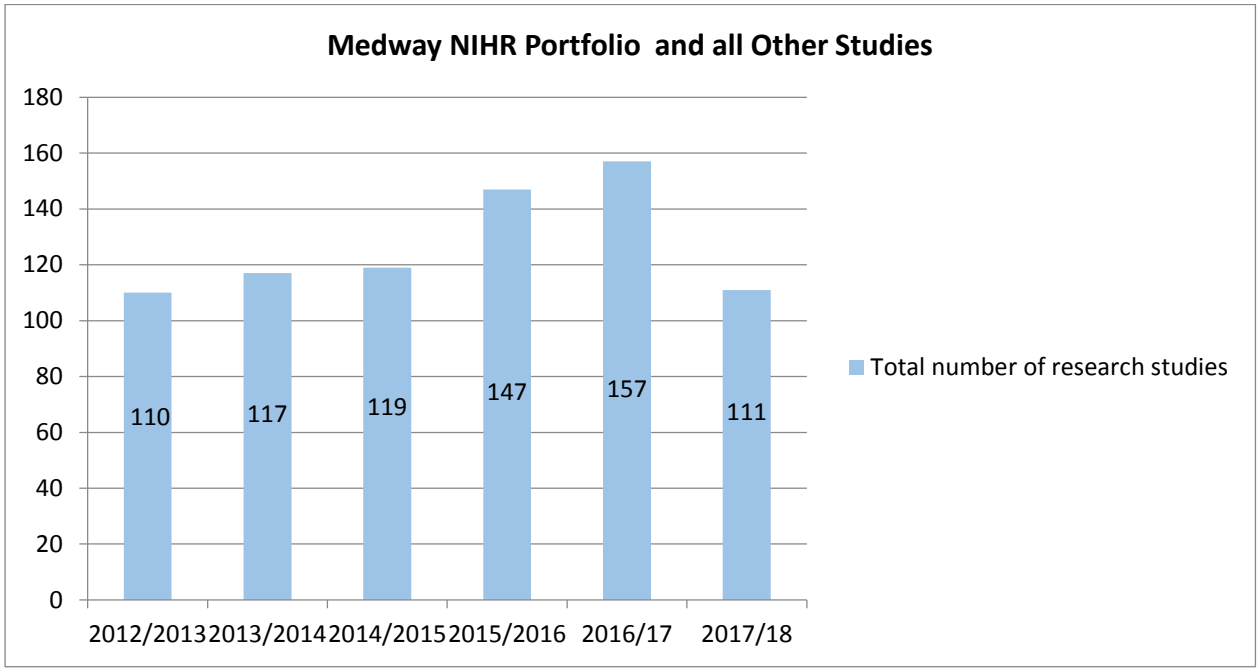


Figure 2. Research activity in oncology in 2017/2018.

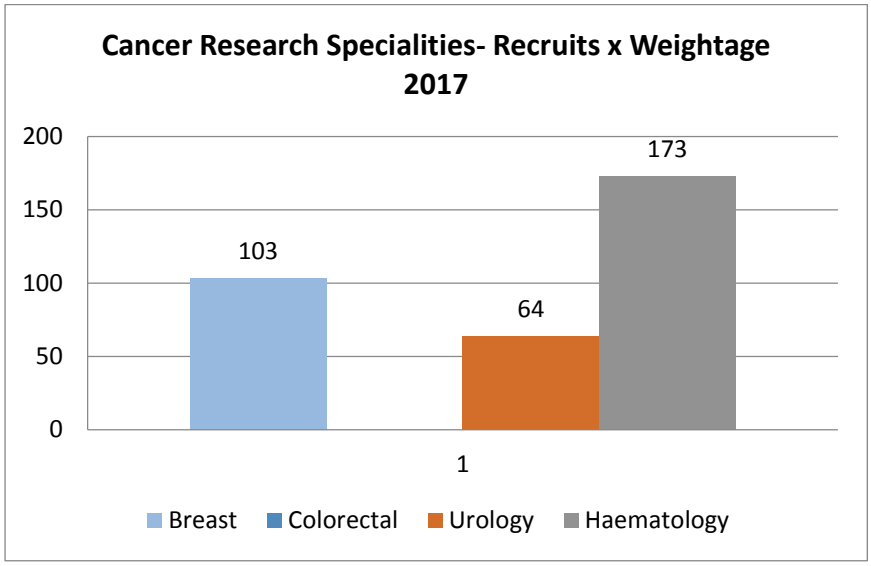


Figure 3. Planned activity in oncology in 2018/2019.

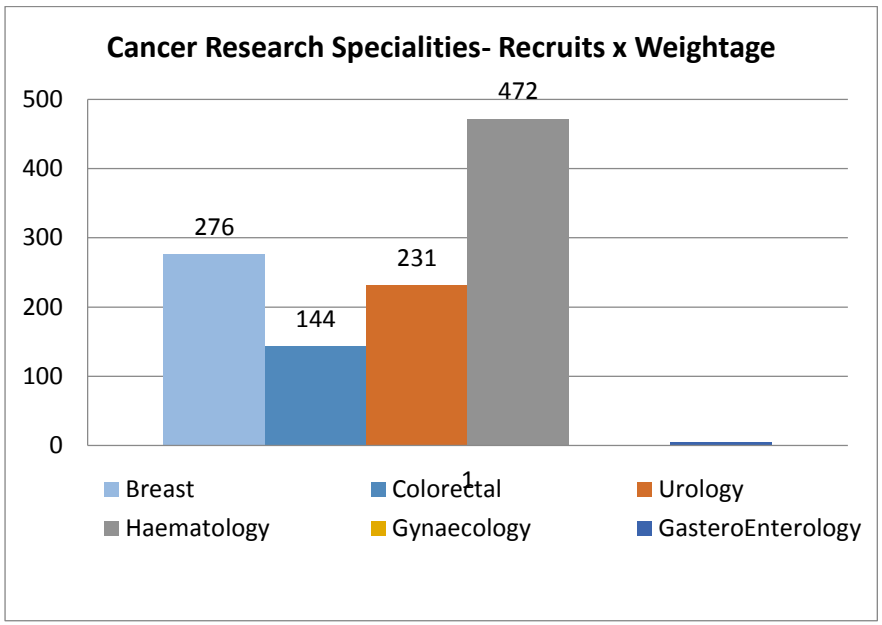


Figure 4. Research activity in other specialities than oncology in 2017/2018.

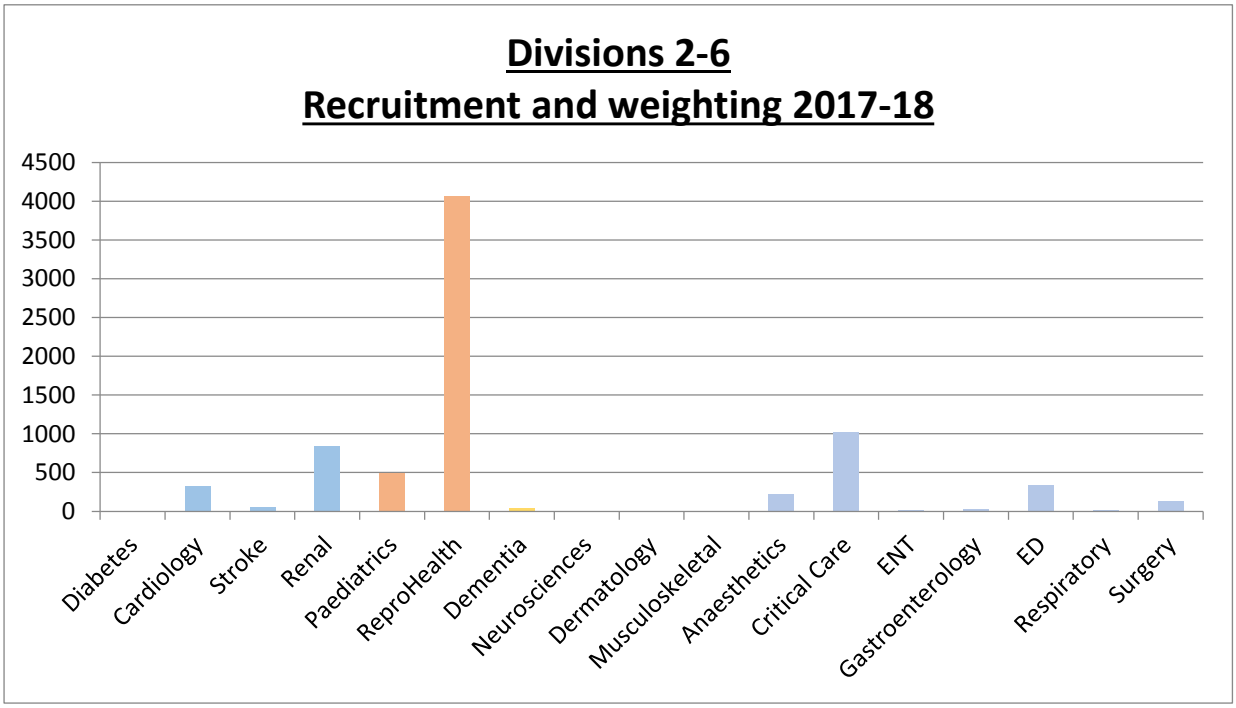


Figure 5. Planned activity per speciality other than oncology in 2018/2019.

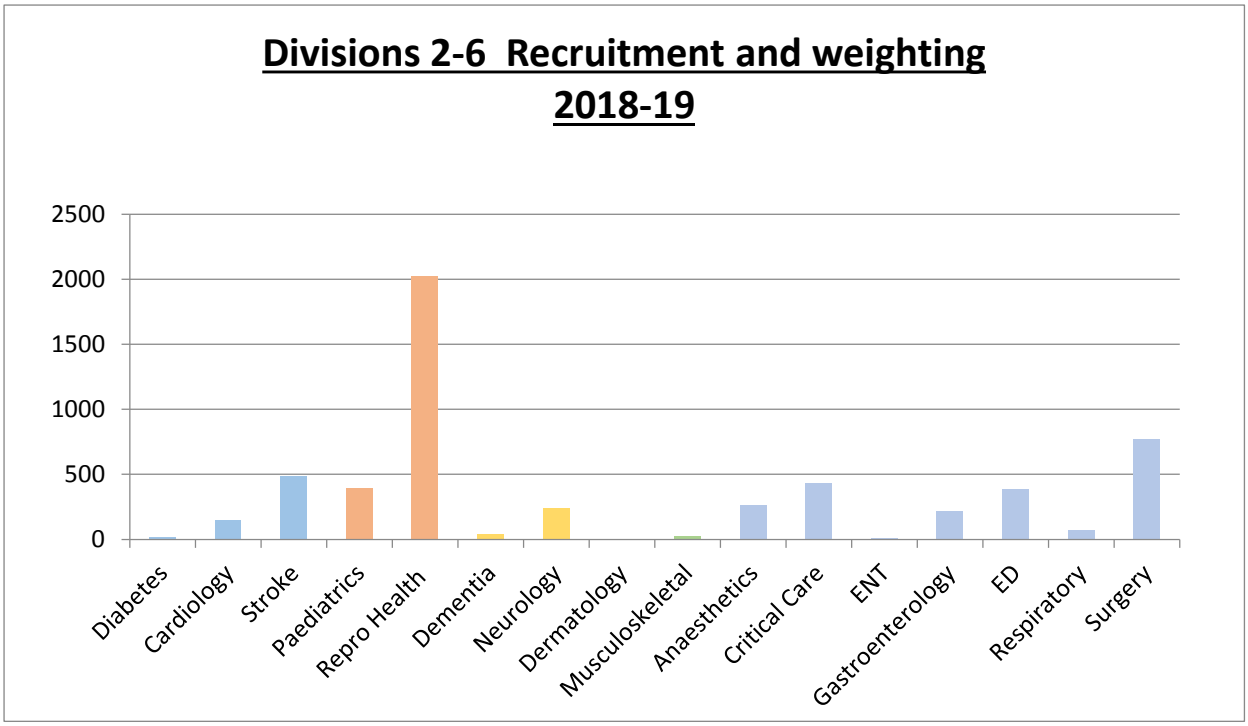


Figure 6. The annual NIHR recruitment target and actual no. of participants in NIHR supported projects (within MFT) between 1st April 2012 and 31st March 2018.

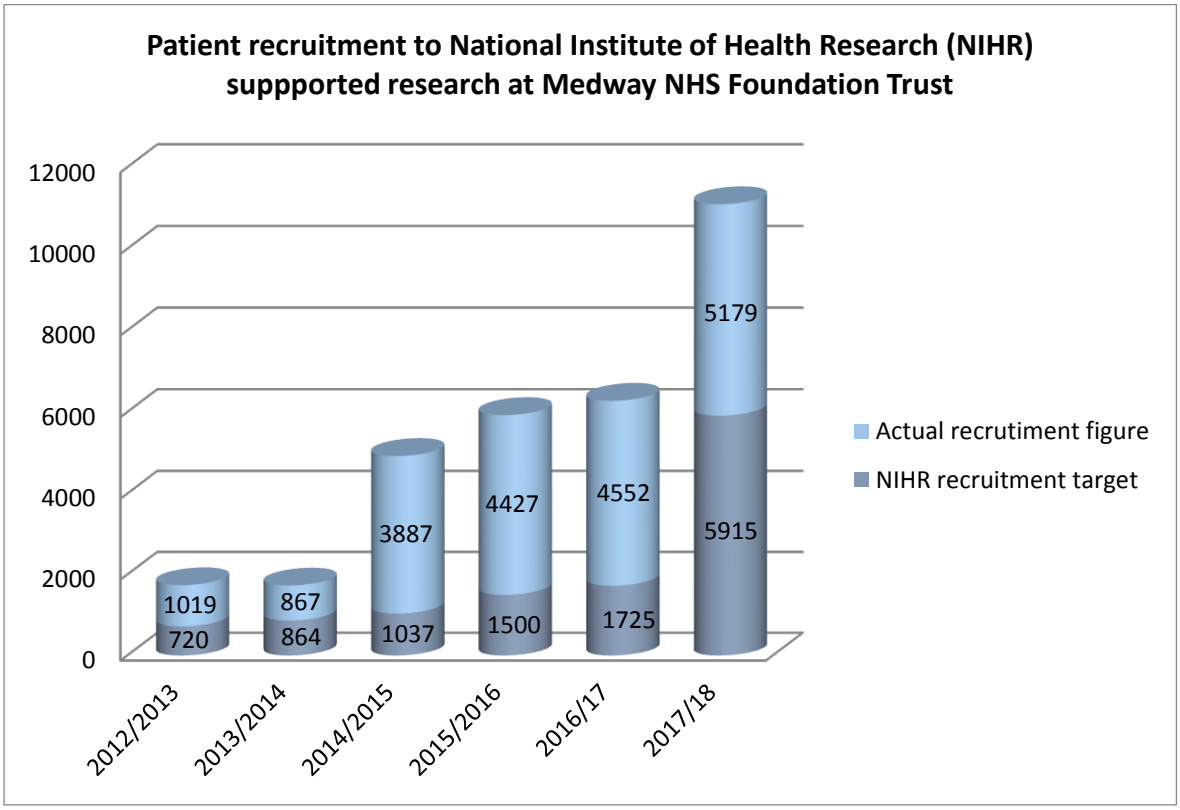


Table 1. The number of research projects by medical speciality being undertaken at MFT for the period 1st April 2017 until 31st March 2018.

*Studies outside of clinical speciality for example educations studies or research into overall patient experience.

Number of Studies by Medical Speciality	2017 – 2018
Anaesthesia and Perioperative Medicine	**5**
Cancer	**33**
Cardiovascular	**6**
Children	**11**
Critical Care	**3**
Dementias and neurodegeneration	**3**
Dermatology	**1**
Diabetes	**2**
Ear Nose and Throat	**2**
Gastroenterology	**1**
Genetics	**1**
Health Services Research	**5**
Infection	**1**
Injuries and Emergencies	**4**
Mental Health	**3**
Metabolic and endocrine	**1**
Musculoskeletal	**1**
Neurological disorders	**1**
Other*	**11**
Renal Disorders	**2**
Reproductive health	**7**
Respiratory and Thoracic	**3**
Stroke	**2**
Surgery	**2**

Table 2. Expected funding allocations to all partners within Kent Surrey and Sussex in 2018/2019.

	17/18	18/19	Acceptable Overplanning 4%	Max Permissible Plan
Ashford and St Peter's Hospitals NHS Foundation Trust **(ASPH)**	£ 596,713	£ 601,487	£ 24,059	£ 625,546
Brighton and Sussex University Hospitals NHS Trust **(BSUH)**	£ 1,538,099	£ 1,704,214	£ 68,169	£ 1,772,382
Dartford and Gravesham NHS Trust **(DAG)**	£ 369,297	£ 372,251	£ 14,890	£ 387,141
East Kent Hospitals University NHS Foundation Trust **(EKHUFT)**	£ 1,122,142	£ 1,018,905	£ 40,756	£ 1,059,661
East Sussex Healthcare NHS Trust **(ESHT)**	£ 422,334	£ 404,596	£ 16,184	£ 420,780
Frimley Park Hospital NHS Foundation Trust **(FHFT)**	£ 666,530	£ 671,862	£ 26,874	£ 698,737
Kent And Medway NHS and Social Care Partnership Trust **(KMPT)**	£ 304,267	£ 321,914	£ 12,877	£ 334,791
Kent Community Health NHS Trust **(KCHFT)**	£ 116,272	£ 134,643	£ 5,386	£ 140,029
Maidstone and Tunbridge Wells NHS Trust **(MTW)**	£ 868,866	£ 788,930	£ 31,557	£ 820,488
Medway NHS Foundation Trust **(MFT)**	£ 829,175	£ 877,267	£ 35,091	£ 912,358
Queen Victoria Hospital NHS Foundation Trust **(QVH)**	£ 60,953	£ 70,584	£ 2,823	£ 73,407
Royal Surrey County Hospital Trust **(RSCH)**	£ 1,139,839	£ 1,034,974	£ 41,399	£ 1,076,373
Surrey and Borders Partnership NHS Foundation Trust **(SABPT)**	£ 263,680	£ 292,157	£ 11,686	£ 303,844
Surrey and Sussex Healthcare NHS Trust **(SASH)**	£ 335,909	£ 355,392	£ 14,216	£ 369,607
Sussex Community NHS Trust **(SCT)**	£ 248,517	£ 250,505	£ 10,020	£ 260,525
Sussex Partnership NHS Foundation Trust **(SPFT)**	£ 723,688	£ 765,662	£ 30,626	£ 796,288
Western Sussex Hospitals NHS Foundation Trust **(WSHFT)**	£ 882,047	£ 800,899	£ 32,036	£ 832,935
South East Coast Ambulance Service NHS Foundation Trust **(SECAMB)**	£ 40,081	£ 40,402	£ 1,616	£ 42,018
Non NHS K&M	£ 152,664	£ 97,700	£ 3,908	£ 101,608
Primary Care **(PC)**	£ 750,397	£ 756,400	£ 30,256	£ 786,656
Medway Community Health CIC	£ 56,928	£ 59,382	£ 2,375	£ 61,758

Report to the Trust Board

NHS Medway NHS Foundation Trust

Date: 27/04/2018

Agenda item 10c

Title of Report	Responding to Deaths
Prepared By:	Hayley Usmar, Clinical Effectiveness Facilitator Denise Thompson, Head of Clinical Effectiveness
Lead Director	Dr Diana Hamilton-Fairley, Medical Director
Committees or Groups who have considered this report	
Executive Summary	**Background:** **The purpose of this report is to provide the Board with:** • The updated Learning from Deaths Dashboard containing data for 2017/18 • The current position and progress made against the Learning from Deaths action plan
Resource Implications	
Risk and Assurance	
Legal Implications/Regulatory Requirements	Failure to comply with national reporting requirements could result in regulatory action or a prosecution under the Care Quality Commission (Registration) Regulations 2009.
Improvement Plan Implication	
Quality Impact Assessment	
Recommendation	**The Board is requested to note:** • The content of the updated Learning from Deaths Dashboard 2017/18 • The progress against the Learning from Deaths Action Plan.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

The National Quality Board (NQB):

Learning from Deaths Update (May 2018)

1. Introduction

The purpose of this report is to provide the Board with:

- The updated Learning from Deaths Dashboard containing data for 2017-18
- The current position and progress made against the Learning from Deaths action plan

2. Background

In March 2017, the National Quality Board published the *National Guidance on Learning from Deaths*. This document builds on the recommendations of the CQC's *Learning, Candour and Accountability*, published in December 2016, and provides guidance on how organisations should monitor, review, respond to and report death with a view to providing a more standardised approach across the NHS. The guidance aims to improve the quality of investigations and embed learning more effectively. The guidance pertains to all deaths, not just those subject to a Serious Incident investigation.

3. Learning from Deaths Dashboard for 2017/18

From April 2017, Trusts have been required to collect and publish specified information on deaths on a quarterly basis. Information pertaining to the Trust's mortality must also be presented in the annual Quality Accounts. In line with this requirement, the Learning from Death Dashboard for Medway NHS Foundation Trust has been updated to include the whole of 2017/18 and is presented overleaf.

Best of care
Best of people

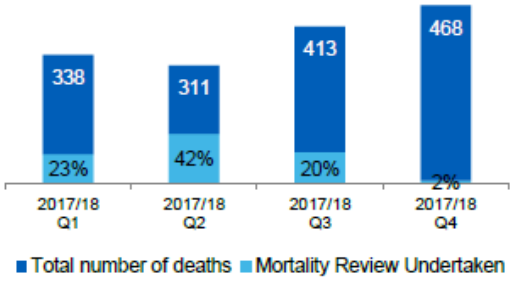
Learning from Deaths Dashboard - 2017/18

NHS
Medway
NHS Foundation Trust

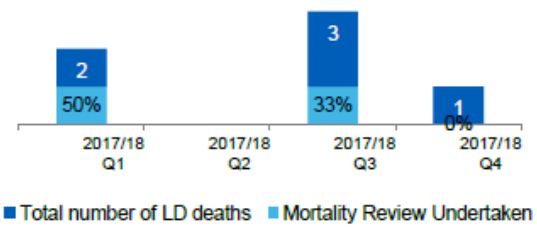
Trust:	Medway NHS Foundation Trust
Org Code	RPA02
Month	May-18
Year	2017-18

		No Learning Disability			Learning Disability		
Financial Year	Quarter	Total deaths	Total deaths reviewed	Deaths avoidable > 50%	Total deaths	Total deaths reviewed	Deaths avoidable > 50%
2017/18	1	338	77	2	2	1	0
2017/18	2	311	131	8	0	0	0
2017/18	3	413	83	5	3	1	0
2017/18	4	0	0	0	0	0	0

Mortality Reviews Undertaken



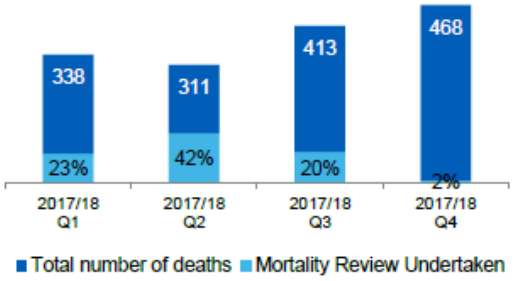
Learning Disability Mortality Reviews Undertaken



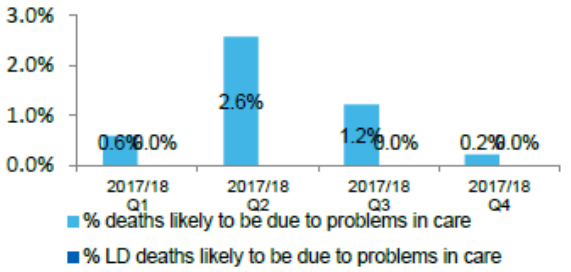
Themes / Issues Identified from Mortality Review and SI Investigation:

- Treatment escalation plans are not being completed in a timely
- Elderly patients are being inappropriately admitted due to lack of community advance planning
- Ward transfers are occurring inappropriately
- Deteriorating patients are not always assessed and treated in a timely manner
- Documentation does not always meet requried standards

Serious Incident Investigations



Deaths likely due to problems in care



SI Type Reported on STEIS	Q1	Q2	Q3	Q4
Diagnostic incident including delay	3	0	1	2
Treatment delay	3	0	0	2
Maternity/Obstetric incident	0	0	0	1
Never Event	0	1	1	0
Pressure Ulcer	0	1	0	1
Slips / Trips / Falls	2	1	2	3
Deteriorating Patient	4	3	3	0

National Mortality Indicators

Hospital Standardised Mortality Ratio (HSMR): The current HSMR figure (for the period Jan 17 - Dec 17) us **107.6**, which is high.

Summary Hospital-Level Mortality Indicator (SHMI): The current SHMI figure (for the period Jul 16 - Jun 17) is **1.03**, which lies within the expected range.

Actions taken following Mortality Reviews and SI Investigations:

- Trust Wide Treatment Escalation Plan Quality Improvement Project to raise awareness and improve compliance
- All patients presenting to ED with a NEWS of ≥3 will be screened for sepsis
- Training, guidelines and policies rolled out to improve prevention of and response to Pressure Ulcers

4. Learning from Deaths Action Plan

In response to the national guidance, the Trust has developed an action plan which shows the key recommendations and progress against these. An overview is given below of the current status and the full action plan can be found on pages 5 – 11.

4.1 Updates and changes

Further to the last Board report, the following changes have occurred:

- Dr David Sulch has been appointed as the chair of the Trust's Mortality and Morbidity group, taking over from Dr Richard Leach (action 1.3).
- The Trust Quality Accounts are currently being prepared and include the relevant mortality metrics (action 2.3).

4.2 Ongoing Training (action 4.1)

Further to the Royal College of Physicians (RCP) training session, 22 members of staff at Medway NHS Foundation Trust have now received Structured Judgement Review methodology training. The Clinical Effectiveness team are currently looking at translating this training into an elearning module to make it more accessible to all staff.

4.3 Exceptions

All actions on the Learning from Deaths Action Plan have progressed as required with the exception of the following action points. A robust monitoring process is in place via monthly review at the Trust Mortality & Morbidity Group, who will ensure that issues are escalated appropriately.

- **Action 9.1** – LD deaths are being reported as necessary to the national programme, however the corresponding Standard Operating Procedures (SOP's) have yet to be updated.
- **Action 9.2** – The necessary procedures and processes are already in place to review LD deaths for potential safeguarding concerns and whether they meet Serious Incident (SI) criteria. The policy has been reviewed and updated in line with the national guidance and is currently awaiting final sign-off; in view of this the due date has been amended to June 2018.
- **Action 5.1** – Providers should offer a bereavement service for families and carers of people who die under their management and care. The Trust currently offers a surgical bereavement service offering relatives the opportunity to have questions about their loved one's care answered by medical staff; however, there is no central bereavement service available offering counselling and associated support. Where this is required, referral to outside agencies is made as appropriate.
- **Action 5.4** - Providers should ensure that their staff, including family liaison officers, have the necessary skills, expertise and knowledge to engage with bereaved families and carers. There is currently no trust-wide training in place for dealing with bereaved families and carers. The Trust must review the need for bereavement training to ensure compliance with national guidance.

Please see full action plan overleaf.

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
1. Board Leadership Mortality Governance should be a key priority for Trust Boards. Executives and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.								
1.1	Have an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda.	Diana Hamilton-Fairley (Medical Director) is the Executive Director with leadership responsibility for mortality.	No further action required.	Lesley Dwyer, Chief Executive	Executive Director in place	September 2017	March 2017	Completed
1.2	Have a Non-Executive Director in place to take oversight of the progress.	The Trust does not currently have a non-executive director appointed for mortality. Sep 17 – Awaiting NED to be appointed. Executive assistants contacted 20/09/2017 to confirm if a NED was appointed at the Board meeting. Oct 17 – NED appointed: Ewan Carmichael	Non-Executive Director to be appointed by the Board.	Dr Diana Hamilton-Fairley, Medical Director	Non-Executive Director in place	September 2017	October 2017	Completed
1.3	Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership.	The Trust has an allocated operational lead for mortality, Dr Richard Leach, Associate Medical Director for Clinical Effectiveness & Research. Dr Leach chairs the Trust Mortality & Morbidity Group (MMG), which consists of multi-disciplinary membership is underpinned by terms of reference and meets on a monthly basis. The MMG reports into the Trust Quality Assurance Committee (QAC) and the Trust Board.	No further action required.	Dr Richard Leach, M&M Chair	Terms of reference, meeting schedules, agendas and minutes of meeting	September 2017	March 2017	Completed
2. Data Collection and Reporting From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths (Policy and approach by end of Q2 and publication of the data and learning points from Q3 onwards. The data should include the total number of the Trusts inpatients deaths (including emergency department deaths) and those deaths that the Trust has subjected to a case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged to have been due to problems in care.								

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
2.1	The mortality review process must use evidence-based methodology for reviewing the quality of care provided to those patients who die. The structured judgment review (SJR) methodology developed by the Royal College of Physicians (RCP) is one such approach.	The mortality proforma and process has been amended in line with the RCP methodology. This was implemented on 01/08/17.	No further action required.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	SJR proforma implemented within the Trust	August 2017	August 2017	Completed
2.2	Trusts must collect and publish on a quarterly basis specified information on deaths through a paper and agenda item to a public Board meeting. The publication of the data and learning points must be from Q3 onwards.	The Trust has adopted the DH national learning from deaths dashboard, which has been populated as of 1 April 2017.	Dashboard to be featured in the Public Session of the Trust Board in September 2017.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	Dashboard published in public session of the Trust Board	December 2017	September 2017	Completed
2.3	Changes to Quality Accounts regulations will require that the data providers publish will be summarised in the Quality Accounts from June 2018.	Preparation of the Trust Quality Account is overseen by the Associate Director of Quality who will ensure inclusion in the Trust Quality Account 2017/18.	Data published will be summarised in the Quality Accounts for 2017/18.	Michelle Woodward, Associate Director of Quality	Quality Account 2017/18	June 2018		Active
2.4	Briefing paper and agenda item to a Public Board meeting outlining the Trust's policy and approach to the new recommendations.	The briefing paper has been written and is on the agenda for the Public Board meeting on 07/09/17. Sep 17 – The paper was presented at Trust Board on 07/09/17.	Complete briefing paper for sign-off by MMG and QAC in advance.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	Paper presented to the Board	September 2017	September 2017	Completed
3. Mortality Governance National Guidance on Learning from Deaths should be aligned to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths. The Trust will need to enhance its current procedures and develop a policy to ensure it meets all the key principles contained within the national guidance.								
3.1	Providers should review an investigation and/or review they undertake following any linked inquest and issue of a "Regulation 28 report to Prevent Future Deaths" in order to examine the effectiveness of their own review process.	The Learning from Deaths Policy reflects this requirement. The Serious Incident Policy is currently in the process of being reviewed and will be adjusted to reflect the recommendation.	Complete review of Serious Incident Policy to reflect the recommendation.	Ann Bushnell, Patient Safety Manager / Denise Thompson, Head of Clinical Audit and Effectiveness	SI policy in place which meets requirements	June 2018		Active

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
3.2	Trusts should have systems for deriving learning from reviews and investigations and acting on this learning. Findings should be part of, and feed into, robust clinical governance processes and structures.	Specialty M&M meetings are established across the Trust. Specialties are required to complete action plans and minutes to capture learning. These meetings feed into directorate governance meetings and specialties also present their findings and learning on a regular basis to the MMG. Sep 17 – Updated Terms of Reference drafted and on the agenda to be agreed at next Trust M&M meeting on 06/10/17. Oct 17 – ToR agreed at Trust M&M 6/10/17.	Review MMG terms of Reference to ensure that the meeting has appropriate attendance, enabling learning to be shared.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	Updated Terms of Reference	September 2017	October 2017	Completed
3.3	Where possible problems are identified relating to other organisations, the relevant organisation is informed. They should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death.	The Trust liaises with other organisations regarding SI investigations under the Serious Incident framework. Joint case record reviews are not currently undertaken. The Serious Incident Policy is currently in the process of being reviewed.	The Learning from deaths and SI policies must reflect this recommendation.	Kim Willsea, Mortality Learning Coordinator / Denise Thompson, Head of Clinical Audit and Effectiveness / Michelle Woodward, Associate Director of Quality	Revised SI policy	March 2018		Active
3.4	Each trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care.	The policy has been drafted. Sep 17 – Policy was agreed at Trust Board on 07/09/17 and subsequently published on the intranet and public section of the Trust website.	To be presented at the Trust M&M meeting 18/08/2017.	Kim Willsea, Mortality Learning Coordinator / Denise Thomson, Head of Clinical Effectiveness and Audit	The new policy published on QPULSE after presentation to Public Trust Board	September 2017	September 2017	Completed
4. Skills and Training Providers should review skills and training to support the National Guidance with specialist training and protected time under their contract hours to review and investigate deaths to a high standard.								

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
4.1	Acute Trusts will receive training to use the Royal College of Physicians Structured Judgment Review Case Note Methodology.	Three clinicians (one from each directorate) have been registered to attend RCP training on 04/10/17. Oct 17 – 4 representatives attended the RCP training on 04/10/17 (Ghada Ramadan, Caris Grimes, William Ogburn and Kimberley Willsea). Nov 17 - The first internal training session took place on 03/11/17 with 7 attendees present. The next session is scheduled for 11/01/18 – 20 attendees are currently registered.	Ensure RCP training is rolled out across the Trust with support from KSS AHSN.	Dr Richard Leach, M&M Chair	All reviewing clinicians trained in the RCP methodology	March 2018		Active
5. Engagement with Bereaved Families and Carers Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.								
5.1	Providers should offer a bereavement service for families and carers of people who die under their management and care. This should include bereavement advisors to help families and carers through the practical aspects following the death of a loved one.	The Trust provides access to bereavement services in some specialties. There is a patient affairs and chaplaincy service in place throughout the Trust, Sep 17 – A new service has been introduced in the Co-ordinated Surgical Care Directorate with a view to roll this out across the Trust. However, this is not a bereavement service as it does not provide counselling. The Trust must consider the need for a Bereavement Service.	A review of the existing provision in place should be undertaken to determine whether a trust wide approach is required.	Karen Rule, Director of Nursing Dr Diana Hamilton-Fairley, Medical Director	Bereavement Service in place throughout the Trust	March 2018		Active
5.2	If the care of a patient who has died is selected for case record review providers should communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed to the future.	The new review process has been implemented and stage 2 reviews will be undertaken to assess the impact of problems in care identified through stage 1 reviews. Communication with family will be undertaken within the remit of the Duty of Candour Policy. Nov 11 – Duty of Candour Policy already reflects requirements for communication where there has been a problem with care.	Duty of Candour of Policy to be reviewed to ensure it reflects the requirements explicitly.	Michelle Woodward, Associate Director of Quality	Revised Duty of Candour Policy	November 2017	November 2017	Completed

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
5.3	If a provider feels that an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.	The SI policy is currently under review. The Duty of Candour Policy is already in place. Nov 17 – Duty of Candour Policy and SI Policy already reflect requirements for communication where there has been a problem with care.	Complete the SI policy and review the Duty of Candour Policy, ensuring they meet national requirements.	Michelle Woodward, Associate Director of Quality	Revised Duty of Candour and SI Policy	November 2017	November 2017	Completed
5.4	When a patient dies under the management and care of a trust, bereaved families and carers should be informed immediately after the death. Providers should ensure that their staff, including family liaison officers, have the necessary skills, expertise and knowledge to engage with bereaved families and carers.	The Trust has a Patient Affairs Office in place as well as an end of Life Care Team. Oct 17 – There is currently no trust-wide training for dealing with bereaved families and carers. This must be reviewed.	Review provision of bereavement training in place.	Karen Rule, Director of Nursing Dr Diana Hamilton-Fairley, Medical Director	Bereavement training provision in place	March 2018		Active
5.5	The provider should ensure that the deceased person's GP is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.	GP's are informed of deaths via the electronic discharge notification (EDN) system. However, this is not currently completed at the same time as the medical certificate. Sep 17 – A new process has been developed to ensure clinicians complete the EDN at the same time as the death certificate. This will be effective from 01/11/17. Nov 17 – this process is now in place. Updated policies have been drafted for approval at Trust M&M on 24/11/17. Dec 17 – Updated SOP's have been agreed and published on the intranet.	Review the policies and procedures to ensure EDN's are completed by the appropriate clinician at the same time as the medical certificate.	Dr Diana Hamilton-Fairley, Medical Director	Timely notification to GP. Updated SOP's	November 2017	December 2017	Completed
6. Children and Young People NHS England is currently undertaking a review of child mortality review process both in hospital and Community. A National Mortality Database is currently being commissioned. Further guidance is expected in late 2017.								
6.1	Undertake a review of policies and processes to ensure that they are in line with current best practice and national guidance.	Policies and procedures are already in place regarding paediatric deaths. Sep 17 – Policy and procedures already in place which meet national guidelines for child deaths. New policy published April 2017.	Review of policies and processes to be done to ensure they are in line with best practice and national guidance.	Richard Patey, Clinical Director FCSS	Updated policy/SOP in place	October 2017	April 2017	Completed

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
7. Maternity Services Maternal deaths and stillbirths occurring in acute and community Trusts should be included by Trusts in quarterly reporting from April 2017. This will also include deaths that occur in local midwifery units, or during home births. The definition also covers up to 42 days after the end of pregnancy.								
7.1	Undertake a review of policies and processes to ensure that they are in line with current best practice and national guidance.	Policies and procedures are already in place regarding maternity service deaths. Nov 17 – The existing policy has been reviewed against the national guidance. The Head of Midwifery & Gynaecology Nursing has confirmed it meets requirements.	Review of policies and processes to be done to ensure they are in line with best practice and national guidance.	Dot Smith, Head of Midwifery & Gynaecology Nursing	Updated policy/SOP in place	October 2017	November 2017	Completed
8. Mental Health Regulations require registered providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay.								
8.1	Undertake a review of policies and processes to ensure that they are in line with current best practice and national guidance.	The SI policy is currently under review. Safeguarding policies are already in place.	Review of policies and processes to be done to ensure they are in line with best practice and national guidance.	Michelle Woodward, Associate Director of Quality , Ann Bushnell, Patient Safety Manager / Denise Thompson, Head of Clinical Audit and Effectiveness / Bridget Fordham, Head of Safeguarding	Revised SI policy	March 2018		Active
9. Learning Disabilities There is unequivocal evidence that demands additional scrutiny be placed on deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review Programme. Once fully rolled out by NHS England, the programme will receive notifications of all deaths of people with Learning Disabilities. This will support a standardised approach and the reviews will be conducted by trained staff.								
9.1	Learning disability (LD) deaths should be referred to the national LeDeR programme for external review from 07/08/2017.	Deaths will be reported as necessary through the LD and Safeguarding Teams. Child LD deaths will be reported through the Families and Clinical Support Services Directorate. Oct 17 – Relevant deaths are being referred already and a death register has been established as required to monitor all LD deaths and their referral to the LeDeR programme. The Safeguarding Team is working on an SOP for this process. There has been a delay in finalising this action due to delays in the roll out of the national programme to the South East. Therefore the deadline has been amended to January 2017.	Ensure procedures are in place.	Bridget Fordham, Head of Safeguarding / Richard Patey, Clinical Director FCSS	Updated SOP's in place	January 2017		Active

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
9.2	Review all deaths of people with learning disabilities for potential safeguarding concerns and whether it meets the criteria for a serious incident.	LD deaths will be reviewed internally through the mortality review process. They are also reviewed by the LD, Safeguarding and Patient Safety Teams for potential safeguarding concerns and whether they meet SI criteria. Nov 17 – The necessary processes and procedures are already in place to underpin the recommendation, however there is a requirement to reference the National guidance within the policy framework, This will be done as part of the SI review planned to be completed by the end of March 2018.	Ensure policies and procedures are in place which meet national requirements.	Bridget Fordham, Safeguarding Lead / Michelle Woodward, Associate Director of Quality	Updated Policies/SOP's in place	March 2018		Active
9.3	Nominate a Lead for the organisation that will attend the Steering Group and act as a point of contact for LeDeR when a death has occurred.	Bridget Fordham has been named as the Lead for the Trust.	No further action required.	Karen Rule, Director of Nursing	Lead appointed for the organisation	September 2017	August 2017	Completed
9.4	Set up a learning Disability death register.	LD deaths are recorded on the mortality spreadsheet. Oct 17 - A new LD register has been established to record deaths and referrals to the LeDeR programme.	No further action required.	Bridget Fordham, Safeguarding Lead	LD Register in place	September 2017	August 2017	Completed

5. Conclusion

The Board is requested to note:

- The content of the updated Learning from Deaths Dashboard for 2017/18
- The progress against the Learning from Deaths Action Plan.

Authors:

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April 2018

NHS
Medway
NHS Foundation Trust

Report to the Board

Committee Date: 03/05/2018 Item No. 11a

Title of Report	**Finance Report Month 12**
Prepared By:	Tracey Easton - Deputy Director of Finance
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee 26th April 2018
Executive Summary	The purpose of this report is to summarise the M12 financial performance of the Trust against the agreed plan. Key points are : 1. Month 12 has been reported as a deficit of £66.4m pre STF, which is adverse to plan by £19.6m. The Trust received the first quarter STF of £2.4m and on 20th April was notified of an additional £1.8m, meaning that the Trust has received £4.2m of STF. The Trust position post STF is a deficit of £62.2m, adverse to plan by £24.3m. This position includes the final position agreed with the North Kent CCGs following the outcome of the two Expert Determination decisions. The Expert Determination found against the Trust for the Non elective pathway, MRET and New to follow up challenges but the remainder of the challenges from the CCG were not upheld. This contractual review has enabled the Trust and CCG to agree a final position for 2017/18 and is being used to support the planning process for 2018/19. Both organisations will be adopting the approach recommended by the ED process in each of the areas concerned. 2. Expenditure – Month 12 ytd expenditure is adverse to plan by £3m, £5.3m over spend on pay, £2.3m favourable on non-pay due to reserves and the release of the prior year provision for bad debt, and £0.7m favourable on interest. There are significant pay overspends in most of the Directorates. 3. Income – Clinical income is below plan by £16.9m at month

Report to the Board of Directors

	12, due to the impact of both the Expert Determination outcome decisions and the original plan being significantly above contract value. 4. Other income – at month 12 other income is below plan by £0.3m. This adverse variance has improved due to increased income from Health Education England, notified in month 12. 5. At month 12 CIP delivery is behind plan by £5.598m. The original plan was for delivery of £12.583m in year of which only £6.985m has been delivered. 6. Cash has been drawn down from DH in the form of loans in line with the revised deficit position. The Trust is holding a cash balance of £9.7m. This is above the minimum liquidity level (£1.4m) required by DH. In 2018/19 the host CCG is reverting to national payment terms, with payments being made on the fifteenth of the month rather than the first. The Trust needs to retain additional cash balances at the month end to ensure sufficient liquidity up to the contract payment date. 7. Capital – The capital spend for 2017-18 is £17.55m, a £3.87m variance to the revised plan. 8. The balance sheet is in negative equity (£11.2m net liabilities) at Month 12 due to the high level of loans which now stand at £217m.
Resource Implications	As outlined
Risk and Assurance	• Contracts and Planning 2018-19 – variations to the 2 year contract are being discussed with the CCG for 2018-19. **The Board is asked to note that the Trust is currently negotiating the 2018-19 contract to ensure that a fair settlement is agreed for the year. There are also ongoing discussions with regards to the potential form of the contract to reduce the contractual issues and allow time to be spent on pathway redesign and management of demand.** **The outturn for 2018-19 for both pay and non-pay was in**

Report to the Board of Directors

	excess of the revised forecast outturn agreed in December 2017, and the draft plan submitted to NHSI in March 2018 was based on that forecast position. The implications of the change in the outturn may lead to additional pressure on maintaining the current planned £52.8m deficit for 2018-19. **Medway system met with the regulators on 25th April to review the draft plan and any changes the Trust or CCG are proposing for the final submission on 30th April.** • CIP Delivery of £15m for 2018-19 is a risk with a significant level of unidentified CIP. **The Board is asked to note that actions are already being taken to improve the delivery process.** ◦ **Additional senior finance resource is working alongside the programmes to develop savings opportunities.** ◦ **Benchmarking analysis of peer Trusts and the national benchmarking data are being used to identify opportunities and inform planning for 2018/19.** ◦ **The new PMO team will be fully in place in June 2018 which will be focused on transformation and delivery of the associated savings. Some members of the team are already in place with more starting over the coming weeks.** • Trust infrastructure and estate remains a risk due to age and condition, and lack of cash for capital investment. **The Board is asked to note that the capital programme is being managed within the capital limits, with prioritisation criteria for spend being risk based as well as invest to save.**
Legal Implications/Regulatory Requirements	Lack of agreement of the proposed control total for 2018-19 may lead to further Regulatory actions. Inappropriate Estate and insufficient Facilities lead to higher than

Report to the Board of Directors

	acceptable risk to Patients, visitors and staff and could lead to further regulatory action.
Improvement Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery. In year, financial stability is one of 4 programmes in Better, Best, Brilliant which includes financial recovery, commercial efficiency and estate planning.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	To note the contents of the report
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

Finance Report

Month 12

2017/18

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Finance Report for March 2018- APPENDICES

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    a. Cost Improvement Programme Summary

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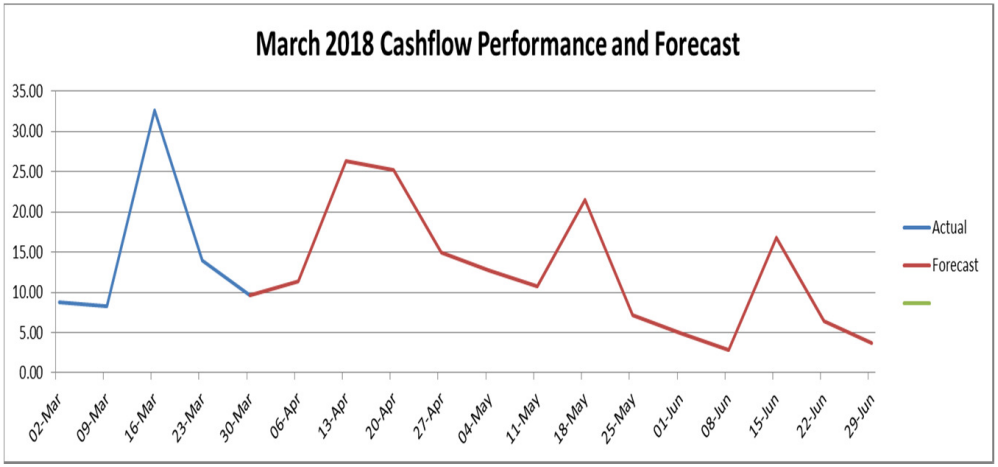
1. Liquidity

1a. Cash Flow

13 Week Forecast

	Actual				Forecast												
Week Ending	02/03/18	09/03/18	16/03/18	23/03/18	30/03/18	06/04/18	13/04/18	20/04/18	27/04/18	04/05/18	11/05/18	18/05/18	25/05/18	01/06/18	08/06/18	15/06/18	22/06/18
BANK BALANCE B/FWD	**2.00**	**8.71**	**8.29**	**32.59**	**13.96**	**9.69**	**11.39**	**26.30**	**25.24**	**15.00**	**12.74**	**10.70**	**21.44**	**7.19**	**4.93**	**2.89**	**16.81**
Receipts																	
NHS Contract Income	7.65	4.55	2.73	1.99	5.25	1.59	17.44	0.28	0.00	0.00	0.00	17.66	0.00	0.00	0.00	17.66	0.00
Other	0.18	0.49	0.71	0.67	0.27	0.45	0.58	2.58	0.28	0.40	0.61	0.40	0.28	0.40	0.61	0.40	0.28
STF Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total receipts	**7.84**	**5.04**	**3.44**	**2.66**	**5.52**	**2.04**	**18.02**	**2.85**	**0.28**	**0.40**	**0.61**	**18.06**	**0.28**	**0.40**	**0.61**	**18.06**	**0.28**
Payments																	
Pay Expenditure (excl. Agency)	(0.34)	(0.36)	(0.33)	(15.28)	(4.64)	(0.33)	(0.34)	(2.83)	(8.12)	(0.35)	(0.34)	(2.64)	(12.22)	(0.35)	(0.34)	(0.34)	(14.52)
Non Pay Expenditure	0.97	(5.10)	(10.07)	(6.73)	(1.63)	(0.02)	(2.76)	(5.33)	(2.40)	(1.71)	(2.31)	(4.60)	(2.31)	(1.71)	(2.31)	(3.80)	(3.11)
Capital Expenditure	(1.75)	0.00	0.00	0.00	(3.52)	0.00	0.00	0.00	0.00	(0.60)	0.00	0.00	0.00	(0.60)	0.00	0.00	0.00
Total payments	**(1.12)**	**(5.46)**	**(10.40)**	**(22.02)**	**(9.79)**	**(0.35)**	**(3.11)**	**(8.16)**	**(10.51)**	**(2.66)**	**(2.65)**	**(7.24)**	**(14.53)**	**(2.66)**	**(2.65)**	**(4.14)**	**(17.63)**
Net Receipts/ (Payments)	**6.72**	**(0.42)**	**(6.96)**	**(19.36)**	**(4.27)**	**1.70**	**14.91**	**(5.31)**	**(10.24)**	**(2.26)**	**(2.05)**	**10.83**	**(14.25)**	**(2.26)**	**(2.05)**	**13.93**	**(17.35)**
Funding Flows																	
FTFF/DOH - Revenue	0.00	0.00	36.60	0.00	0.00	0.00	0.00	4.40	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	7.06
STF Advance	0.00	0.00	(5.34)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FTFF/DOH - Capital	0.00	0.00	0.00	1.80	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Incentive Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	(1.12)	0.00	0.00	0.00	(0.15)	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	(0.08)
Dividend payable	0.00	0.00	0.00	0.04	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00	**0.00**	**31.26**	**0.72**	**0.00**	**0.00**	**0.00**	**4.25**	**0.00**	**0.00**	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**0.00**	**6.98**
BANK BALANCE C/FWD	**8.71**	**8.29**	**32.59**	**13.96**	**9.69**	**11.39**	**26.30**	**25.24**	**15.00**	**12.74**	**10.70**	**21.44**	**7.19**	**4.93**	**2.89**	**16.81**	**6.45**

Fig1. Cashflow Forecast



Commentary

The opening cash balance for March 2018 was £1.6m, with a closing balance of £9.7m. This additional cash holding is mainly due to a requirement to retain sufficient month end cash balances following the CCG's decision to delay settlement of monthly contract invoices to the 15th of the month from the new financial year. In addition, £5.2m was received from Medway CCG at the end of the year in settlement of contract invoices.

The graph shows the actual cashflow for March and the projected weekly cashflow up to and including w/e 29 Jun 2018.

Receipts in the month were £24.3m, plus £32m loans & funding, therefore the total cash inflow for March was £56.3m. Payments, including capital in the month were £48.2m.

The Trust received £55.8m of deficit loan funding during 2017/18 in the form of uncommitted revenue loans with a further £19.9m in working capital loans and £2.4m STF . The Trust has also drawn PDC of 3.2m and capital loans of £11.3m in relation to the Emergency Department capital project, CT Scanner and Fire Safety projects.

Monthly payments for 2017/18 averaged at £29.5m, with 57% relating to payroll costs. This includes £9.5m per month for direct salary payments and £7.2m in relation to employer costs. Monthly receipts (excluding loans & STF) for 17/18 have averaged at £22.7m.

Whilst the Trust has experienced severe cash pressures during the final quarter of the year, the availability of additional revenue cash support during March has enabled both NHS and non-NHS creditor balances to be reduced significantly with all approved invoices being paid to term. It is expected that this will greatly reduce pressure from suppliers as we commence the start of the new financial year.

2. Financial Performance

2a. Consolidated Income & Expenditure

Consolidated I&E (March 2018)

	Current Month			Year to Date (YTD)			Annual		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Forecast*	*Plan*	*Variance*
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	16,770	19,852	-3,082	219,528	238,371	-18,843	219,528	238,371	-18,843
High Cost Drugs	1,975	1,717	258	22,518	20,596	1,923	22,518	20,596	1,923
Other Operating Income	3,420	2,314	1,106	24,312	24,623	-311	24,312	24,623	-311
Total Revenue	**22,165**	**23,883**	**-1,718**	**266,359**	**283,590**	**-17,231**	**266,359**	**283,590**	**-17,231**
Expenditure									
Substantive	-14,998	-16,287	1,289	-171,094	-194,561	23,467	-171,094	-194,561	23,467
Bank	-2,331	-454	-1,877	-25,333	-1,078	-24,255	-25,333	-1,078	-24,255
Agency	-2,598	-919	-1,679	-17,445	-12,917	-4,528	-17,445	-12,917	-4,528
Total Pay	**-19,926**	**-17,660**	**-2,266**	**-213,873**	**-208,556**	**-5,316**	**-213,873**	**-208,556**	**-5,316**
Clinical supplies	-3,041	-2,973	-68	-36,537	-36,631	95	-36,537	-36,631	95
High Cost Drugs Expense	-1,498	0	-1,498	-19,441	0	-19,441	-19,441	0	-19,441
Drugs	-1,105	-2,440	1,334	-12,868	-30,059	17,191	-12,868	-30,059	17,191
Consultancy	-43	-67	25	-1,528	-959	-568	-1,528	-959	-568
Other non pay	-8,149	-3,440	-4,709	-36,275	-41,276	5,001	-36,275	-41,276	5,001
Total Non Pay	**-13,836**	**-8,920**	**-4,916**	**-106,648**	**-108,926**	**2,278**	**-106,648**	**-108,926**	**2,278**
Total Expenditure	**-33,761**	**-26,580**	**-7,182**	**-320,521**	**-317,482**	**-3,039**	**-320,521**	**-317,482**	**-3,039**
EBITDA	**-11,596**	**-2,697**	**-8,900**	**-54,162**	**-33,892**	**-20,270**	**-54,162**	**-33,892**	**-20,270**
Post EBITDA									
Depreciation	-890	-807	-83	-9,797	-9,693	-104	-9,797	-9,693	-104
Interest	-271	-264	-7	-2,503	-3,186	683	-2,503	-3,186	683
Dividend	0	-4	4	0	-81	81	0	-81	81
Profit/(loss) on sale of asset	0	0	0	0	0	0	0	0	0
Net (Surplus) / Deficit - Pre STF	**-12,758**	**-3,772**	**-8,986**	**-66,462**	**-46,852**	**-19,610**	**-66,462**	**-46,852**	**-19,610**
STF Income	0	1,050	-1,050	4,251	9,006	-4,755	4,251	9,006	-4,755
Net (Surplus) / Deficit - Post STF	**-12,758**	**-2,722**	**-10,036**	**-62,211**	**-37,846**	**-24,365**	**-62,211**	**-37,846**	**-24,365**

2b. Run Rate Analysis - Financial

Anaylsis of 15 monthly performance - Financials

	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue														
Clinical income	18.6	22.6	18.5	19.1	19.8	20.0	20.7	19.8	15.6	19.2	13.7	20.0	16.4	16.8
High Cost Drugs	1.6	1.6	1.7	1.9	1.9	1.8	1.8	1.7	2.2	1.9	1.6	1.5	2.0	2.0
STF Income	1.0	2.4	0.1	0.9	0.5	0.6	0.4	0.6	0.4	0.9	- 1.9	-	-	-
Other Operating Income	2.1	3.0	2.0	1.6	2.1	2.0	2.0	1.9	1.7	1.9	1.9	1.9	1.9	3.4
Total Revenue	**23.4**	**29.5**	**22.3**	**23.6**	**24.3**	**24.4**	**24.9**	**24.0**	**19.8**	**23.9**	**15.3**	**23.4**	**20.4**	**22.2**
Expenditure														
Substantive	-14.0	-13.6	-14.0	-14.3	-14.3	-14.1	-14.3	-13.9	-14.5	-14.2	-14.1	-14.8	-13.5	-15.0
Bank	-0.8	-0.9	-1.1	-1.2	-2.7	-1.8	-2.4	-2.3	-2.4	-2.2	-2.0	-2.6	-2.3	-2.3
Agency	-3.6	-3.9	-2.2	-1.9	-0.2	-1.3	-1.6	-1.4	-1.3	-1.1	-0.9	-1.1	-1.9	-2.6
Total Pay	**-18.3**	**-18.4**	**-17.3**	**-17.4**	**-17.2**	**-17.2**	**-18.3**	**-17.6**	**-18.2**	**-17.4**	**-17.0**	**-18.5**	**-17.7**	**-19.9**
Clinical supplies	-3.1	-3.0	-2.7	-3.8	-2.8	-3.1	-3.3	-3.3	-3.2	-3.0	-2.9	-2.9	-2.4	-3.0
High Cost Drugs Expense	0.0	0.0	-1.5	-1.5	-1.5	-1.5	-1.5	-9.2	-2.0	-1.9	-1.5	-1.7	-1.7	-1.5
Drugs	-2.4	-2.4	-1.0	-1.2	-1.1	-1.1	-1.4	6.3	-2.0	-1.7	1.0	-1.3	-0.8	-1.1
Consultancy	0.0	0.0	-0.2	-0.1	-0.2	-0.2	-0.3	-0.1	0.0	-0.1	-0.1	-0.1	-0.1	0.0
Other non pay	-2.9	-7.0	-3.1	-3.3	-2.0	-4.3	-1.4	-2.6	-3.2	-2.3	0.3	-3.0	-3.2	-8.1
Total Non Pay	**-8.4**	**-12.4**	**-8.5**	**-9.9**	**-7.6**	**-10.2**	**-7.9**	**-8.9**	**-10.4**	**-8.9**	**-3.2**	**-9.0**	**-8.2**	**-13.8**
Total Expenditure	**-26.7**	**-30.8**	**-25.9**	**-27.3**	**-24.8**	**-27.4**	**-26.2**	**-26.5**	**-28.6**	**-26.3**	**-20.1**	**-27.5**	**-26.0**	**-33.8**
EBITDA	**-3.3**	**-1.3**	**-3.6**	**-3.8**	**-0.5**	**-3.0**	**-1.3**	**-2.5**	**-8.8**	**-2.4**	**-4.8**	**-4.1**	**-5.6**	**-11.6**
Post EBITDA														
Depreciation	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.9
Interest	-0.2	-0.2	-0.3	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3
Dividend	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	-0.9	**-1.0**	**-1.1**	**-0.9**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.2**
Net Surplus / (Deficit)	**-4.2**	**-2.2**	**-4.7**	**-4.7**	**-1.5**	**-4.0**	**-2.3**	**-3.5**	**-9.8**	**-3.5**	**-5.9**	**-5.1**	**-6.5**	**-12.8**

2c. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Substantive	Consultants	191	212	-21	2.48	2.40	0.07	2.39	29.50	28.92	0.58	28.38
	Junior Medical	357	372	-15	1.89	1.99	-0.10	2.27	23.80	23.97	-0.17	23.39
	Nurses & Midwives	1139	1565	-427	4.03	5.40	-1.37	3.96	48.72	64.93	-16.21	47.38
	Scientific, Therapeutic & Technical	342	519	-177	1.13	1.56	-0.43	1.36	15.97	18.68	-2.70	16.63
	Healthcare Assts, etc.	475	595	-120	1.01	1.23	-0.21	0.98	12.41	15.12	-2.71	11.54
	Admin & Clerical	837	949	-112	2.06	2.39	-0.33	2.08	26.05	28.78	-2.73	24.40
	Chair & NEDs	0	7	-7	0.01	0.01	0.00	0.04	0.16	0.15	0.00	0.16
	Executives	6	9	-3	-0.02	0.14	-0.17	0.14	1.25	1.80	-0.55	1.41
	Other Non Clinical	429	499	-70	0.89	1.00	-0.11	0.91	10.98	11.99	-1.01	10.97
	Pay Reserves	0	0	0	1.52	0.16	1.37	-0.08	2.25	0.23	2.02	-0.08
	Substantive Total	**3,776**	**4,727**	**-951**	**15.00**	**16.29**	**-1.29**	**14.04**	**171.10**	**194.56**	**-23.46**	**164.15**
Agency	Consultants	6	0	6	0.09	0.26	-0.17	0.42	1.67	3.25	-1.6	4.16
	Junior Medical	13	0	13	-0.01	0.36	-0.37	0.52	2.20	4.27	-2.1	7.18
	Nurses & Midwives	127	0	127	1.70	0.12	1.58	2.31	9.15	2.13	7.0	17.75
	Scientific, Therapeutic & Technical	27	0	27	0.64	0.05	0.60	0.18	2.93	0.71	2.2	2.82
	Healthcare Assts, etc.	0	0	0	0.02	0.01	0.01	0.14	0.13	0.17	0.0	1.63
	Admin & Clerical	8	3	6	0.13	0.09	0.04	0.32	0.68	2.03	-1.4	5.53
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	19	0	19	0.02	0.03	-0.01	0.10	0.69	0.35	0.3	1.45
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Agency Total	**201**	**3**	**198**	**2.60**	**0.92**	**1.68**	**4.00**	**17.44**	**12.92**	**4.53**	**40.53**
Bank	Consultants	12	0	12	0.11	0.00	0.11	0.00	2.16	0.00	2.2	0.00
	Junior Medical	42	0	42	0.52	0.00	0.52	0.05	5.31	0.01	5.3	0.08
	Nurses & Midwives	158	0	158	0.69	0.43	0.27	0.02	6.80	0.59	6.2	2.41
	Scientific, Therapeutic & Technical	23	0	23	0.04	0.00	0.04	0.04	0.67	0.01	0.7	0.57
	Healthcare Assts, etc.	222	0	222	0.66	0.00	0.66	0.59	6.21	0.13	6.1	3.52
	Admin & Clerical	60	4	56	0.11	0.02	0.09	0.14	2.61	0.26	2.4	1.28
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	74	1	72	0.19	0.00	0.19	0.09	1.57	0.08	1.5	0.58
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Bank Total	**591**	**5**	**585**	**2.33**	**0.45**	**1.88**	**0.94**	**25.33**	**1.08**	**24.25**	**8.44**
	Workforce Total	**4,567**	**4,735**	**-167**	**19.93**	**17.66**	**2.27**	**18.98**	**213.87**	**208.56**	**5.32**	**213.12**

	Current Month						Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
Staff Group:	WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Consultants	210	212	-2	2.68	2.67	0.01	2.81	33.33	32.17	1.16	32.54
Junior Medical	413	372	41	2.40	2.35	0.05	2.84	31.31	28.25	3.05	30.65
Nurses & Midwives	1,424	1,566	-142	6.43	5.95	0.48	6.29	64.68	67.65	-2.98	67.53
Scientific, Therapeutic & Technical	392	519	-127	1.81	1.61	0.20	1.59	19.57	19.40	0.17	20.02
Healthcare Assts, etc.	697	595	102	1.70	1.24	0.46	1.71	18.75	15.41	3.34	16.68
Executives	6	9	-3	-0.02	0.14	-0.17	0.14	1.25	1.80	-0.55	1.41
Chair & NEDs	0	7	-7	0.01	0.01	-0.00	0.04	0.16	0.15	0.00	0.16
Admin & Clerical	906	955	-50	2.30	2.51	-0.20	2.55	29.34	31.06	-1.73	31.22
Other Non Clinical	521	500	21	1.10	1.03	0.06	1.10	13.25	12.43	0.82	12.99
Pay Reserves	0	0	0	1.52	0.16	1.37	-0.08	2.25	0.23	2.02	-0.08
Workforce Total	**4,567**	**4,735**	**-167**	**19.93**	**17.66**	**2.27**	**18.98**	**213.87**	**208.56**	**5.32**	**213.12**

2d. Run rate analysis pay

		Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	178	179	180	184	187	186	189	189	192	190	193	192	192	191
	Junior Medical	321	330	315	320	320	320	348	346	354	339	359	356	352	357
	Nurses & Midwives	1,134	1,120	1,087	1,096	1,148	1,148	1,152	1,142	1,161	1,148	1,128	1,125	1,138	1,139
	Scientific, Therapeutic & Technical	448	446	437	437	426	425	429	442	446	438	433	425	419	342
	Healthcare Assts, etc	472	479	470	478	491	489	492	492	492	494	485	480	484	475
	Admin & Clerical	821	817	894	889	825	835	840	839	841	831	831	842	839	837
	Chair & NEDs	6	5	3	11	7	2	6	6	1	1	-	-	-	-
	Executives	7	7	7	8	8	7	7	6	6	6	6	6	6	6
	Other Non Clinical	438	441	440	445	446	445	449	442	441	436	437	435	440	429
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Substantive Total	**3,823**	**3,824**	**3,833**	**3,868**	**3,857**	**3,853**	**3,912**	**3,904**	**3,935**	**3,883**	**3,872**	**3,861**	**3,871**	**3,776**
Agency	Consultants	20	28	20	15	14	9	14	10	11	12	4	3	8	6
	Junior Medical	53	56	47	40	33	28	24	24	12	23	20	17	14	13
	Nurses & Midwives	339	411	168	125	141	102	171	153	153	90	93	153	105	127
	Scientific, Therapeutic & Technical	37	35	46	32	38	35	50	46	34	31	32	24	18	27
	Healthcare Assts, etc	63	53	1	1	-	-	-	-	-	-	-	-	-	-
	Admin & Clerical	47	24	12	8	8	5	4	4	3	3	3	5	4	8
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	51	47	31	22	26	2	28	21	26	20	19	18	19	19
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Agency Total	**611**	**654**	**325**	**243**	**261**	**181**	**291**	**258**	**238**	**179**	**171**	**220**	**168**	**201**
Bank	Consultants	-	-	-	-	7	11	10	13	14	15	14	15	12	12
	Junior Medical	64	107	71	79	97	96	45	41	48	39	32	41	35	42
	Nurses & Midwives	1	3	5	22	21	33	137	126	125	124	105	195	167	158
	Scientific, Therapeutic & Technical	3	11	1	1	10	12	11	12	12	16	17	22	22	23
	Healthcare Assts, etc	134	209	130	142	161	173	249	207	203	195	182	208	191	222
	Admin & Clerical	64	52	263	105	84	83	114	74	91	75	58	59	55	60
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	44	40	37	41	44	47	71	59	65	56	59	66	62	74
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Bank Total	**310**	**422**	**507**	**390**	**423**	**455**	**637**	**532**	**558**	**518**	**467**	**606**	**544**	**591**
	Workforce Total	**4,743**	**4,900**	**4,665**	**4,502**	**4,540**	**4,489**	**4,840**	**4,694**	**4,730**	**4,580**	**4,510**	**4,687**	**4,583**	**4,567**

Analysis of 15 monthly performance - £

		Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.46	2.19	2.55	2.36	2.55	2.52	2.47	2.37	2.54	2.41	2.40	2.39	2.48	2.48
	Junior Medical	1.86	2.08	1.84	1.95	2.00	1.90	2.09	1.81	2.22	2.01	2.05	2.08	1.96	1.89
	Nurses & Midwives	4.14	3.96	3.94	4.03	4.12	4.04	4.13	4.05	4.08	4.07	3.88	4.06	4.05	4.03
	Scientific, Therapeutic & Technical	1.42	1.36	1.33	1.36	1.34	1.32	1.33	1.37	1.38	1.36	1.36	1.27	1.31	1.13
	Healthcare Assts, etc	0.97	0.93	1.00	1.05	1.04	1.03	1.03	1.04	1.02	1.05	1.04	1.05	1.04	1.01
	Admin & Clerical	2.07	2.08	2.26	2.43	2.14	2.20	2.20	2.20	2.15	2.20	2.27	2.22	2.11	2.06
	Chair & NEDs	0.01	0.04	0.01	0.02	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.02	0.01	0.01
	Executives	0.10	0.14	0.17	0.16	0.12	0.11	0.10	0.09	0.09	0.09	0.09	0.14	0.18	0.02
	Other Non Clinical	0.92	0.91	0.90	0.94	0.93	0.90	0.91	0.92	0.91	0.90	0.90	0.94	0.92	0.89
	Pay Reserves	0.00	0.00	0.02	0.02	0.07	0.06	0.07	0.07	0.07	0.07	0.07	0.66	0.52	1.52
	Substantive Total	**13.96**	**13.69**	**14.01**	**14.32**	**14.32**	**14.09**	**14.34**	**13.93**	**14.48**	**14.17**	**14.07**	**14.83**	**13.54**	**15.00**
Agency	Consultants	0.37	0.42	0.37	0.18	0.03	0.14	0.25	0.15	0.18	0.09	0.02	0.08	0.09	0.09
	Junior Medical	0.64	0.52	0.39	0.24	0.18	0.23	0.21	0.12	0.12	0.21	0.12	0.26	0.14	0.01
	Nurses & Midwives	1.69	2.03	0.19	1.25	0.37	0.61	0.76	0.69	0.75	0.43	0.44	0.72	1.24	1.70
	Scientific, Therapeutic & Technical	0.10	0.18	0.29	0.19	0.16	0.23	0.26	0.32	0.20	0.18	0.22	0.02	0.23	0.64
	Healthcare Assts, etc	0.19	0.14	0.01	0.00	0.00	0.02	-	-	-	-	-	0.03	-	0.02
	Admin & Clerical	0.41	0.21	0.13	0.01	0.06	0.04	0.01	0.04	-	0.12	0.04	0.03	0.10	0.13
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Other Non Clinical	0.16	0.11	0.21	0.07	0.07	0.04	0.08	0.06	0.06	0.05	0.05	0.06	0.06	0.02
	Agency Total	**3.55**	**3.61**	**1.58**	**1.94**	**0.87**	**1.27**	**1.57**	**1.38**	**1.31**	**1.08**	**0.89**	**1.14**	**1.86**	**2.60**
Bank	Consultants	0.00	0.00	0.00	0.00	0.21	0.19	0.21	0.25	0.26	0.22	0.21	0.24	0.20	0.11
	Junior Medical	0.24	0.29	0.25	0.03	1.16	0.45	0.59	0.48	0.58	0.47	0.50	0.58	0.43	0.52
	Nurses & Midwives	0.01	0.05	0.09	0.23	0.50	0.39	0.53	0.61	0.56	0.51	0.44	0.81	0.83	0.69
	Scientific, Therapeutic & Technical	0.01	0.04	0.00	0.01	0.04	0.04	0.03	0.05	0.05	0.12	0.08	0.10	0.10	0.04
	Healthcare Assts, etc	0.31	0.58	0.33	0.35	0.81	0.47	0.54	0.57	0.51	0.49	0.48	0.52	0.48	0.66
	Admin & Clerical	0.15	0.15	0.97	0.58	0.89	0.21	0.39	0.23	0.28	0.21	0.18	0.18	0.16	0.11
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Other Non Clinical	0.08	0.09	0.07	0.08	0.23	0.09	0.16	0.11	0.14	0.12	0.13	0.14	0.14	0.19
	Bank Total	**0.80**	**1.20**	**1.70**	**1.21**	**2.05**	**1.84**	**2.45**	**2.30**	**2.38**	**2.15**	**2.02**	**2.58**	**2.34**	**2.33**
	Workforce Total	**18.30**	**18.50**	**17.29**	**17.47**	**17.23**	**17.20**	**18.36**	**17.61**	**18.17**	**17.40**	**16.98**	**18.54**	**17.74**	**19.93**

3. Balance Sheet

3b. Debtors

Aged Debtors

	Total	Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
NHS						
CCGs and NHS England	23.53	4.22	0.42	0.85	11.57	6.48
NHS FTs	1.94	0.39	0.23	0.18	0.15	1.01
NHS Trusts	1.60	0.27	0.19	0.13	0.19	0.83
Health Education England	0.36	0.11	0.00	0.00	0.00	0.25
Special Health Authorities	0.05	0.00	0.00	0.00	0.00	0.05
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**27.49**	**4.99**	**0.85**	**1.15**	**11.90**	**8.61**
Non NHS						
Bodies external to Government	2.46	0.48	0.14	0.09	0.24	1.52
other WGA bodies	0.01	0.00	0.00	0.00	0.00	0.01
Local Authorities	0.05	(0.05)	0.00	0.00	0.01	0.09
Total Non NHS	**2.53**	**0.43**	**0.14**	**0.09**	**0.25**	**1.62**
Bad Debt Provision	(1.83)	0.00	0.00	0.00	0.00	(1.83)
Other Receivables	0.00	0.00	0.00	0.00	0.00	0.00
Total Receivables	**28.20**	**5.41**	**0.99**	**1.25**	**12.15**	**8.41**

Commentary

Total outstanding Trade Receivables as at the 31 March 2018 are £28.20m. This includes a £1.83m bad debt provision.

NHS Debt is £27.49m, £12.4m of this relates to billed overperformance for 2017/18 up to the end of September.

Non NHS Debt is £2.53m, with £1.01m owing from Medway Community Healthcare.

Fig.1 shows aged debt analysed by Ageing Category; Fig.2 shows the rolling receivables trend; & Fig.3 provides a list of the top ten debtors by value.

Fig 1 Aged Receivables Analysis

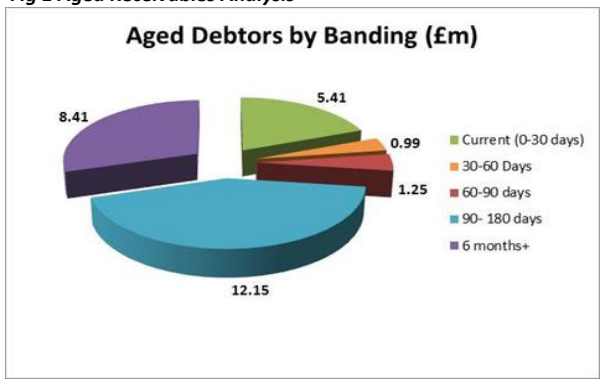


Fig 2 - Debtor Trends

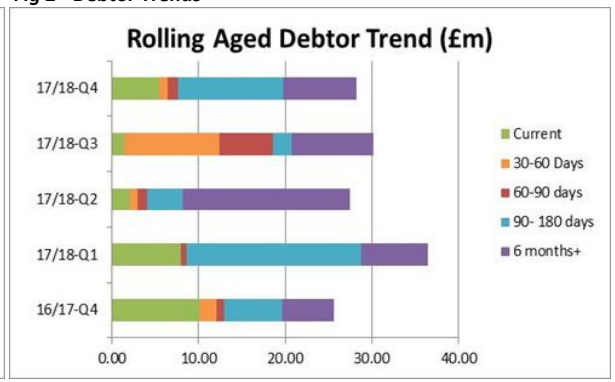


Fig.3 Top Ten Debtors

Top 10 Debtors

		£m
1	NHS MEDWAY CCG	11.04
2	NHS SWALE CCG	5.30
3	NHS DARTFORD GRAVESHAM & SWANLEY	3.30
4	NHS WEST KENT CCG	1.15
5	MEDWAY COMMUNITY HEALTHCARE CIC	0.99
6	EAST KENT HOSPITALS UNIVERSITY NHS.FOUNDATIOI	0.85
7	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	0.78
8	QUEEN VICTORIA HOSPITAL NHS TRUST	0.76
9	DARTFORD & GRAVESHAM NHS TRUST	0.56
10	NHS ENGLAND	0.50

3c. Creditors

Aged Creditors

	Total	Current	31 to 60 Days	61 to 90 Days	91 - 180 Days	6 months +
	£m	£m	£m	£m	£m	£m
NHS FTs	1.72	0.32	0.20	0.12	0.05	1.04
NHS Trusts	2.13	0.57	0.35	0.19	0.13	0.88
Public Health England	0.01	0.00	0.00	0.00	0.00	0.00
CCGs and NHS England	0.00	0.00	0.00	0.00	0.00	0.00
Special Health Authorities	0.10	0.08	0.00	0.00	0.01	0.01
Other DH bodies	0.24	0.02	0.02	0.02	0.02	0.17
Total NHS Payables	**4.20**	**0.99**	**0.57**	**0.33**	**0.20**	**2.11**
Other WGA bodies	(0.01)	(0.01)	0.01	0.00	0.00	0.00
Local Authorities	0.04	0.04	0.00	0.00	0.00	0.00
Bodies external to Government	10.38	4.95	2.10	0.77	0.55	2.01
Total Non NHS Payables	**10.42**	**4.98**	**2.10**	**0.77**	**0.55**	**2.01**
Capital	3.77	3.77	0.00	0.00	0.00	0.00
Payroll	2.88	2.88	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00
Total Other Trade Payables	**6.65**	**6.65**	**0.00**	**0.00**	**0.00**	**0.00**
Total Trade Payables	**21.27**	**12.62**	**2.68**	**1.10**	**0.76**	**4.12**

Commentary

Total outstanding creditors as at 31st March were £21.3m of which 41% (£8.7m) were overdue based on 30 day payment terms.

Following receipt of a Working Capital Loan from the DoH in Mid March, the Trust has began to pay approved invoices in approx 30 days from the invoice date. However prior to receipt of this Loan, payment days were between 60 and 90 Days.

Average payment days for 17/18 were 78.14 days.

There are currently £5.31m of unapproved invoices that are more than 60 days old, unapproval relates to issues with Purchase Orders and inability to validate historical NO PO invoices. The Finance team is working to reconcile these balances with suppliers and with Procurement and Operational Teams to clear the balance down as quickly as possible. Enforcement of NO PO/NO PAY should ensure that such significant balances of aged unapproved invoices do not accumulate in the future.

The Trust has £4.12m creditors over 6 months; Fig. 1 shows aged creditors analysed by ageing category; Fig.2 shows the rolling creditor trend; & Fig.3 provides a list of the top 10 creditors by value.

Fig.1 - Aged Payables Analysis

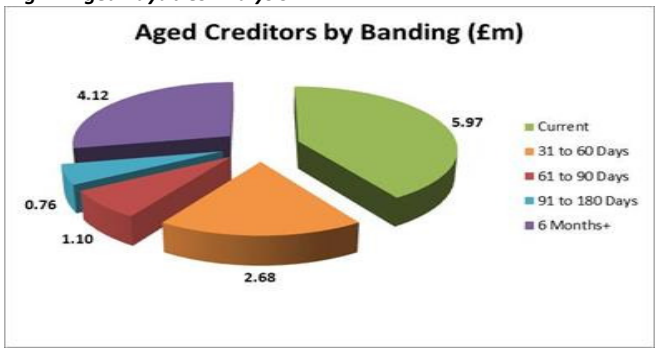


Fig.2 - Creditor Trends

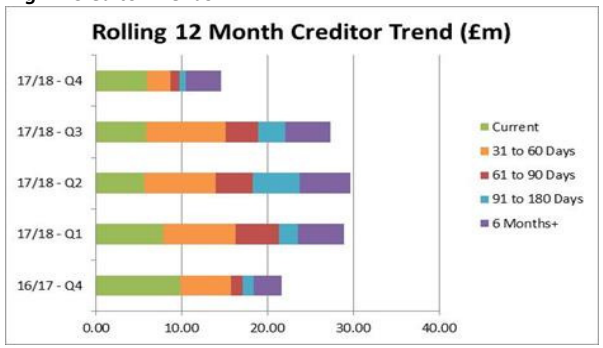


Fig.3 - Top 10 Creditors

	Top 10 Creditors	£m
1	MAIDSTONE TUNBRIDGE WELLS NHST (RWF)	1.15
2	NHS SUPPLY CHAIN-ORDERS	1.12
3	DARTFORD & GRAVESHAM NHS TRUST (RN7)	0.95
4	KINGS COLLEGE HOSPITAL NHS TRUST (RJZ)	0.78
5	MEDWAY COMMUNITY HEALTHCARE CIC	0.76
6	GLOBE LOCUMS LTD	0.62
7	NHS SUPPLY CHAIN	0.56
8	EAST KENT HOSPITALS NHS TRUST (RVV)	0.39
9	KENT INST OF MEDICINE & SURGEY (KIMS)	0.38
10	KENT COMMUNITY HEALTH NHS FT (RYY)	0.37

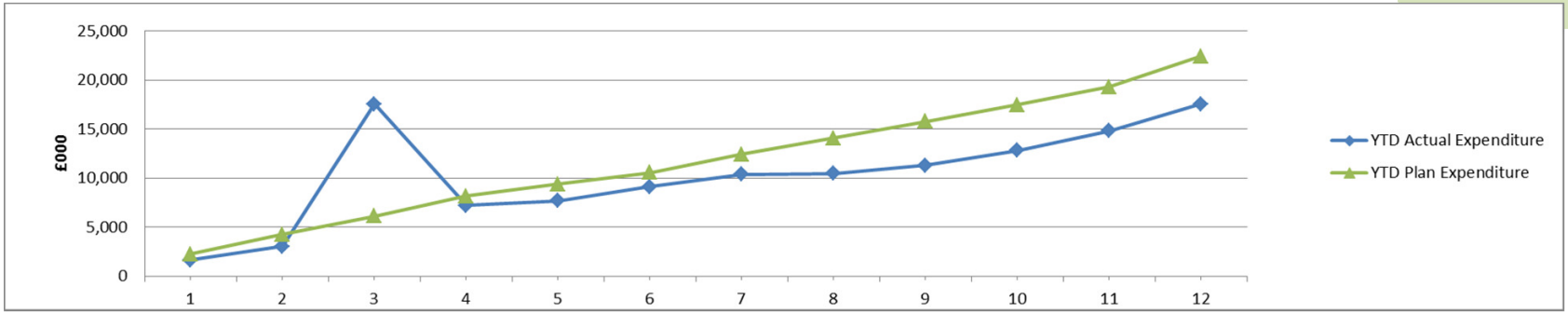
4. Capital

4a. Capital

Capital Programme Summary

	Current Month			Year to Date		
	Actual	Plan	Variance	Actual	Plan	Variance
	£m	£m	£m	£m	£m	£m
Expenditure						
Recurrent Estates & Site Infrastructure	-0.33	0.77	-1.11	3.33	4.98	-1.65
IM&T	1.13	0.22	0.91	2.47	1.94	0.53
Medical & Surgical Equipment	1.84	0.18	1.66	2.28	1.37	0.91
Specific Business Cases	-0.12	0.17	-0.28	1.10	1.81	-0.72
Transform Projects (ED/AAU)	0.23	0.98	-0.75	8.21	10.32	-2.12
Medical Asssessment Unit (MAU)	0.01	0.50	-0.49	0.17	1.00	-0.83
Total	**2.76**	**2.82**	**-0.06**	**17.55**	**21.42**	**-3.87**

The total capital spend for the closing period of March 2018 amounted to £17.55m representing a total underspend of £3.87m against the revised plan of £21.42m. The principal projects which have underspent are the Emergency Department (ED) for £2.1m with a projected completion date of 31st March 2019 and backlog maintenance within Estates slipping by £2.29m. The Medical Assessment Unit (MAU) which has been specifically funded by the Emeregncy Fund with £1m of funding has also suffered slippage of £0.83m.



5. Cost Improvement Programme

5a. 2017/18 Cost Improvement Programme Summary

	Acute & Continuing Care £0	Surgery £'000	Womens & Childrens £'000	Corporate £'000	Estates £'000	Central £'000	TOTAL £'000
Divisional Schemes	2,111	2,002	1,186	877	263	260	**6,699**
Medicine Management						2,100	**2,100**
Procurement	2,112	509	163	1		1,061	**3,846**
TOTAL	**4,223**	**2,512**	**1,349**	**878**	**263**	**3,421**	**12,645**

6. Better Practice Payment Code

For the Year 2018 (From Period : 01 to Period: 12)

NHS Payables	Number of Invoices	Percentage of Activity	Value of Invoices	Percentage of Value
Total NHS Invoices paid Outside of Target	1,742	98.42%	20,216,121	95.85%
Total NHS Invoices paid within Target	28	1.58%	876,190	4.15%
Total Paid within the year	**1,770**		**21,092,312**	

Non NHS Payables	Number of Invoices	Percentage of Activity	Value of Invoices	Percentage of Value
Total Non -NHS Invoices paid Outside of Target	67,886	94.82%	104,335,561	90.73%
Total Non -NHS Invoices paid within Target	3,705	5.18%	10,664,095	9.27%
Total Paid within the year	**71,591**		**114,999,655**	

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018

Agenda item 11c

Title of Report	**Communications and Engagement report**
Prepared By:	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications and Engagement
Committees or Groups who have considered this report	NA
Executive Summary	The first quarter of the year has been particularly busy in terms of communications, both internally and externally. Winter pressures have generated ongoing media enquiries, and at the same time we have been keen to keep patients and public informed. We have implemented a campaign to raise awareness of the stroke services consultation and ensure people had enough information to respond to the survey. Community engagement continues to evolve and grow, with our messages now penetrating a much more diverse audience, who are supported to make their views known. Meanwhile, within the Trust we strive to keep staff informed about developments, and to have their input into improvement plans, particularly in relation to our performance and regarding our financial position.
Resource Implications	NA
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA

Report to the Board of Directors

Improvement Plan Implication	Communications and engagement activity is aligned with the Better, Best, Brilliant improvement plan
Quality Impact Assessment	NA
Recommendation	The Board is asked to note the report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The first quarter of the year has been particularly busy in terms of communications, both internally and externally.

1.2 Winter pressures have generated ongoing media enquiries, and at the same time we have been keen to keep patients and public informed.

1.3 We have implemented a campaign to raise awareness of the stroke services consultation and ensure people had enough information to respond to the survey.

1.4 Community engagement continues to evolve and grow, with our messages now penetrating a much more diverse audience, who are supported to make their views known.

1.5 Meanwhile, within the Trust we strive to keep staff informed about developments, and to have their input into improvement plans, particularly in relation to our performance and regarding our financial position

2 ENGAGING COLLEAGUES

2.1 A significant focus for internal communications in recent weeks has been on preparing for the CQC inspection.

2.2 Various materials were produced to ensure staff were fully informed about what to expect, supported to speak openly and honestly in conversations with inspectors, and to showcase their work.

2.3 Handbooks, slide decks, briefing sheets, daily messages and screensavers were among the methods used to engage staff in the visit.

2.4 An all staff briefing (attended by more than 200 staff members) was held to showcase Trust progress and highlight where further work is required.

2.5 In recent months information about the Trust's finances has also been shared with staff, with the Chief Executive explaining the current position in her weekly messages and on video as well as at a well-attended briefing in the restaurant.

2.6 The Chair and Chief Executive have discussed the situation with local MPs and councillors and other stakeholders, all of whom have offered their support.

2.7 We have continued to be open about the current financial position, and to develop understanding about the challenges we face, as well as to explain actions being taken as part of our Better, Best, Brilliant improvement plan and financial recovery.

2.8 A communications campaign was implemented in Medway and Swale to engage a wide audience, including staff, in the formal public consultation on urgent stroke services.

2.9 Staff, as well as patients and public, were urged to take part in the consultation which has now closed. Internally managers were provided with information to ensure their staff were fully briefed.

2.10 The Communications team continues to work with the Organisational and Professional Development Team to engage staff in a cultural change project. This has included focus groups, an 'unconference' and facilitated discussions within teams.

3 MEDIA

3.1 We responded to 26 separate media enquiries during the past two months. The majority of these were from regional and local media, although there were a number of enquiries from national journals.

3.2 We have continued to receive regular enquiries from national and local media on how the hospital the hospital is getting back on track with elective surgery following winter pressures.

3.3 While there has been little coverage focusing on the Trust specifically, regional and local press have referenced the Trust in articles about ambulance handovers, surgery cancellations and A&E four-hour performance.

3.4 The HSJ and our local paper reported on Lesley Dwyer's inclusion in the Top 50 NHS Chief Executives in the country.

3.5 The stroke services consultation had significant radio, TV, print and online coverage on regional BBC TV and radio, ITV Meridian, and across a range of Kent newspaper titles. Quotes from our Medical Director have had prominence in the print and online pieces.

3.6 Our Medical Director was also selected for interview by regional TV following the announcement of a medical school for Kent, part of which will be on the Medway university campus.

Report to the Board of Directors

3.7 Our upcoming Governor elections have been advertised in the local media, as well as members' events.

3.8 On a negative note the Medway Messenger ran a piece about a patient with disabilities who suffered delays to her treatment while she was nil by mouth. We apologised to the patient and her family.

3.9 The Trust's Human Resources and Organisational Development Team won HR Team of the Year which was reported in the Medway Messenger.

3.10 The local press ran features on the six staff members who received Pride in Medway Awards.

3.11 The Trust's fundraising activities have received local coverage in recent weeks, in particular our Knit a Chick campaign in the run-up to Easter which raised an impressive £1,444.71. Details of upcoming fundraising events are regularly featured in the local press.

Report to the Board of Directors

4 SOCIAL MEDIA

4.1 During the past month Medway has become the most-followed acute trust in Kent on Twitter.

4.2 Our engaging and regular content, particularly during the snowy weather and Easter periods, has led to an increased overall following across all channels.

4.3 Trust social media account followers now total 3,833 on Twitter (up from 3,401 at the last update), 5,517 on Facebook (up from 5,268) and 552 on Instagram (up from 423), representing a steady increase across all channels. Among the acute trusts in Kent, we are now the most-followed on Twitter and Instagram, while we are second only to Dartford and Gravesham NHS Trust on Facebook.

4.4 In addition to promoting key news updates, our social media accounts raised awareness of where people could seek healthcare and advice over the Easter period; further award nominations and recognitions for our staff ; charity-led events, including the successful the Knit-a-Chick Easter Appeal; and our regular members' and governor events.

4.5 The Trust social media accounts also continued to distribute key messages to the public regarding stroke services consultation. Our messages encouraged the public to take part in the consultation, highlighted why we believe Medway should be one of

the sites for a hyper acute stroke unit, and raised awareness of the extension to the consultation deadline.

4.6 We are continuing to use our staff mobile phone app - @MFT - to highlight messages and updates to staff, pointing them in the direction of our social media channels which in turn should help to increase our follower numbers. The app is also useful for staff training and as a helpful resource for other information

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 A governor coffee morning was held in Sittingbourne in late March. The Chief Executive joined several governors to meet members of the public on a Saturday morning

5.1.2 Although attendance was low, there were some productive conversations with those residents who attended. This led to an attendee praising the event in a letter to the local media

Report to the Board of Directors

5.1.3 Trust Governor Matt Durcan, along with our Community Engagement Officer attended the Kent Malayalee Association Health and Wellbeing day where they spoke about the Trust, the stroke consultation, the role of governors, and encouraged attendees to stand for election.

5.1.4 We continue with our awareness campaign to highlight opportunities to become a governor through upcoming elections.

5.1.5 A membership recruitment stand was held in the main entrance of the hospital to raise the profile of the governors' role as well as encouraging membership of the Trust as a means to become more engaged.

Report to the Board of Directors

5.2 Members

5.2.1 At a member event held in March around 20 attendees listened to our Chief Executive speak about our achievements one year on from exiting special measures.

5.3 Supporting services to engage with patients and public

5.3.1 Our Community Engagement Officer continues to support patient engagement within the hospital. She has started to work with the Trust's Macmillan Recovery Package Facilitator to ensure patient representation in understanding the patient recovery journey in cancer patients.

5.3.2 Further community presentations on breast screening and organ donation by Trust clinicians are planned

5.4 Reaching out to less engaged audiences

5.4.1 The Trust is a partner in the NHS Youth Forum and we will be having our first meeting on 22 April 2018.

5.4.2 The agenda will look at NHS services, the aims of the youth forum and a presentation on managing exam anxiety.

5.4.3 We continued to strengthen our engagement with young people, and our Community Engagement Officer recently gave a presentation to the Gillingham and Twydall Area Youth Centre Network.

5.4.4 As part of our programme to reach out to less engaged communities our Community Engagement Officer recently attended two mosque opening days in Gillingham and met a number of attendees

5.4.5 We have met members of the Stroke Association and assisted them to complete stroke consultation questionnaires.

5.4.6 We attended the Medway Neurological Network's Fayre to hear the views of local people. At the same event new members were recruited to the Trust.

5.4.7 We continue to build a database of organisations and community groups who want to engage more fully with the Trust, with regular requests being received for our Community Engagement Officer to visit with the support of Trust

5.4.8 Since the last report we have begun to reach out to the Roma community and have made some good links to facilitate two-way conversations.

5.5 Engagement in the STP

5.5.1 We actively support the current stroke services review being consulted upon across Kent and Medway, facilitating at public events and widely distributing the survey.

5.6 Engagement for NHS 70

5.6.1 We have started to engage and involve our staff and local community in our NHS 70 summer fair and July open day.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018 Item No. 12a

Title of Report	Corporate Governance Report
Presented By:	Sheila M Murphy: Trust Secretary: Director of Corporate Compliance and Legal Services
Lead Director	Sheila M Murphy: Director of Corporate Compliance and Legal Services
Committees or Groups who have considered this report	Not Applicable (N/A)
Executive Summary	The report outlines current activity and issues in corporate governance and incorporates the report to Board of 1 March 2018
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trust wide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	Yes
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	The Board is requested to note the report, the assurance and risks stated.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 This report gives a brief overview of corporate governance activity and issues arising.

2 CARE QUALITY COMMISSION

2.1 The Trust underwent a Core Service inspection on the 10 & 11 April 2018. Following this NHS Improvement (NHSI) will undertake a Well Led: Use of Resources assessment scheduled for the 30 April 2018 with the Well Led review due to take place on the 2 and 3 May 2018.

The Trust is provided with limited immediate feedback on the last day of inspection however this indicated that the CQC were impressed with the welcome they received from staff and the multidisciplinary team practice that they saw in all areas of the hospital that they visited.

The following two concerns were raised:

- Fridge temperatures not being checked or recorded in the Emergency Department (resus) and in the radiology department in MRI.
- Administration of CT Contrast medium out of hours was not in line with best practice or Trust policy - only one radiographer present when a second member of staff should be present to check the contrast medium.

No major risks or red flags were raised.

2.2 Well Led Inspection

In addition to the Well Led: use of resources inspection on 30 April there will be an on-site Well Led inspection over two days, focusing on the well-led key lines of enquiry at trust level, and drawing on the CQC wider knowledge of the Trust obtained during the core inspection. Their assessment includes Trust-wide leadership, governance, management and culture and will also consider improvements and changes since the last inspection.

The Trust will receive a full inspection report subsequent to the review.

2.3 Preparation for Inspections

To assist with the CQC preparation and to reflect on the progress the clinical services have made since the last inspection each core service was asked to produce a presentation highlighting progress and achievements since the last inspection and the work they are currently undertaking to further improve. The presentations have been used for internal communication and shared more widely across the trust and with NEDs and Governors. Morning SCRUM meetings provided a useful tool to drive progress, identify actions and ensure actions continue to be monitored. Actions have been escalated to Executive owners and if necessary raised via the project issues log to the CQC Assurance Group.

In addition a communications plan was been developed and the following three handbooks have been reviewed updated.

Staff handbook
Board/NED/Senior Management handbook
CQC Inspector handbook

2.4 CQC Improvement Plan

Outstanding actions resulting from the previous CQC inspection were extracted and placed into the Scrum, to be addressed via the daily burndown process.

Significant progress has been made and a summary of the current position is as follows:

		Must Do	Should Do
Blue	Action has been completed and there is evidence that the action has been embedded in daily practice	15	20
Red	The action is off track and unrecoverable within the current timescales. Requires a re-plan	0	1
Amber	The action is off track and plans are being put in place to mitigate the delay. The action is expected to return to the planned delivery date	0	4
Green	Action is on track to deliver on time	2	2

The one red action indicated in the table has been downgraded from the previous status of green. This action relates to the monitoring of turnaround times for production of clinic letters to GPs following clinic appointments. An update received on the 16 April18 states that the initial investigation suggests there are between 780 and 16,180 letters outstanding on the EPN system, further investigation is being undertaken to determine the precise extent of the backlog.

2.5 CQC Unannounced Inspections

The Trust is expecting at least one unannounced visit following the core service inspection. This may take place during the day or out of normal working hours and will often involve a smaller inspection team. The CQC could re-visit areas that they have already inspected. As with previous inspections, the CQC team will meet with the Trusts senior lead on duty at the time of the visit and they will feed back if there are any immediate safety concerns.

3 RISK AND REGULATION ASSURANCE

The Trust was inspected by the Human Tissue Authority (HTA) on Thursday 26 October 2017, this was our first inspection against the revised Codes of Practice and Standards April 2017. The HTA noted the suitability of the Designated Individual, Licence Holder and premises and the inspection resulted in only one minor shortfall against the standards which has subsequently been addressed and the HTA have indicated this in their report published on the HTA website.

This was an extremely successful inspection with many areas of good and innovative practice noted. In particular, the HTA were very impressed with the mortuary quality manual, Standard Operating Procedures, risk assessments, audits and records such as the viewing form and training programs for porters and undertakers, the latter they had not seen in any other establishment. The peer review of consent for paediatric post mortem was considered very good practice.

There are no further matters arising between March and May to report to Board.

Report to the Board of Directors

4 DOCUMENTATION MANAGEMENT

4.1 The table below shows the status of the corporate policies, all have been approved and are available on the intranet and internet.

Corporate Policy	Document Owner	Status
Conflicts of Interest	Company Secretary	Approved; Available on intranet and website
Consent	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Duty of Candour	Medical Director	Requires review
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Emergency Preparedness, Resilience and Response	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Estates and Facilities	Director of Finance	Approved; Available on intranet and website
Fire Safety	Director of Finance	Approved; Available on intranet and website
Health and Safety	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Human Resources and Organisational Development	Director of Workforce and OD	Approved; Available on intranet and website
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Medicines Management	Medical Director	Approved; Available on intranet and website
Risk Management Strategy	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Safeguarding	Director of Nursing	Approved; Available on intranet and website
Serious Incidents	Medical Director	Requires review
Standing Financial Instructions	Director of Finance	Approved; Available on intranet and website
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet and website

Report to the Board of Directors

5 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

5.1 NHS England EPRR Assurance Programme 2017

The October Local Health Resilience Partnership was attended by Katy White and Paul Mullane. Medway Clinical Commissioning Group presented the Trust audited NHS England Assurance Programme outcome for 2017. It was confirmed that the Trust were fully compliant with the prescribed core standards and as detailed within the report to Board on the subject have two areas of corrective action in relation to the deep dive on the subject of Governance.
Two additional items were raised in the discussion: ED attendance at the Trust EPRR Group where it was felt on the evidence submitted that the department were not completely committed and that of a Communications Team representative being moved back to the core membership of the group from the additional membership list. These items have been addressed and resolved.

5.2 Kent Resilience Forum Seminar

The KRF Seminar was held at the County Showground on 19 October. The theme for this year reflected the National Threat profile of Terrorism. Sessions were received from experts on counter terrorism and those involved in the management and deployment of terrorist attacks and included discussion on the Grenfell Fire response. The learning from this event will be reflected upon to strengthen the Trust position especially in relation to Psychosocial impacts of response on staff.

5.3 Shoreham Air Show Mass Fatalities Seminar 27 October, Crawley

The EPRR Manager was invited to attend a detailed debrief of the incident by the Coroner Service as part of her work on the Kent Resilience Forum; Mass Fatalities Group. The learning from this will support the Trust in terms of the Disaster Victim Identification Mortuary process via a newly forged alliance with the Mortuary Lead APT from the public mortuary involved as well as the wider resilience programme benefits for Kent and Medway.

5.4 NHS E Concept of Operations for managing Mass Casualties – Received 16 November

A gap analysis has been undertaken against the Trust Major Incident Plan.
An update to the Mass Casualty Section of Trust Major Incident Plan will include reference to the document and:

1. The requirement to expand Critical Care Capacity and maintain that for 96 hours
2. An initial planning assumption in relation to casualty dispersal by SECAmb agreed by Mr R Jain and Dr A DaCosta
3. The fact that via Mutual Aid Military Doctors can be requested to enhance the skill set of our Trauma and Orthopaedic Surgeons.

5.5 Priestfield Stadium – Safety Advisory Group Exercise 21 November

The recommendation by the EPRR Manager at the Exercise is that Medway Hospital have the graded Fixtures List annually and are privy to the Football Safety Advisory Group Minutes. This will allow for better communication of higher risk attendees at the Stadium and a more robust review of ED Staffing associated with that risk.

5.6 Mutual Aid Planning

Following on from NHS England's Exercise Fluctus held on 1st November a task and Finish Group will be hosted by NHS England between Christmas and New Year to review planning assumptions in relation to an ED closure and the impacts across the system that would need to be considered within Mutual Aid. The NHS England local lead is Matthew Drinkwater.

5.7 Significant Incident 30 January/ 1 February Failure of ISDN Main Hospital Switchboard 01634 830000 line for Incoming Calls. Both Significant Incident Scale Matrix - Serious, reported to Medway and Swale CCGs/ North Kent CCGs on call.

Stand-alone DDI lines not affected.
31 January incident 13:00 - 23:30 Director Liz Capp- Gray/ Karen Rule out of hours
1 February Incident (Insert time) Director Karen Rule.
Alternative contact details for on call teams shared with CCG for General Practitioners
Trust Communications - Warning/Informing instigated - Internal and External
Debrief Report requested from British Telecom and Daisy in relation to infrastructure.
For Trust debrief with recommendations to Trust EPRR Group 12 February.

5.8 Annual Report and Work Plan 2018

The assurance statement in relation to Corporate Governance for this period is contained in the Emergency Preparedness, Resilience and Response (EPRR) Annual Report to Board agreed for presentation via the May Board Agenda.

This additionally contains the forward EPRR Work Plan 2018 19 for agreement commencing 1 May 2018 alongside the annual confirmation that the Trust Board membership are fully aware of its duty as a Category 1 Responder; as mandated by the Civil Contingencies Act 2004.

6 COMPLAINTS AND COMPLIANCE DASHBOARD

6.1 The compliance dashboard gives an overview of performance across a range of corporate governance key performance indicators and is monitored at the monthly Directorate Performance Review Meetings. There is an overarching Trust level

dashboard (attached at appendix 1) and each directorate (clinical and corporate) has a dashboard tailored to the relevant KPIs of that service.

COMPLIANCE DASHBOARD 17/18 - TRUSTWIDE

Freedom of Information		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
1.1	% of closed FOIs completed in 20 working days	90%	47%	62%	61%	78%	40%	70%	94%	38%	54%	70%	49%	39%	45%	68%	66%
1.2	No. of FOIs overdue	N/A	0	0	93	72	64	43	65	75	56	61	57	52	61	65	70

Information Governance		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
2.1	IG Training (>95%)	95%	0%	0%	81%	80%	78%	77%	77%	75%	80%	77%	80%	80%	78%	80%	80%
2.2	No. breaches reported to the ICO	N/A	1	0	1	0	1	1	1	0	0	1	0	0	0	1	0

Data Protection		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
3.1	% of closed SARs completed in 40 calendar days	85%	74%	81%	95%	87%	93%	95%	88%	88%	82%	81%	85%	71%	68%		

Complaints		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
4.1	Number of complaints received	N/A	N/A	N/A	N/A	52	61	62	66	66	81	73	63	41	73	79	84
4.2	% of red assessed complaints with final response within 60 working days	85%	0%	0%	33%	40%	61%	28%	67%	40%	59%	38%	17%	N/A	N/A	N/A	N/A
4.3	% of amber assessed complaints with final response within 30 working days	85%	19%	25%	19%	48%	57%	60%	68%	70%	72%	31%	59%	35%	32%	N/A	N/A
4.4	% of green assessed complaints with final response within 10 working days	85%	52%	41%	57%	28%	37%	58%	54%	39%	29%	100%	47%	58%	0%	N/A	N/A
4.5	% complaints acknowledged within 3 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4.6	Number of referred complaints taken up by the Ombudsman	N/A	1	1	3	1	0	0	0	1	0	0	0	0	1	0	2
4.7	Ombudsman Outcomes - upheld	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4.8	Ombudsman Outcomes - partially upheld	N/A	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0
4.9	Ombudsman Outcomes - not upheld	N/A	0	1	0	2	0	1	1	0	0	0	0	0	0	0	0

Serious Incident Reporting		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
5.1	No. of Serious Incidents reported on STEIS in month	N/A	13	20	20	9	24	21	7	13	14	18	9	10	10	11	8
5.2	No. of Serious Incidents reported on STEIS within 48 hours of incident date	N/A	2	6	1	2	3	4	5	4	6	5	3	4	4	5	2
5.3	48 hour compliance rate	0%	85%	70%	95%	78%	88%	81%	29%	69%	57%	72%	67%	60%	60%	55%	75%
5.4	No. of Serious Incident 72 hour reports due for submission in month	N/A	8	24	19	9	21	25	5	14	11	19	10	10	10	12	2
5.5	No. of Serious Incident 72 hour reports submitted in month	N/A	2	6	2	4	15	14	4	13	8	19	10	10	10	12	2
5.6	72 hour report compliance rate	0%	75%	75%	89%	56%	29%	44%	20%	7%	27%	0%	0%	0%	0%	0%	0%
5.7	Number of Serious Incident Reports due for Submission (60 Working Day)	N/A	15	6	7	15	16	20	15	20	19	9	11	11	20	7	10
5.8	Number of Serious Incidents Reports submitted	N/A	0	2	3	9	9	2	1	1	3	3	2	2	5	1	2
5.9	60 Day Report Submission Compliance Rate	0%	100%	67%	57%	40%	44%	90%	93%	95%	84%	67%	82%	82%	75%	86%	80%

Incident Reporting		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
6.1	Number of incidents triggering Duty of Candour	N/A	29	30	30	27	39	35	33	23	28	24	15	19	29	33	30
6.2	Number of incidents triggering DOC where this was applied	N/A	2	2	1	1	8	0	2	2	3	1	1	0	1	1	2
6.3	Number of incidents awaiting review	N/A	57	58	86	123	209	175	281	395	527	488	490	818	741	852	936
6.4	Number of incidents overdue review	N/A	57	58	86	123	209	65	183	272	407	413	404	721	639	746	930
6.5	Number of incidents being reviewed and overdue	N/A	182	159	263	243	305	2357	2261	2244	2367	2496	2189	2533	2483	2642	2578
6.6	Awaiting final approval and overdue	N/A	157	310	618	296	280	156	707	1594	2342	2937	2856	4005	4717	2625	978

Risk		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
7.1	% of risks within review period by Directorate	100%	20%	24%	20%	28%	20%	31%	52%	39%	53%	45%	42%	39%	43%	42%	0%
7.2	% of staff trained on MOLLIE risk management module by Directorate	85%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53%	45%	42%	39%	43%	42%	0%
7.3	% of risk where current score is less than the initial score by Directorate	85%	35%	38%	36%	35%	41%	37%	25%	28%	27%	29%	28%	29%	25%	23%	0%

Policies		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
8.1	% of Corporate policies in date	95%	0%	0%	85%	85%	85%	86%	86%	87%	79%	79%	81%	81%	94%	94%	94%
8.2	% of other procedural documents in date	95%	N/A	N/A	71%	71%	71%	72%	72%	78%	77%	82%	88%	87%	80%	82%	85%

Central Alerts System		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
9.1	CAS alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EPRR and Business Continuity Planning		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
10.1	% of Business Continuity Plans overdue	0%	0%	0%	22%	21%	22%	27%	38%	41%	41%	46%	45%	48%	4%	4%	4%
10.2	% Major Incident Training (Gold)	95%	0%	0%	0%	0%	0%	0%	85%	85%	85%	77%	88%	88%	8%	8%	8%
10.3	% Significant Incident Training (Gold)	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	58%	71%	83%	0%	0%	0%
10.4	% Significant Incident Training, Silver	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.5	% Major Incident Training, Silver	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.6	% Major Incident Training, Bronze	95%	0%	0%	0%	0%	0%	14%	14%	14%	14%	9%	18%	18%	0%	0%	0%

Health and Safety		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
11.1	No. reports sent within 10 days and investigated (RIDDOR 2013)	N/A	0	0	1	0	0	1	0	2	1	0	1	0	1	2	3
11.2	No. of incidents which were RIDDOR reportable but not sent within 10 days and investigated (RIDDOR	0	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0
11.3	No. manual handling key workers in post	192	72	72	72	69	69	69	69	74	74	74	63	63	67	65	65
11.4	No. H&S key workers in post	128	90	90	90	62	62	62	62	62	62	62	55	55	44	42	42
11.5	% Fire safety training completed	95%	100%	100%	86%	87%	86%	83%	83%	83%	81%	67%	82%	82%	83%	79%	85%
11.6	% H&S training completed	95%	89%	91%	91%	89%	89%	85%	89%	90%	83%	87%	92%	93%	90%	86%	95%
11.7	% Manual Handling training completed	95%	87%	93%	93%	88%	88%	84%	87%	87%	82%	85%	84%	86%	86%	81%	87%

Legal		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
12.1	No. of inquests	N/A	7	6	4	0	0	0	0	0	7	8	8	8	13	6	3
12.2	% of documentation returned to coroner on time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
12.3	No. Claims Received - Clinical Negligence	N/A	2	4	6	0	0	4	4	8	5	3	2	8	2	6	7
12.4	No. Claims Received - Employers Liability Claims	N/A	0	0	1	2	1	0	0	0	0	0	0	0	1	0	1
12.5	No. Claims Received - Public Liability Claims	N/A	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0
12.6	% of documentation returned to NHSLA on time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

EDN Completion		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
13.1	% completed in 24 hours	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%	81%	81%	74%	74%	75%	75%
13.2	% completed in 48 hours	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	84%	84%	76%	78%	78%	80%	80%
13.3	Backlog - All Outstanding EDNs	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1180	2339	893	1154	1192	1348	1314
13.4	Backlog longest wait time, in days (average for Directorates)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1668	1048	1751	1732	1760	1794	1791

		Q4 (Jan - Mar 17)				Q1 (Apr 17-Jun 17)				Q2 (Jul 17-Sep 17)				Q3 (Oct 17-Dec 17)				Q4 (Jan 18-Mar 18)			
Care Quality Commission		ACCD	CSD	W&CD	Trustwide	ACCD	CSD	F&CSD	Trustwide	ACCD	CSD	F&CSD	Trustwide	ACCD	CSD	F&CSD	Trustwide	ACCD	CSD	F&CSD	Trustwide
13.1	Compliance against Safe domain (as per CQC Assure)	Req Improvement	Good	Req Improvement	Req Improvement	Req Improvement	Req Improvement	Req Improvement	Req Improvement												
13.2	Compliance against Effective domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Good					Req Improvement											
13.3	Compliance against Caring domain (as per CQC Assure)	Req Improvement	Good	Good	Good																
13.4	Compliance against Responsive domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Req Improvement																
13.5	Compliance against Well led domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Good																
13.6	No. of Requirement actions (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	13	N/A	N/A	N/A	13	N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A	
13.7	No. of Enforcement actions (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A	
13.8	No. of Warning notices (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	N/A	

Report to the Board of Directors

Board Date: 03/05/2018 Agenda item 12b

Title of Report	**Board Assurance Framework**
Prepared By:	Fiona Egan – Deputy Director of Corporate Compliance
Lead Director	Sheila Murphy – Trust Secretary: Director of Corporate Compliance & Legal Services
Committees or Groups who have considered this report	N/A
Executive Summary	The role and purpose of the Board Assurance Framework is to clearly identify the principle risks which may prevent the organisation from achieving its strategic objectives. The Trust has identified its four Strategic Objectives for 2018 and the Principle Risks to the organisation which may prevent the Trust from achieving these objectives, i.e. the Strategic Risks. The revised Board Assurance Framework for 2018/2019 has been developed from the Strategic Objectives and their related Strategic Risks, along with assurance that these risks are being appropriately mitigated, with gaps in control and further actions identified, please see appendix 1. Going forward, relevant Board Committees are requested to review the Strategic Risks related to their terms of reference and report on their level of assurance to the Board. Those risks associated with objectives which do not relate directly to one of the Board Committees i.e. Integrated Health Care, are requested to be considered directly by the Board.
Resource Implications	N/A
Risk and Assurance	Within report
Legal Implications/Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These

Report to the Board of Directors

	include financial, corporate and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.
Improvement Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Board is requested to review the Board Assurance Framework and the level of assurance to the Board.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The Trust has identified its four Strategic Objectives for 2018 and the Principle Risks to the organisation which may prevent the Trust from achieving these objectives, i.e. the Strategic Risks, which were identified by the Board as part of the Board Development session in February 2018.

1.2 The revised Board Assurance Framework for 2018/2019 has been devised from the Strategic Objectives and their related Strategic Risks, along with assurance that these risks are being appropriately mitigated, with gaps in control and further actions identified.

1.3 Going forward, Board Committees are requested to review the Strategic Risks related to their terms of reference and report on their level of assurance to the Board.

1.4 Those risks associated with objectives which do not relate directly to one of the Board Committees i.e. Integrated Health Care, are requested to be considered directly by the Board.

2 REVISED BOARD ASSURANCE FRAMEWORK

2.1 The role and purpose of the Board Assurance Framework is to clearly identify the principle risks which may prevent the organisation achieving its strategic objectives.

2.2 Assurance that these strategic risks are being managed is kept under review by the Board in order that the Board can be appropriately assured that the organisation is working effectively towards achieving its objectives. Any further actions or gaps in control are also kept under review by the Board, as part of the Board Assurance Framework.

2.3 The revised Board Assurance Framework for 2018/2019 is presented at appendix 1.

3 RECOMMENDATION

3.1 The Board is requested to review the Strategic Risks and the level of assurance to the Board that these risks are being managed appropriately and in particular those risks related to Integrated Health Care.

Strategic Objective One - Integrated Health Care: We will work collaboratively with our local partners to provide the best of care and the best patient experience.

Strategic Aim

Working strategically, as a trusted partner in the Sustainability and Transformation Plan (STP) we will work with partner organisations and the public to transform out-of-hospital care through the integration of primary, community and social care and re-orientate elements of traditional acute hospital care into the community. We will work collaboratively and progressively to develop an Accountable Care System (ACS), ensuring that protecting our local Trust interests does not stand in the way of achieving benefits for the wider health economy and public.

Board / Board Committee for review - Trust Board

Strategic Risks	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Assurance
Failure of partnership and integration There is a risk that the Trust may not be seen as an organisation to partner with.	**12** (4x3)	**9** (3x3)	**6** (2x3)	The Trust has one of the lowest delayed transfers of care rates in the country. The Trust is working closely with the STP and is the leader of the STP clinical strategy and carer delivery for Medway, North and West Kent. The Trust has developed a frailty pathway including community programme for elderly (PACE), nurse practitioner in the Emergency Department (ED), community geriatrician clinics and nursing home attendance. Monthly monitoring has shown a reduction in falls in the community; the Trust is developing a similar model for Chronic Obstructive Pulmonary Disease (COPD). Consultation on stroke services is now underway across the county following a long period of review and engagement.
Brand failure – The Trust may have a brand failure in that confidence may be lost in the Trust.	**12** (4x3)	**9** (3x3)	**6** (2x3)	
Collaborating with partners There may be a lack of confidence in the Trust by fellow STP partners and the STP may fail.	**16** (4x4)	**9** (3x3)	**6** (2x3)	

Gaps in control and Actions to address

The Trust Improvement Plan is aligned with the STP and will take account of STP strategy. On-going work regarding Accountable Care Partnerships (ACP) and engagement with GPs. Strategic commissioner arrangements have been put in place and will operate in shadow form from April 2018.

Strategic Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care.

Strategic Aim

We will protect people from harm, giving them treatments that work and ensuring that they have a good experience of care. We will create an open and sharing environment where research and innovation can flourish achieving dual aims of enhancing the quality of patient care and contributing to the financial sustainability of the organisation. We will have a culture where staff are given the opportunity, training and resources to research and innovate. We will proactively develop partnerships with other organisations, underpinned by robust governance arrangements, to enable execution and exploitation of innovation projects to benefit the population that we serve.
We will do this by increasing the use of modern technology and the availability of quality information systems. We will take both a local and whole systems approach to implementing a digital strategy that will result in providing real time access to patient information across all providers of healthcare in Kent and Medway.

Board / Board Committee for review - Finance Committee

Strategic Risks	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Assurance
Capability – There may be difficulty in making appropriate decisions on requirements if the future shape of services is not clearly defined Risks presented by lack of IT capability in certain areas.	**16** (4x4)	**12** (4x3)	**9** (3x3)	Trust wide reorganisation to better align services and encourage innovation. Working with Getting it Right First Time (GIRFT) to improve efficiency and effectiveness of surgical pathways. Innovative front door model streaming to Primary Care (MEDOCC), ambulatory emergency centre and assessment areas. Introduced patient forum for patients undergoing emergency laparotomy; virtual trauma clinic and bereavement service for family of surgical patients.
Competition - There is a risk presented by competition from other providers.	**16** (4x4)	**12** (4x3)	**9** (3x3)	

Gaps in control and Actions to address

Better, Best, Brilliant improvement programmes looking at ways to improve use of digital technology, such as Extramed, to provide the best of care for patients. Development of Digital Strategy within Trust and across STP footprint.

Strategic Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do.

Strategic Aim

We will maximise in house efficiency in service delivery and operational management. We will regain and retain financial control. We will be outward looking, actively working in partnership with the wider health economy through the Kent and Medway Sustainability and Transformation Plan to maximise transformation opportunities in service delivery workforce, back-office functions, digital strategy and estates utilisation.

Board / Board Committee for review - Finance Committee

Strategic Risks	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Assurance
Going Concern The Trust's Going Concern assessment is threatened by failure to achieve its planned deficit reduction and budget for 2017/18 risk of further licence conditions and potential regulatory action	**16** (4x4)	**16** (4x4)	**6** (2x3)	Recovery programmes with monthly Cost Improvement Programmes (CIP) sprints, keeping focus on achieving CIPs and efficiencies; improvements in procurement, grip and control, vacancy control measures. Agency usage has reduced, bank usage increased. Carter and Model Hospital have identified a potential £30m opportunity that is being reviewed and actions developed to achieve. Monthly reporting of actual compared to budget performance reviewed at Performance Review Meetings (PRMs) and presented to the Board. Monthly NHS Improvement Performance Review Meetings
Risk that our central funding ceases to be available Risks to the Trust's Viability / Sustainability. May be unable to field adequate resources to maintain services that are high quality and safe.	**16** (4x4)	**16** (4x4)	**6** (2x3)	
Unable to deliver our financial control total The Trust may be unable to invest and unable to establish financial sustainability. The Trust may not be able to realise efficiencies or receive income for all activity.	**16** (4x4)	**16** (4x4)	**6** (2x3)	

Gaps in control and Actions to address

BBB improvement programme supporting the Financial Recovery of the Trust. Escalation regarding CCG contacts as agreed and discussed at the monthly NHSI PRMs and joint commissioner meetings. Further engagement at senior level to ensure that CIP schemes are identified and implemented. Controls to capture and validate CIP and budget delivery.

Strategic Objective Four - Our People: We will enable our people to give their best and achieve their best.				
Strategic Aim				
We will have effective and appreciative leadership throughout the organisation, creating a high performance environment where staff have clarity about what is expected of them, receive regular feedback and understand that poor performance will be addressed. Our employees will be engaged, committed to continuous improvement and embrace change. We will be an employer of choice.				
Board / Board Committee for review - Quality Committee				
Strategic Risks	**Initial Risk (CxL)**	**Current Risk (CxL)**	**Target Risk (CxL)**	**Assurance**
Recruit / Retain sufficient qualified staff The Trust may be unable to attract, recruit and retain high quality staff impacting on a continued dependency on temporary staff and safe staffing levels, affecting quality of care, and financial costs.	**16** (4x4)	**12** (4x3)	**4** (2x2)	The Trust has undertaken a huge recruitment drive locally, nationally and internationally, introducing recruitment and retention incentives. For the first time in late 2017 the Trust had more starters than leavers and this has been maintained. . Shifts are reviewed on a daily basis and employment of the same agency staff where possible to maintain continuity. The Trust has developed a clinical compact for all senior clinicians of all professions - forming the basis of the promoting professionalism programme. The Trust has undertaken a review of our governance structures and processes. The Quality Assurance Committee is developing a Quality and Safety framework that will be used from the wards to the board. Medical Model and patient surveillance e.g. NEWS, Physician associate posts developed.
Gaps in control and Actions to address				
Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).				

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018

Agenda item 12c

Title of Report	**NHS Improvement (NHSI) Self-Certification 2018**
Prepared By:	Tracey Cotterill – Director of Finance & Business Services
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	
Executive Summary	Providers need to self-certify the following after the financial year end: • The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • The provider has complied with required governance arrangements (Condition FT4(8)) • If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) The Director of Corporate compliance and Legal Services has prepared the self-certification for Condition FT4(8). The Director of Finance has prepared the self-certification for Condition G6(3) and Condition CoS7(3). Taken to Private Board.
Resource Implications	N/A
Risk and Assurance	
Legal Implications/Regulatory Requirements	Self-certification before 30 June 2018 is an NHSI regulatory requirement.
Quality Impact	N/A

Report to the Board of Directors

Assessment				
Recommendation	The Board are requested to review and approve the self-certification			
Purpose and Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☐	☐	☐

NHS
Medway
NHS Foundation Trust

Self-Certification for Trusts – 3 May 2018

1. EXECUTIVE SUMMARY

1.1. A Trust's Provider Licence contains obligations for providers of NHS services that enable NHS Improvement (NHSI: incorporating Monitor) to fulfil its duties as the regulator of NHS Foundation Trusts and to oversee the way that Foundation Trusts are governed.

1.2. The standard licence conditions are grouped into seven sections (https://www.gov.uk/government/publications/the-nhs-provider-licence). The first section, containing the General Conditions, sets out standard requirements and rules for all licence holders. Sections 2 to 5 of the licence concern NHSI's functions: setting prices, enabling services to be provided in an integrated way, safeguarding choice and competition and supporting commissioners to maintain service continuity. Section 6 is about translating the well- established core of NHSI's current oversight of Foundation Trust governance in to the provider. The final section, 7, contains definitions and notes.

1.3. The Single Oversight Framework (SOF) (https://improvement.nhs.uk/resources/single-oversight-framework/) bases its oversight on the NHS provider licence. Foundation Trusts are subject to provider licence conditions (including Condition G6, Condition FT4 and Condition CoS7(3)). Since April 2017 NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance.

1.4. Providers need to self-certify the following after the financial year end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- The provider has complied with required governance arrangements (Condition FT4(8))
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)

1.5. NHSI has removed the requirement for these compliance assessments to be submitted to them. Instead, there is no set process for assurance of how the conditions are met and it is at providers' discretion as to how they carry this process out but Boards need to understand and sign off on compliance.

1.6. NHSI have supplied templates to assist with the process and these have been completed and attached.

2. CONDITION G6

2.1. Condition G6(2) requires NHS foundation trusts to have processes and systems that:

- Identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring

2.2. Providers must annually review whether these processes and systems are effective.

3. CONDITION FT4

3.1. NHS foundation trusts must self-certify under Condition FT4(8).

3.2. Providers should review whether their governance systems achieve the objectives set out in the licence condition.

3.3. There is no set approach to these standards and objectives but NHSI expect any compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems

3.4. Providers should select 'confirmed' or 'not confirmed' for each declaration as appropriate and set out relevant risks and mitigating actions in each case. Where providers choose 'not confirmed' for any declaration, they should explain why in the free text box provided.

3.5. Providers must review whether their governors have received enough training and guidance to carry out their roles.

4. CONDITION COS7

4.1. Only NHS foundation trusts designated as providing commissioner requested services (CRS) must self-certify under Condition CoS7(3).

4.2. A CRS designation is not simply a standard contract with a commissioner to provide services. Commissioner requested services are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable

5. AUDITS

5.1. NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

6. RECOMMENDATION

6.1. The Board are requested to review and approve the Submission for Conditions G6(3) and CoS7(3) prepared by the Director of Finance and the Submission for Condition FT4(8) prepared by the Director of Corporate Compliance and Legal Services.

Worksheet "Training of governors"

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Lesley Dwyer	**Name**	Sheila M Murphy
Capacity	CEO	**Capacity**	Director: Corporate Compliance
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board receives a corporate governance report at each of its public board meetings. This highlights to the Board any areas of deficiency and remedial actions/improvements are built into the annual work plan and objectives for the Corporate Governance Directorate.	Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board is kept updated on corporate governance and applicable NHS Improvement guidance through the Board report from the Director of Corporate	Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	All Board committees have terms of reference and report after each meeting via a Key Issues Report to the Board. A governance structure for the layers below Board Committees is in place, with all Groups having terms of reference that reflect reporting lines and accountabilities.	Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Not confirmed	Under NHSI's Risk Assessment Framework, as in previous years, the Trust has significant financial risk.	Please complete both Risks and Migitating actions & Explanatory Information
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Board member capability is reviewed by the two Nominations and Remuneration committees - one is a Non-Executive Committee that considers Executive performance and capability and the other is a Council of Governors led committee which considers Non-Executive performance. The Board approves and reviews the Quality Accounts and progress against their delivery, retaining oversight and assurance of areas identified for improvement, why priorities have been chosen, how improvement will and has been achieved and measured.	Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed']	Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The annual plan for the Trust projects a deficit of £37m. The Trust is reliant on revenue support to enable it to continue to deliver services. At this time the board anticipates requiring external funding in the form of loans from DH, having insufficient internally generated funds to meet the Trust's needs in the financial year. This position is being closely monitored.
The board has agreed a financial control target with NHSI and there is a significant cost improvement plan in year. Further work continues on the deveopment of a longer term financial recovery plan tomove the Trust towards a return to financial balance. The financial recovery plan is linked to programmes across the STP where appropriate to maximimise efficiencies.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Lesley Dwyer	**Name**	Stephen Clark
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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Report to the Board of Directors

Board Date: 03/05/2018 Agenda item 12d

Title of Report	**Emergency Preparedness, Resilience and Response Annual Report**
Prepared By:	Sheila Murphy, Trust Secretary
Lead Director	Sheila Murphy, Trust Secretary
Committees or Groups who have considered this report	Emergency Preparedness, Resilience and Response Group on 12 February 2018
Executive Summary	This report will be presented to the Executive Group on completion prior to its submission to the Board in May. It is therefore written for submission to the Board, rather than the Executive, and is provided for information and review purposes prior to its onward submission to the Board. The EPRR Annual Report provides assurance to the Board that the Trust is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response. In May 2017 the Trust Board agreed the Work Plan for Emergency Preparedness, Resilience and Response for 2017/18. The Trust is a Category One Responder subject to the Civil Contingencies Act 2004. The Annual Report is the conclusion of the Work Plan and associated annual NHS England Emergency Preparedness, Resilience and Response Core Standards Framework Audit 2017/18 that was commissioned by NHS Medway CCG. The Board are requested to endorse the 2018/19 draft Work Plan attached.
Resource Implications	N/A
Risk and Assurance	Trust compliance with the annual audit of NHS England Emergency Preparedness, Resilience and Response Core Standards (2015) was recorded at the Local Health Resilience Partnership in October 2017 by NHS Medway CCG as 'Fully Compliant'. The Board received a report on the self-

	assessment process and outcome in September 2017 via the Executive Group. NHS South East Coast Ambulance Service undertook an audit in February 2018 on part of the Core Standards wholly related to Chemical, Biological, Radiological and Nuclear planning and response capabilities and found the Trust to be Fully Compliant; this will be reported to NHS England in April 2018. The Trust Integrated Audit Committee commissioned KMPG to audit Business Continuity in 2017. KMPG gave assurance in November that all Business Continuity Management processes were compliant; however compliance within Directorates to ensure that their Business Continuity Plans had adhered to the annual review did not give the required assurance despite the governance arrangements in place. The Trust target for EPRR Training defined in a Training Needs Analysis is aligned to the Trust target percentage of 95% for Mandatory Training. There is no national or regulated compliance for EPRR Training. A shortfall of 31% was evidenced (64% achieved) mainly within Bronze (operational) training where staff were subject to operational pressures and did not attend the planned sessions. Assurance has been given that these staff will be given priority in 2018/19 and reoffered training in the First quarter with Directorates being asked to assist with the release of this cohort of staff.
Legal Implications/Regulatory Requirements	The Civil Contingencies Act 2004
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	It is requested that the Board: • Re-affirms its understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act 2004) • Endorses the 2018/19 EPRR work plan.
Purpose and Actions required by the Board :	**Approval** ☒ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Emergency Preparedness, Resilience and Response – Annual Report to Board 2018 (Period May 2017 – May 2018)

1. The Civil Contingencies Act (2004)

1.1. The Civil Contingencies Act (2004) and accompanying non-legislative measures, deliver a single framework for civil protection in the United Kingdom capable of meeting the challenges of the twenty-first century. The Act is separated into two substantive parts: local arrangements for civil protection (Part 1) and emergency powers (Part 2).

1.2. Part 1 of the Act and supporting Regulations and statutory guidance on Emergency Preparedness establish a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into two categories, imposing a different set of duties on each.

1.3. Those in Category 1 are organisations at the core of the response (e.g. emergency services, local authorities, NHS bodies).

1.4. The Civil Contingencies Act (2004), requires the Trust to put in place the following with fellow Category 1 responders

- Risk Assessment
- Develop Emergency Plans
- Develop Business Continuity Plans
- Warning and Informing
- Sharing Information
- Co-operation with other local responders.

1.5. This Annual Report provides assurance to the Board that Medway NHS Foundation Trust is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response (EPRR) as defined within the duties above.

2017/18 Assessing and Documenting Compliance

2. NHS EPRR Core Standards (2015)

2.1. The Trust undertook a primary self-assessment on compliance against the NHS England Core Standards for Emergency Preparedness Resilience and Response Framework (2015). The self–assessment translated into a Statement of Compliance ratified by the Trust EPRR Group in August 2017. The Medway NHS Clinical Commissioning Group audited the Trust in September 2017 via the NEL Commissioning Support Unit and published their findings to the Trust and NHS England South (South-East) in October 2017 at the NHS Local Health Resilience Partnership Meeting. The submission stated that out of the 57 of the core standards which are applicable to the organisation it is fully compliant. Full compliance equates to a statement that 'Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve'.

2.3. Within the 2017 Self-Assessment and Audit, Developmental Standards aligned to Governance as a 'Deep Dive' was issued by NHS England. Following agreement between NHS England and Medway CCG it was confirmed that the Trust was fully compliant on four out of the six standards, On one standard Non-Compliant but with evidence of progress and in EPRR Work Plan for next 12 months and on one Non-Compliant with Deep Dive Standard and not in EPRR Work Plan within next 12 months.

2.4. Within this Annual Report assurance can be given that the Trust has corrected this position and a Non-Executive Director as a Core-Member of the Trust Emergency Preparedness, Resilience and Response Group; first recorded date of attendance November 2017 and secondly, that the outcome of the Annual NHS England EPRR Assurance Process is programmed to be published in the Trust Annual Report.

2.5. In addition to the above NHS South East Coast Ambulance Service undertook an audit in February 2018 on part of the Core Standards wholly related to Chemical, Biological, Radiological and Nuclear planning and response capabilities and found the Trust to be Fully Compliant; this will be reported to NHS England in April 2018.

3. Business Continuity Aligned to ISO 22301

3.1. The Trust's business continuity arrangements had last audited within the 2013/14 financial year by NHS Kent and Medway Commissioning Support Unit (KMCS) on behalf of NHS Medway Clinical Commissioning Group. The Trust scored 95.8% compliance.

3.2. In line with the NHS England guidance of three year audit cycles of Business Continuity Management; the Trust commissioned KPMG in May 2017 to undertake a full review of the Trust Business Continuity Programme. After a thorough audit of documentation, processes and application KPMG reported back to the Trust Integrated Audit Committee in November 2017. The outcome being a rating of 'Significant Assurance with minor improvement opportunities' The audit report was well received with the minor improvement opportunities immediately being actioned via an amendment to the Annual EPRR Work Plan in November 2017. The improvement opportunities included further refinement of the Trust Strategic Business Impact Analysis to consider priority and dependencies, Session Plan documentation for author training on Service and IT System Business Continuity Plans and development of exercise planning template and debrief template for use by Directorates in the testing their plans.

3.3. Review and publication of Directorate Service Business Continuity Plans has been tracked and any non-compliance against review dates was reported back to Directors for corrective action as well as reported to the EPRR Group. The out-turn position for 2017/18 (April 2018) was that out of a total of 108 Plans 70% were reviewed within the agreed timescale.

3.4. Business Impact Assessments aligned to External, Estates and Information Technology Projects

3.4...1. Clancy DocWra Water Main Replacement Works - The Trust EPRR Manager joined Medway Council Traffic Management, South East Coast Ambulance Service, Kent Fire and Rescue Service and Clancy DocWra to undertaken planning by way of Business Impact Assessment and negotiation of mitigation in relation to the upgrade of the surrounding Water Main outside the boundary of the Trust but directly effecting the Trust in terms of water pressure and traffic management. The smooth communication between the Trust and Clancy Docwra led to a generous donation to the hospital of a cheque for the Charitable Fund.

3.4...2. Medway Council Road Resurfacing – Montgomery Road 15 February 2018 – The Trust EPRR Manager joined Medway Council Traffic Management Project Team to undertaken planning by way of Business Impact Assessment and planning of mitigation in relation to the upgrade of the road surface for the main entrance to the Trust. This allowed for seamless work to be undertaken with very little impact on Staff, Visitors, Ambulance and Kent Fire and Rescue

Service, Taxis and Buses. Pleasingly we are now all benefitting from a smooth surface from the Rock Avenue junction.

3.4...3. Level 1 Flooring Project - The Trust EPRR Manager joined the Estates Project Team to undertaken planning by way of Business Impact Assessment and planning of mitigation in relation to the replacement of main corridor flooring on level 1 of the hospital. The mapping of mitigation and communication plans to maintain access throughout, despite the potential isolation of areas on first review, was very successful.

3.4...4. Exercise Happy Families (Critical Clinical IT Systems) 10 August. Exercise Happy Families was designed as an exercise to give assurance in relation to planned and unplanned Critical Clinical IT System downtime preparedness for the organisation. Trust Policy Documents considered within the exercise were PAS IT System Business Continuity Plan, EuroKing IT System Business Continuity Plan, eReferral IT System Business Continuity Plan, Symphony IT System Business Continuity Plan, ExtraMed IT System Business Continuity Plan and the eDN IT System Business Continuity Plan. The exercise allowed for validation of business continuity arrangements of two planned downtimes of the systems which were actioned without incident.

3.4...5. Project Water Outage 6 Hours 2 September. The Trust EPRR Manager joined the Estates Project Team to undertaken planning by way of Business Impact Assessment and planning of mitigation in relation to 3 projects all requiring a water outage that could be undertaken, if planned well, all at the same time to minimise disruption to the Hospital. These were the Connection of the new Emergency Department building, A reconfiguration of pipework in the Boiler House and removal of values in A Block. This required co-ordination of 3 separate contracting teams and enactment of the Trust Water Resilience Plan; in terms of communication, bottled water deployment and command and control. The works were all concluded without issue and it was agreed that this had been a good exercise of the Water Resilience Plan for a managed project.

3.4...6. Pillar Feed Replacement Project 24, 25-29 September - The Trust EPRR Manager joined the Estates Project Team to undertaken planning by way of Business Impact Assessment and planning of mitigation in relation to the replacement of electrical infrastructure. On this occasion Residences, Offices and a KMPT service have all been consulted and received support in the replacement of Pillar Feeds connecting mains electricity to their buildings; with the associated electrical downtime during each disconnection and reconnection.

3.4...7. The Trust EPRR Manager joined the Estates Project Team to undertaken planning by way of Business Impact Assessment and planning of mitigation in relation to the upgrade of the electrical infrastructure in the D Block (Behind the Emergency Department) inclusive of Trauma and Orthopaedic Wards and Xray. To date the mapping of mitigation and communication plans to maintain services, during the contracted work, has been very successful.

4. Exercises, Seminars and Incidents requiring a Trust response

4.1. Within the NHS England Core Standards for Emergency Preparedness Resilience and Response Framework (2015) there is a standard requirement that the Trust evidences a Live Exercise every three years, a table top exercise annually and communications exercises bi-annually. The last live exercise was Exercise Lapwing in June 2015 and therefore the duty to perform the next live exercise falls in 2018/19.

4.1...1. In May 2017 National Cyber Attack NHS England Major Incident declared 12 May. Although the Trust was not effected a requirement was put in place by NHS England for Trusts to submit assurance on two fronts; firstly technically in relation to patching, to prevent the risk of Cyber Threats, had been put in place and secondly via a SITREP in relation to any operational impact. The Trust was stood down formally by NHS England on 25 May.

4.1...2. On 17 May Trust Significant Incident IT Hardware Failure took place. This affected the following IT Systems which all were mitigated by staff immediately instigating their IT System Business Continuity Plans: Symphony, RIS, PACs and iLab. The incident control closed in the early hours of May 18 on assurance from the IT Directorate that the Trust position had been corrected and was stable.

4.1...3. 23 May Southern Water Incident - No water on loss of power support to Burham Treatment Works affecting some of the population in our catchment area. Six areas affected (Strood, Cliffe, Cliffe Woods, Hoo, Upper Upnor and Wainscott). The Trust was informed by Medway Council, who were working with Southern Water. Our actions for business continuity and care of our Community Patients included; Informing the Community Midwifery Team, Informing Hospital at Home – re patients discharged into those areas and consideration in relation to discharges into those areas effected where the Council supporting by deploying bottled water until the incident was closed, overnight, by Southern Water.

4.1...4. 24 May escalation of National Threat Level from Severe to Critical – (CRITICAL an attack is expected imminently) directly following intelligence that the perpetrator of the Manchester Arena Terror Attack 22 May was not acting alone. Gateway Ref 06835 Letter from the NHS National Incident Director was actioned. The Trust applied the Local Health Resilience Partnership Plan and gave assurance via NHS England assurance template.

4.1...5. Major Incident Stand-by Flat Fire Hextable 11 June. A Major Incident Standby had been made early in the response to a fire based on the potential number of casualties. Both Darrent Valley and Medway Emergency Departments had been alerted Darrent Valley had released press communications with unintended consequences that the press line requested that the Public use other Emergency Departments. On Major incident declared the call was validated by Medway Hospital Site Manager. The number of casualties for Medway Hospital was four in total. This satisfied the criteria for business as usual so an early intervention was made to stop the Trust cascade for a full response activation.

4.1...6. Exercise Ragdoll (Live Exercise) 23 June - This was the first live exercise ever held in Kent and Medway by an acute Trust and Kent Police for an infant abduction. The aim was to test and validate the Kent Police Child Abduction (Hospitals) Emergency Plan and to test and validate the Medway NHS

Foundation Trust Infant Abduction Plan. Key recommendations were used to uplift and republish the Trust Plan, which was republished in August 2017 and shared with Kent Police as an Annex to their own document.

4.1...7. On Major incident declared the call was validated by Medway Hospital Site Manager. The number of casualties for Medway Hospital was four in total (one of who was a KRFS staff member). This satisified the criteria for Business as Usual so an early intervention was made to stop the Trust cascade for a full response activation.

4.1...8. Trust participation in Kent Resilience Forum Exercise July 4, The Trust took part in a Kent Resilience Forum multi-agency Mass Fatalities Exercise (Exercise United) at Tovil, Maidstone. A number of recommendations were raised on the back of this exercise to strengthen the Kent Resilience Forum Mass Fatalities Plan, Local Resilience Partnership Mass Fatalities Plan and the two designated Hospital Mortuary Operational Disaster Victim Identification (Mass Fatalities Plans).

4.1...9. First Communications Exercise 3 August - The main concern raised post exercise was that the cascade took two operators, in working hours, 30 minutes. Although the cascade is designed so the Emergency Department would be ready to respond earlier than, for example, the Tactical Control Room or Strategic Control, it is still appropriate to look at an technological solution for a multi-operator system to speed up the overall cascade. The EPRR Group agreed that the installation of the pre-purchased Open Scape Alarm Response System (OSCAR) be implemented to give the availability of a fully auditable campaign system.

4.1...10. Activation of Mobilisation of Outbreak Team August 25 - The Trust were requested via West Kent Clinical Commissioning Group to make ready to mobilise a vaccination team in response to a Hepatitis A incident. The Trust committed to provision of a full team and made ready under a Patient Group Direction. The team were stood down, with thanks, as West Kent determined that they were able to complete the mobilisation without the planned Medway support.

4.1...11. 15/16 September escalation of National Threat Level from Severe to Critical - Following the Parsons Green terrorist attack the national threat level was raised over the weekend to CRITICAL, meaning that an attack is expected imminently. In anticipation of the level being increased proactive work was undertaken to ensure that the Trust was in a state of preparedness. The appropriate assurance was given to NHS England.

4.1...12. Exercise Becquerel 30 August - The Trust undertook a table top exercise in Nuclear Medicine, with the Transport Provider for radioactive sources; to test the resilience of the Transport Emergency Procedure for Radioactive sources on the Highway. The learning from this exercise has been used to strengthen the Trust Nuclear Medicine Deployment Plan for recovery of goods in transit and give greater assurance to our Regulators and Partners

4.1...13. The Kent Resilience Forum Seminar was held at the County Showground on 19 October. The theme for this year reflected the National Threat profile of Terrorism. Sessions were received from a leading international authority on the

subject of Counter Terrorism who works closely with NATO. The Department of Communities and Local Government, a Warrant Officer of the EOD who carried out explosives demonstrations, The Assistant Chief Constable with Manchester Police on her role in the deployment to the Manchester Arena Bombing, The former Emergency Planning Manager; on her role and that of Guys Hospital in the Westminster Bridge Attack, The UK Crisis Response Officer for the British Red Cross on her role at Manchester and the Grenfell Fire. The Duty Manager of the London Resilience Forum and lastly the Chief Executive of Southwark Council who stepped up to take over the Grenfell Fire response. The powerful learning from this event will be reflected upon to strengthen the Trust position especially in relation to psychosocial impacts of response on staff

4.1...14. Shoreham Air Show Mass Fatalities Seminar 27 October, Crawley - The Trust EPRR Manager was invited to attend an event organised by the Coroner Service as part of her work on the Kent Resilience Forum; Mass Fatalities Group. The seminar was a very detailed debrief of the incident. The learning from this will support the Trust in terms of the Disaster Victim Identification Mortuary process via a newly forged alliance with the Mortuary Lead APT from the public mortuary involved as well as the wider resilience programme benefits for Kent and Medway.

4.1...15. October 2017 saw the re-launch of the Trust Winter Resilience Plan and the completion of an annual table-top exercise (Vivaldi 2) to test winter resilience. The exercise aim was to prepare the Trust for Winter 2017/18 by fully testing and validating the Winter Resilience Plan and associated Policies and Procedures, strengthening communication and resilience between partners and maximising the understanding of the Single Health Resilience Early Warning Database (SHREWD) System and its capabilities. The immediate requirement to update the Trust Surge and Escalation Plan to include the Single Health Resilience Early Warning Database and the Trust escalation triggers and associated actions was immediately escalated to the author of the Trust Surge and Escalation Plan via the Director of Clinical Operations for Acute and Continuing Care (Unplanned and Continuing Care Directorate). All other learning outcomes were minor revisions to the Winter Resilience Plan that were actioned to give the required assurance to the Executive and North Kent Clinical Commissioning Groups prior to the Trust plan's inclusion within the North Kent Clinical Commissioning Groups overarching Winter Resilience Plan. The annual planning cycle will commence in May 2018.

4.1...16. The Trust activated the Significant Incident Plan in relation to a Formalin Spill in Theatre 6 on 11 August. Recommendations strengthened the management of Formalin within the Trust in addition to a training review on initial hazardous material incident actions for staff (prior to arrival of Kent Fire and Rescue).

4.1...17. Football Safety Advisory Group, Priestfield Exercise 21 November - The EPRR Manager had a last minute offer from Medway Council to observe the Priestfield Stadium Exercise. The recommendation placed, by the EPRR Manager at the Exercise is that Medway Hospital have the graded Fixtures List annually and are privy to the Football Safety Advisory Group Minutes. This will allow for better communication of higher risk attendees at the Stadium and a more robust review of ED Staffing associated with that risk

4.1...18. Significant Incident; 30 January/ 1 February Failure of ISDN Main Hospital Switchboard 01634 830000 line for Incoming Calls. On both occasions alternative contact details were shared with the Clinical Commissioning Group for the General Practitioners and warning/informing communications were put in place both internally and externally.

4.1...19. Kent Resilience Forum Exercise Vanguard, 6 February - Exercise Vanguard was a table top exercise attended by the Trust looking at multiple simultaneous attacks on Priestfield Stadium, Canterbury City Centre and Blue Water that created Mass Casualties with ballistic Injuries. It was the precursor to the Live Exercise (Shakespeare) that will take place in April and to which volunteers for the Trust have put themselves forward; as casualty actors. Exercise Vanguard allowed for a critical re-review of the Major Incident Plan and further building of a working relationship with Kings Trauma Centre and the Police Counter Terrorism Unit who have issued the Trust with guidance on Forensic capture in Theatres of spent ballistics.

4.1...20. South Coast Ambulance Service (SECAmb) EPRR Assurance CBRN Audit 8 February - The Trust was pleased to meet with SECAmb for the annual EPRR Assurance Audit of CBRN Documentation and Equipment on 9 February where Full Compliance was assured. (Especially, as the ED New Build Project has meant in the past two years that the location of this facility has required very careful planning, risk assessment and communication with SECAmb, Kent Fire and Rescue Service, Staff and Contractors). The formal report is being reported to NHS England in April 2018.

4.1...21. Adverse Weather 27 February to 3 March. The Trust convened a joint Tactical and Strategic Control in relation to the adverse weather event and associated disruption to travel. A structured debrief has taken place and will be reported within the first Trust EPRR Group of the 2018/19 Work Plan to ensure learning identified is managed via the Corrective Action process.

4.1...22. White Powder Incident 12 March – Two self-presenting casualties suspected that they had been in contact with a biological substance. The substance was later proved to be non-hazardous by Kent Police. The incident prompted the use of the Trust Decontamination Unit and in such will be presented to the first Trust EPRR Group of the 2018/19 Work Plan to ensure any learning identified is managed via the Corrective Action process.

1. Training

6.1. Within 2017/18 EPRR Training was aligned to the Trust target percentage of 95% for Mandatory Training although the subjects are deemed as Essential Training by the Trust. There is no national or regulated compliance for EPRR Training.

6.2. All new staff are required to have EPRR Awareness as part of the Trust Induction Programme.

6.3. It is noted that the Trust has undertaken two re-structures within this reporting period; this has been considered within two upgrades to the EPRR Training Needs Analysis. This report therefore is only based on staff in post currently, and the position on 12 April 2018 rather than those trained who have since changed role or left the organisation.

2017/18			
Count in people	Required	Completed	%
Gold	12	10	83%
Silver	10	8	80%
Bronze	275	169	61%
Loggists	12	9	75%
Writing and Reviewing a Business Continuity Plan	22	13	59%
Writing and Reviewing an IT System Business Continuity Plan	15	12	80%
	344	**221**	**64%**

6.4. Of those staff across the organisation identified or recently added on the bespoke Annual EPRR Training Needs Analysis for 2017/18 The shortfall in Gold, Silver and Bronze training will be addressed in the first quarter of 2018/19 by extending the training offering again to those staff as a matter of priority.

2. Risk Register

7.1. Two items are documented on the EPRR Risk Register and mitigating actions are scheduled into the 2018/19 Work Plan:

- The deployment of OSCAR, a multi-operator telecommunications system to be deployed for Major Incident cascade; to reduce cascade time and increase resilience.
- The Trust are awaiting 24 PRPS Suits for Decontamination from NHS England, The current stock holding is the minimum prescribed. Mutual aid arrangements have been detailed and communicated.

3. EPRR Work Plan Items uncompleted in 2017/18

8.1. The following items will move forward from 2017/18 to 2018/19

- Exercise Faith (Live Major Incident Exercise), to match Kent Police exercise resourcing
- Exercise Blackstart, to realign to the Estates work plan on A Block Substation and availability of High Voltage Appointed Persons/UK Power Networks

4. EPRR Corrective Actions unresolved in 2017/18

9.1. The following items remain as identified on the EPRR Corrective Action Database as unresolved and assurance will continue to be requested on their planned closure by the EPRR Group in 2018/19

- Update of Trust Disaster Victim Identification Process in Mortuary Operational Plan based on best practice and changes to Kent Resilience Forum Mass Fatalities Plan.
- Post Grenfell Fire – Refinement of Psychosocial Information from NHS England Working Group in 2018.

5. Suggested EPRR Group Work Plan 2018/19

The EPRR Group Work Plan 2018/19 has been drafted for agreement at Appendix 1. It takes into account the duties as set out by the Civil Contingencies Act 2004 and any requirement to complete new work that may arise in the course of completing the Work Plan:

- The NHS England EPRR Framework (Nov, 2015)
- The NHS England Business Continuity Management Toolkit (Feb, 2016)
- The Information Governance Toolkit Submission 2018/19
- Trust Strategic Business Impact Assessment including but not limited to:
  - Assessment of the impacts of planned capital programmes and the Estates Department planned maintenance programme for 2018/19
  - Assessment of the impacts of planned IT infrastructure and system changes planned by Health Informatics for 2018/19
  - Review of the Kent Community Risk Register
- Planned EPRR Policy and Plan updates for 2018/19
- EPRR Group Work Plan Actions not closed in 2017/18
- EPRR Group Corrective Actions not closed in 2017/18
- Delivery of the Trust EPRR Training Scheme
- Prescribed attendance via the Local Health Resilience Partnership on Kent Resilience Forum Sub and Working Groups by membership of the Local Health Resilience Partnership Delivery Group

6. Recommendation to Board

It is requested that the Board re-affirm their understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act (2004):

- Co-operation
- Information sharing
- Risk assessment
- Emergency planning
- Business continuity management
- Communicating with the public.

The Board are requested to note the continued designation of an Executive Lead for EPRR for 2018/19 to attend the Local Health Resilience Partnership and Chair the Trust Emergency Preparedness Resilience and Response Group.

The Board are requested to note the continued designation of a Non-Executive Director for EPRR for 2018/19 to attend the Trust Emergency Preparedness Resilience and Response Group.

The Board are requested to endorse the 2018/19 EPRR Work Plan at Appendix 1.

Emergency Preparedness, Resilience and Response – Annual Work Plan 2018 – 19

Appendix 1.

Local Health Resilience Partnership – Assurance Programme				
ID	**Identification**	**Status**	**Requirement**	**Assurance Route**
EPRR Framework	Self-Assessment	Annual – July 2018	Civil Contingencies Act/NHS EPRR Assurance	Trust EPRR Group August 2018
EPRR Framework	External Audit	Annual – September 2018	Civil Contingencies Act/NHS EPRR Assurance	Clinical Commissioning Group
EPRR Framework	External Audit CBRN	Annual – February 2019	Civil Contingencies Act/NHS EPRR Assurance	South East Coast Ambulance Service
EPRR Framework	EPRR Annual Report	Annual - May 2019	Civil Contingencies Act/NHS EPRR Assurance	Trust Board
EPRR Framework	Trust Annual Report Statement	Annual – May 2019	Civil Contingencies Act/NHS EPRR Assurance	Trust Board

Plans, Policies and Standard Operating Procedures for review 2018/19				
Name	**Identification**	**Status**	**Requirement**	**Assurance – Trust EPRR Group**
Corporate Policy Emergency Planning Resilience and Response	POLCOM045	Annual Review Exp Sept 2018	NHS EPRR Assurance	August 2018
Medical Gas Resilience/Significant Incident Addendum	SOP0120	Support to Medical Gas Committee	NHS EPRR Assurance/ Community Risk Register	August 2018 Assurance required from Medical Gas Committee that update has been undertaken.
Chemical/Biological/Radiological/Nuclear Plan	OTCOM088	Revision – ED Project Exp Aug 2018	NHS EPRR Assurance	August 2018 and ad hoc based on Project risk.
Winter Resilience Plan	OTCOM033	Annual Review Oct 2018	NHS EPRR Assurance	August 2018
Trust Gritting and Snow Clearance	SOP0158	Revision – Post Adverse Weather Feb 18	NHS EPRR Assurance	August 2018
Setting Up Tactical Control	SOP0161	1st Review	NHS EPRR Assurance	August 2018

Room in Trafalgar Conference Suite Procedure				
Management of Staff Strike Action	AGN00136	3 Yearly Review Exp Dec 2018	NHS EPRR Assurance	November 2018
Change in Threat Level Severe to Critical Procedure	SOP0381	1st Review	NHS EPRR Assurance	November 2018
Resilience Direct	SOP0388	1st Year Review	Local	November 2018
Fire Response Plan	OTCGR202	1st Year Review EPRR Support to Fire Safety reporting to Fire, Health and Safety Group	NHS EPRR Assurance/ Community Risk Register	November 2018 Assurance required from Fire, Health and Safety Group
Fire Response Plan – Management of KFRS Strike Addendum	New	EPRR Support to Fire Safety reporting to Fire, Health and Safety Group	NHS EPRR Assurance/ Community Risk Register	November 2018 Assurance required from Fire, Health and Safety Group
Major Incident Plan	POLCS006	Annual Review	Civil Contingencies Act/NHS EPRR Assurance	February 2019
Significant Incident Plan	OTCOM006	Annual Review	Civil Contingencies Act/NHS EPRR Assurance	February 2019
Strategic Business Impact Assessment	SBIA and Scope	Annual Review	NHS EPRR Assurance	May 2019
Heatwave Plan	POLCOM011	Annual Review	NHS EPRR Assurance -re-alignment to NHS England Heatwave Plan	May 2019
Operational Plan – Helipad and Secondary Landing Sites	New	As per Project Plan EPRR Support to Estates Projects on relaunch of Helipad	NHS EPRR Assurance	
Directorate Service Business Continuity Plans	BCP Tracker	Annual Reviews	NHS EPRR Assurance/ Compliance Dashboard monthly	Each Group
Directorate IT System Business Continuity Plans	BCP Tracker	Annual Reviews	NHS EPRR Assurance Compliance Dashboard monthly	Each Group

Exercises

ID	Identification	Status	Requirement	Assurance – EPRR Group
Part Major Incident Live – Rail Care Team/Outpatients	Exercise Cutting	Adhoc	NHS EPRR Assurance	May 2018
Major Incident Live Exercise	Exercise Faith	Three yearly	NHS EPRR Assurance	November 2018
Electrical Resilience Exercise	Exercise Black Start #2	Best Practice	Best Practice	August 2018
Major Incident Communications Exercise	2018/19 Communications #1	Annual	NHS EPRR Assurance	August 2017
Major Incident Communications Exercise	2018/19 Communications #2	Annual	NHS EPRR Assurance	May 2019
Infant Abduction Table Top Exercise	Exercise Ragdoll #2	Best Practice post Plan upgrade 2017	NHS EPRR Assurance	November 2018
Winter Resilience Assurance Exercise	Exercise Vivaldi #3	Annual	Best Practice	October 2017
External Exercise – East Kent Flooding	Exercise Rosemary	Multi-Agency	Civil Contingencies Act/NHS EPRR Assurance	KRF Reported

Incidents				
ID	**Identification**	**Status**	**Requirement**	**Assurance – EPRR Group**
Major Incident Declarations Standby and Declared by SECAmb activating Trust	Incident Reports	Best Practice	NHS EPRR Assurance	Each Group
Significant Incident Declarations Moderate – Critical	Incident Reports	Best Practice	NHS EPRR Assurance	Each Group
Self-Referrals to Emergency Department – CBRN Plan Activation	Incident Reports	Best Practice	NHS EPRR Assurance	Each Group
Adverse outcomes post Business Impact Assessment Estates and Information Technology Projects	Incident Reports	Best Practice	NHS EPRR Assurance	Each Group

Resource Capabilities - Equipment				
ID	**Identification**	**Status**	**Requirement**	**Assurance – EPRR Group**
Powered Respiratory Protective Suits	Planned Protective Maintenance	Annual - September 2017	NHS EPRR Assurance	November 2018
Powered Respiratory Protective Suits	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
RAMGENE (Radiation Monitors)	Planned Protective Maintenance	Annual – September	NHS EPRR Assurance	November 2018
RAMGENE (Radiation Monitors)	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
Decontamination Unit	Planned Protective Maintenance	Annual – September	NHS EPRR Assurance	November 2018
Decontamination Unit	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
Police Documentation Team Boxes	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
CBRN Small Equipment	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
Tactical Incident Cupboards x2 and Master on Call File	Assurance Checks	Monthly or if used/updated	NHS EPRR Assurance	Each EPRR Group

Resource Capabilities –Staff via Training Needs Analysis				
ID	**Identification**	**Status**	**Requirement**	**Assurance – EPRR Group**
New Trust Staff - Induction	Induction	Once	CQC/ Civil Contingencies Act/NHS EPRR Assurance	(Board from Learning and Development)
Strategic Major Incident	Gold – Major Incident/Exercise Admiral	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Tactical Major Incident	Silver – Major Incident/ Exercise Master	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Operational Major Incident	Bronze – Major Incident/Exercise Crew	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Strategic Significant Incident	Gold – Significant Incident	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Tactical Significant Incident	Tactical – Significant Incident	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Operational Significant	Bronze – Significant	Annual Awareness in	Civil Contingencies Act/NHS	August 2018

Incident	Incident	Business Continuity Awareness Week	EPRR Assurance	
Writing and Reviewing a Service Business Continuity Plan	N/A	Designated Directorate Staff - Once plus refreshers	Best Practice	Each EPRR Group
Writing and Reviewing an IT System Business Continuity Plan	N/A	Designated Directorate Staff Once plus refreshers	Best Practice	Each EPRR Group
Resilience Radio Handsets	Radio Training	Once plus refreshers	Best Practice	Each EPRR Group
Trust Loggists	Loggist Training	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Emergency Department CBRN Training (PRPS Suits and RAMGENE Monitors)	ED Designated Clinical Staff	Annual via ED CRBN Lead	Best Practice	Each EPRR Group

Civil Contingences Act - Kent Resilience Forum/Partnership Work				
ID	**Identification**	**Status**	**Requirement**	**Assurance Route**
Local Health Resilience Partnership	LHRP Strategic Meeting	Accountable EPRR Officer (Executive)	Civil Contingencies Act/NHS EPRR Assurance	NHS England
Local Health Resilience Partnership – Delivery Group (EPRR Leads)	EPRR Leads Group	Acute EPRR Manager	Civil Contingencies Act/NHS EPRR Assurance	Local Health Resilience Partnership
Mass Fatalities	KRF - Subgroup	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Pandemic Influenza	KRF – Task and Finish group	Secondary EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Risk Assessment	KRF – Main Group	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Trauma Network	Trauma Network EP Leads	Trauma Network	NHS EPRR Assurance	Trauma Board
Railcare Team	Acute Hospitals Lead	Trust nominated	NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Medway Safety Advisory Group and COMAH Plan	KRF - Subgroups	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group /Report to

Review Group				Commissioners via Commissioning Support Unit
Swale Safety Advisory Group and Resilience Groups	KRF - Subgroups	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group /Report to Commissioners via Commissioning Support Unit
Media and Communications Group	KRF Sub - Group	Trust Communications Team Representative	Civil Contingencies Act	Post meeting report to EPRR Leads Group

Please note the above is a share of the Civil Contingencies Act responsibilities for the NHS – The Groups not allocated for attendance by this Trust currently are:

KRF - Plans and Capabilities Group
KRF - Training and Exercising Group
KRF - East Kent Safety Advisory Groups
KRF - Business Continuity Group
KRF – Marine Aquatics Group
KRF – Pan Kent Flood Group
KRF – New Threats Group
KRF - Safety Advisory Chairs Group
KRF – West Kent Safety Advisory Groups
KRF – Local Authority Emergency Planning Group
KRF – Strategic Group
KRF – Executive Group
KRF – North Kent Safety Advisory Groups
KRF – Humanitarian Group

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018

Agenda item 12e

Title of Report	**IG and General Data Protection Regulations (GDPR) Report**
Prepared By:	Sheila M Murphy
Lead Director	Sheila M Murphy
Committees or Groups who have considered this report	Executive Group
Executive Summary	Update on GDPR preparation, implications and IG generally
Resource Implications	Yes: significant volume of work to achieve compliance
Risk and Assurance	Yes: achieving and maintaining compliance
Legal Implications/Regulatory Requirements	Legal and Regulatory
Improvement Plan Implication	None
Quality Impact Assessment	None
Recommendation	Note
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

NHS
Medway
NHS Foundation Trust

IG and General Data Protection Regulations (GDPR) Report

Sheila M Murphy
Trust Secretary: Director of Corporate Compliance and Legal Services

16 APRIL 2018

Best of care
Best of people

1 INTRODUCTION

1.1 In addition to the existing work required by IG within the Trust, the GDPR comes into force on 25 May 2018. Hill Dickinson LLP is working with the IG team to prepare and ensure that the Trust is compliant with the new legislation. There is a considerable amount of work that has to be undertaken by 25 May.

1.2 The work listed in the proposal by Hill Dickinson LLP will aim to be completed by the deadline. In relation to reviewing the existing contracts held by the Trust, Hill Dickinson LLP will only be able to assist on reviewing the documents should departments within the Trust be able to provide copies for review.

1.3 Organisations in breach of GDPR can be fined up to 4% of their annual global turnover or €20 Million (whichever is greater). This includes liability for breaches caused by other organisations that have access to our data either as a joint controller or a supplier.

2 PRIORITIES FOR GDPR COMPLIANCE BY 25 MAY

Contracts

2.1 The team is focusing on contracts outside of the EU where the Trust is a data controller or data processor. There does not seem to be a centralised contracts register which is creating difficulties in identifying where the contracts are held.

Privacy Notices

2.2 The first drafts of the five main privacy notices for patients, children, carers, staff and members and governors have been produced. These are due to be finalised by18 April and will be placed on the Trust's website and intranet. In addition the current privacy notice which is available on the Trust's website will be reviewed for compliance with GDPR. Further work will be required to create easy read versions post go-live and translation into the Trusts top five languages.

Individual Rights SOPs

2.3 The first draft of the eight Individuals' Rights SOPs has been produced. These are, Right to Access, Right to Restrict Processing, Right to be informed, Right to automated decision making including profiling, Right to Object, Right to Portability, Right to Erasure and Right to Rectification. Comments have now been obtained on the first draft and work is currently taking place to finalise the SOPS.

Training

2.4 Currently 2 levels of training have been arranged in addition to the mandatory IG training. SIRO, Caldicott and DPO training on GDPR will take place on 24 April and Data Flow Mapping for all heads of service will take place on 23, 24 and 27 April.

Data Privacy Impact Assessments (DPIA)

2.5 A DPIA must be considered for certain types of processing, or any other processing that is likely to result in a high risk to individuals. The IG team

implemented screening checklists to assist deciding when to undertake a DPIA which is completed by the IT project Managers.

2.6 A review of the current internal process is expected to be completed by the end of w/c 16 April.

Data Flow Mapping (DFM)

2.7 DFM looks at how information comes into the Trust, how it is moved around internally and how it is transferred externally.

2.8 The DFM process has not been robustly completed at the Trust and prior to 2017 Connecting for Health data mapping templates were used which asked for minimal information.

2.9 In 2017 the IG team created an action plan to rectify this situation however, only 23 (of 82) submissions were received before the clinical teams were restructured. During this time the project was put on hold.

2.10 The majority of DFMs received were from Corporate services and the Directorate previously known as “Families & Clinical Support Services Directorate”.

2.11 The implementation of the GDPR has added focus onto how organisations use individuals’ information and the ICO has since published new templates (in April 2018) breaking functions down to identify the difference between when the Trust is acting as a Controller or a Processor. Some of the questions within the new templates have remained the same whilst additional questions and criteria have been added and expanded on.

3 ADDITIONAL ACTION REQUIRED BY 25 MAY 2018

3.1 A number of policies are being drafted such as Corporate Records Strategy, Data Security Incident report, Rights of the Individual and Data Protection policy.

3.2 All IG policies will need to be reviewed to ensure they are compliant with the GDPR however the team are focusing on the high risk ones first.

3.3 The IG team and Hill Dickinson LLP has been liaising with our Procurement, IT, Business Intelligence and Research and Development teams, to ascertain existing contracts the Trust holds which could be considered as high risk because of transferring data outside of the EEA or have been commissioned outside of frameworks, using non-NHS standard contracts.

IT and BI have been contacting suppliers to ensure their contracts are GDPR compliance. Hill Dickinson LLP has provided guidance on those of which we are aware of however it has become clear some departments hold contracts/agreements that have not been assessed which could lead to the Trust being liable should breaches occur.

The Procurement team has confirmed where services are being purchased on frameworks, national contracts are being used which include GDPR clauses.

4 MAINTAINING GDPR COMPLIANCE AFTER MAY 2018 AND THE ROLE OF THE DPO

4.1 Post the 25 May 2018 the DPO is tasked with monitoring compliance with the GDPR and other data protection laws, and ensuring data protection policies, awareness-raising, training, and audits are in place/completed and will act as the named contact for staff and members of the public.

4.2 The Trust must take into account the DPO's advice and the information the DPO provides on our data protection obligations.

4.3 When carrying out a DPIA, the DPO must monitor the process to ensure consideration of the risk associated with processing operations, and takes into account the nature, scope, context and purposes of processing.

4.4 The DPO acts as the main point of contact for the ICO. The DPO must be easily accessible to the Trust's employees, individuals and the ICO and must ensure all 8 Individuals' Rights are respected and managed and complaints logged.

4.5 The Trust must ensure annual review of all Data flows is completed and forwarded to the DPO/IG team for review.

4.6 The Trust must ensure that privacy notices are accurate and up to date so individuals know how their information is being used.

4.7 The IG team will create easy read versions and leaflets of the privacy notices for patients to comply with equality and diversity.

4.8 The IG team will create easy read guides for staff so they are aware of their responsibilities under the GDPR such as acknowledging and understanding the Rights of the Individual.

4.9 The IG team will ensure that national guidance from NHS Digital and the ICO is reviewed and implemented as and when required.

4.10 Review of all IG and IT polices to ensure that they are GDPR compliant.

4.11 Ensuring that the Board and Senior Managers are kept up to date with changes to legislation, which includes the repeal of The Data Protection Act 1998 to be replaced by the Data Protection Bill 2019 which will include changes e.g. the interaction between FOIA/EIR and the DPA.

5 STATUS OF TRUST IG

5.1 Additional key areas to address:

- Improving the IG culture through training. Improving the IG culture through communication.
- Breach investigation and reporting to the ICO of all Data Security Incidents.
- Data sharing/Data mapping – Annual requirements now highlighted by the GDPR.
- IG support for all new projects via IT.
- IG advice for all services provided by the Trust.

- Corporate Records Management Freedom of Information Compliance
- Working with the IAO's to ensure compliance (see below).
- Support to the SIRO, Caldicott Guardian and Data Protection Officer on changes to legislation and National Guidance.
- Attending local and National groups for networking and ensuring that knowledge is kept up to date within the IG team.
- Ensuring the evidence for the IG/Data Security and Protection Toolkit is submitted annually and audited via our external auditors annually.
- Ensuring electronic audits such as Summary care records audits and physical audits such as ward spot checks are completed.

5.2 There is currently a high risk to the Trust as there has been no IG manager in post since the end of December 2017. The current IG structure is lean and requires strengthening. Going forward the GDPR requirements for the Data Protection Officer (DPO) will be significant as they are now the main point of contact if anyone has concerns over how their information is being used/shared/stored and the DPO will require administrative support to ensure that they are fully supported to be able to carry out their statutory responsibilities in accordance with very stringent timescales. This includes the processing of complaints and individuals' rights requests, as well as enquiries from external organisations, including the ICO and individuals

INFORMATION ASSET ONWERS (IAO)

5.3 Despite a number of attempts to successfully engage IAOs through meetings and correspondence there is a lack of engagement by the IAOs as a result the IG team is unable to complete risk assessments for assets or advise on potential mitigation.

5.4 The IAOs should provide the IG team and SIRO with an annual assurance statement on electronic and physical assets. For example electronic systems not under the control of the IT team and physical assets such as Corporate Records. The assurance statement includes but is not limited to confirmation that for each asset, the annual data flow mapping has been reviewed, DPIA has been reviewed if processes have changed and Business Continuity plans are in place should the assets become unavailable due to a Cyber Attack.

5.5 Failure to adequately data This could lead to data breaches that will, under the new GDPR arrangements be subjected to a fine of up to 20 million euros or 4% of annual global turnover (whichever is greater).

NEW TOOLKIT

5.6 The new IG Toolkit, from NHS Digital, was fully released and went live on 6 April 2018. The toolkit has had fundamental changes and is now centred around the 2016 National Data Guardian review standards which were published by Dame Fiona Caldicott. The 10 standards are for all organisations working with patient

data including Community teams, Social services and private providers such as Virgin.

5.7 The IG team is currently mapping the old and new requirements, some areas still remain the same, such as ensuring the Trust has IG policies in place, annual training and incident reporting but also new standards have been added in relation to cyber security.

5.8 The initial meeting of the Toolkit working group has been set up for 20 April. The group consists of individuals working in key areas within the Trust which the IG team will support to ensure the Trust has appropriate processes in place to protect information including IT, BI, Medical Records, Procurement, Coding, HR and Data Quality. Progress against the new requirements is tracked via the Information Governance Group. Similar to the previous toolkit the baseline submission is due at the end of October and a final submission is due at the end of March.

SUMMARY

A significant amount of work remains to be undertaken to ensure compliance by 25 May which itself will require appropriate resources to support compliance going forward.

At present, with the assistance of Hill Dickinson LLP the Trust is on track to be compliant with GDPR by 25 May however, other outstanding issues with IG within the Trust will still need to be addressed.

Report to the Board of Directors

Board Date: Thursday, 03 May 2018 Item No: 12e

Title of Report	**2017/18 Data Security Protection Requirements**
Prepared By:	Rachel Adams, Information Governance Officer
Lead Director	Sheila Murphy, Trust Secretary and Director of Corporate compliance and Legal service
Committees or Groups who have considered this report	Written in combination with the Information Governance team and IT department.
Executive Summary	Assurance paper for NHS Improvement in relation to the Trust current position in regards to the new Data Security Protection Requirements
Resource Implications	To be assessed
Risk and Assurance	Failure to comply with the new requirements will leave the Trust open to vulnerabilities from cyber attacks and other data security breaches
Legal Implications/Regulatory Requirements	Failure to implement the GDPR will lead to the Trust being non-compliant with UK Laws.
Improvement Plan Implication	The Information Governance and IT teams are currently reviewing all requirements and updates will be provided via the key issue reports from the Information Governance group
Quality Impact Assessment	Not undertaken
Recommendation	This paper is for assurance and noting only at this time.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

In January 2018, to improve data security and protection for health and care organisations the Department of Health and Social Care, NHS England and NHS Improvement published a set of 10 data and cyber security standards. These standards have been transformed into the new Data Security and Protection toolkit and are based on the National Data Guardian (NDG) review completed by Dame Fiona Caldicott, in July 2017.

NHS Improvements requires all Trusts to respond to a set of 10 questions in relation to the current position of the Trust by the 11 May. The answers are RAG rated as Fully Implemented, Partially implemented and not implemented. Currently the Trust has no not implement, 4 partially and 6 fully implemented. As part of the new assurance process the Board must be seen to be aware of the current position.

2 LEADERSHIP OBLIGATION 1: PEOPLE

2.1

Requirement Detail	Initial Response	Status
Senior Level Responsibility: The Trust has a named senior executive responsible for data and cyber security. Ideally this person will also be your Senior Information Risk Owner (SIRO), and where applicable a member of your organisation's board.	The SIRO for the Trust is Tracey Cotterill, Director of Finance & Business Services	Fully Compliant
Complete the Information Governance Toolkit v14.1 in 2017/18	Final submission of the v14.1 toolkit was signed off on the 31 March 2018 with a score of 68% with all requirements marked as satisfactory.	Fully Compliant
Prepare for the introduction of the General Data Protection Regulation (GDPR) in May 2018	The IG team is working with Hill Dickinson LLP to prepare the Trust for the changes under the GDPR.	Partial Compliance

Report to the Board of Directors

Requirement Detail	Initial Response	Status
Training Staff: All staff must complete appropriate annual data security and protection training. This training replaces the previous IG training whilst retaining key elements of it: https://www.e-lfh.org.uk/programmes/data-security-awareness/	The Trust is fully compliant with regards to content of the training materials. However, mandatory training compliance is still c 85% with a target of 95%.	Partial Compliance

3 LEADERSHIP OBLIGATION 2: PROCESSES

3.1

Requirement Detail	Initial Response	Status
Acting on CareCERT advisories: Organisations must: * Act on CareCERT advisories where relevant to your organisation; *Confirm within 48 hours that plans are in place to act on High Severity CareCERT advisories, and evidence this through CareCERT Collect; and *Identify a primary point of contact for your organisation to receive and co-ordinate your organisation's response to CareCERT advisories, and provide this information through CareCERT Collect. Note: Action might include understanding that an advisory is not relevant to your organisation's systems and confirming that this is the case. More information on CareCERT (including CareCERT Collect) can be found here: https://nww.carecertisp.digital.nhs.uk/ Organisations wishing to sign up or log in to CareCERT Collect should go to: https://nww.carecertcollect.digital.nhs.uk	CareCERTs are currently subscribed to and reviewed by the IT senior management team. These are primarily assessed and processed by either the Head of IT, The IT Operations Manager or the Enterprise Architect. The reciept and review of all CareCERTs is now automated to allow the Technical IT teams to review all CareCERTs. The IT Operations Manager is now registered on CareCERT collect and has responded to the only current High Priority Alert.	Complete
Continuity planning: A comprehensive business continuity plan must be in place to respond to data and cyber security incidents.	The IT Operations Manager is currently working with a Civil Service Data Security resource to draft a full Business Continuity Plan (BCP) for cyber security.	Partial Compliance

Requirement Detail	Initial Response	Status
Reporting incidents: Staff across the organisation report data security incidents and near misses, and incidents are reported to CareCERT in line with reporting guidelines.	Cyber security incidents are primarily reported by Trust staff to the IT service desk or out of hours via the engineer on-call process. Details of these reports and the resulting actions are provided to CareCERT. Datix reports are used for non-urgent events such as loss of encrypted hardware and are assigned to IT management staff.	Complete

4 LEADERSHIP OBLIGATION 3: TECHNOLOGY

Requirement Detail	Initial Response	Status
Unsupported systems: Your organisation must: - Identify unsupported systems (including software, hardware and applications); and - Have a plan in place by April 2018 to remove, replace or actively mitigate or manage the risks associated with unsupported systems. NHS Digital good practice guide on the management of unsupported systems can be found at: https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care (and associated documents on the main CareCERT web site)	The Trust is aware of infrastructure platforms known to be out of support or at risk. This includes: - A small number of servers running MS Server 2003. - A small number of workstations running Windows XP. - The Siemens ISDX Telephony Exchange. - A small number of systems that operate without supplier support. For all these cases, there are mitigations in place to minimise risk and maintain security within achievable means. The reviewed BCP mentioned in LO.2.Process.6 will fully document the reporting process for cyber security incidents to all staff.	Partial Compliance

Report to the Board of Directors

Requirement Detail	Initial Response	Status
On-Site Assessments: Your organisation must: - Undertake an on-site cyber and data security assessment if you are invited to do so by NHS Digital; and - Act on the outcome of that assessment, including any recommendations, and share the outcome of the assessment with your commissioner.	The Trust has recently completed a review of cyber security with external auditor KPMG. There has also been a recent penetration test of the Kent and Medway Community of Interest Network (CoIN). These assessments and tests have been completed by the Trust independently the Trust has not been specifically invited to undertake any additional assessment by NHS Digital. The Trust has additional local network tests planned for 2018/19	Fully Compliant
Checking Supplier Certification: Your organisation should ensure that any supplier of IT systems (including other heath and care organisations) and the system(s) provided have the appropriate certification. A list of certification frameworks is provided below: - ISO/IEC 27001:2013 certification - Supplier holds a current ISO/IEC27001:2013 certificate issued by a UKAS accredited certifying body and scoped to include all core activities required to support delivery of services to the organisation. - Cyber Essentials (CE) certification - The supplier holds a current CE certificate from an accredited CE Certification Body. - Cyber Essentials Plus (CE+) certification - The supplier holds a current CE+ certificate from an accredited CE+ Certification Body. Digital Marketplace - Supplier services are available through the UK Government Digital Marketplace under a current framework agreement. - Other types of certification may also be applicable. Please refer to Cyber Security Services 2 Framework via Crown Commercial..	For the past 5 years, any externally hosted or cloud based system has been asked to provide details of their ISO27001 or Cyber Essentials accreditation. This is present within a standardised Output Based Specification (OBS) utilised by the ITPMO, for all new IT system purchases. For suppliers supporting solutions hosted within Trust data centres, the Trust has requested that these suppliers connect via N3 Code of Connectivity. This ensures that suppliers have submitted and had ratified an Information Governance Statement of Compliance (IGSoC) reviewed and approved by N3. Where supplier compliance has not been possible, papers have been submitted at Executive level providing details of risks and safeguards in order to facilitate a decision.	Fully Compliant

Report to the Board of Directors

NHS
Medway
NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018

Agenda item 13a

Title of Report	**Workforce Report**
Prepared By:	Leon Hinton, Director of Operational HR
Lead Director	Leon Hinton, Director of Operational HR
Committees or Groups who have considered this report	HR Senior Team; Executive Group
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital. The Trust's recruitment campaigns, including national, local and international have delivered 64 candidates to-date via Cpl, 156 candidates to-date via HCL and 109 from other partner agency providers. The initial Philippines recruitment plan for nursing continues with a total of 194 nurses being processed for posts at MFT. Trust turnover has decreased to 11.78% (-0.03% from 11.81%) and is likely to plateau for the next two months, sickness remains under 4% (-0.36%) at 3.93%, compliance with StatMan (statutory and mandatory training) compliance has significantly improved to 85.04% (+8.16%) against target of 85% (better), appraisal compliance improved to 85.04% (+1.62%) against target of 85% (better). The year-end position of pay bill spent on substantive staff (80%) is significantly higher (+3%) than for 2016/17 (77%); agency usage for the financial year decreased by 11% from £40.5m to £17.4m, whilst bank usage increased by 8% from £8.4m to £25.3m. The Trust met its NHSI agency ceiling for 2017/18.
Resource Implications	None

Report to the Board of Directors

Risk and Assurance	• Nurse Recruitment • Temporary Staffing Spend The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Workstream as part of the cost improvement programme
Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.
Improvement Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).
Quality Impact Assessment	Not applicable
Recommendation	Not applicable
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Report to the Board of Directors

1 INTRODUCTION

1.1 This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital.

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During March 2018, 11 FTE nurses joined the Trust on a substantive basis, alongside nine FTE substantive CSWs.

2.2 The international campaign in the Philippines continues. Harvey Nash, our international partner agency working on our Filipino nurse recruitment campaign, is continuing to process 193 of the Filipino nurses that remain engaged in the process (47 individuals have withdrawn and or failed to follow-up on the offer). One nurse joined the new six week objective structured clinical examination (OSCE) training programme in February and is scheduled to undertake her OSCE exam on 27 April along with eight other international nurse colleagues who joined the Trust in February.

2.3 Further to the collaborative regional procurement approach to International Nurse Recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. One NMC registered Cpl international neonatal nurse arrived in March, and a further 63 offers are in process. Five HCL nurses have commenced in post with a further 156 offers are in process (including 129 offers made during the recent Philippines campaign).

2.4 The Trust is also working with four additional permanent recruitment agency providers: Person Anderson; Imperial MS, MSI Group and Xander Hendrix. Agency partners are working with the Trust on developing a pipeline of nurses with start dates from March 2018 onwards. The table below summarises the Trust's recruitment pipeline via all our partner agency providers:

Agency Provider	Commenced in post	Pipeline	Agency total	Anticipated starters over the next 12 months from pipeline
Harvey Nash	1	***193***	194	(5%) **10**
Cpl Healthcare	1	***63***	64	(40%) **25**
HCL	5	***156***	160	(40%) **62**

Person Anderson	8	***48***	56	(90%) **43**
Imperial MS	3	***31***	34	(40%) **13**
MSI Group	1	***7***	8	(40%) **3**
Xander Hendrix	0	***11***	11	(60%) **7**
Total	19	**509**	527	**163**

(Table 1: Nurse recruitment pipeline)

2.5 The Trust has commissioned the services of HealthSectorJobs (HSJ), a specialist health sector advertising company to undertake a four-week targeted nurse recruitment advertising campaign on behalf of the Trust, two nurses have been offered following this campaign. A further three nurse have interviews booked in April. HSJ agreed a shared risk approach to this campaign.

2.6 The Trust has been granted access to a Nursing CV database on a 12-week free trial (ends May 2018). This proactive approach has resulted in two band 7 nurses and one matron being shortlisted and booked for interview. A further 84 CVs have been reviewed with 60 shortlisted by the clinical senior management team and contacted by the Resourcing Team to discuss working at the Trust.

2.7 Table 2 below summarises offers made, starters and leavers for March 2018. 15 of the 'registered nurse' leavers are ward-based nurses and ward-based midwives. 7 nurses were part of a transfer of service outside of the Trust. The nine remaining staff members were ward managers and specialist nurses.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	**41** (20 NHS Jobs/open days, and 21 international)	**8** (includes 2 pre-registration international recruits)	**33**
Clinical Support Workers	**4** (2 open days and 2 apprentices)	**4**	**13**

(Table 2: Monthly starters and leavers)

2.8 Three FTE consultants have been recruited by the Trust since January 2018.

2.9 One Physicians' Associate (PA) commenced in post in March and a further 10 PA candidates have been scheduled for interview in April to cover six vacant PA Masters training posts.

Report to the Board of Directors

3 DIRECTORATE METRICS

3.1 The table below (table 2) shows performance across five core indicators by the directorate. Turnover, at 11.78% (-0.03% from February), remains above the tolerance level of 8% and is likely to plateau for the next three months. Sickness absence (-0.36% at 3.93%) remains below the tolerance level of 4%. HR Business Partners will work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results. In conjunction with outputs from the January unconference and culture workstreams, with the aim to implement a service-specific retention plan through quarter 4 17/18 and quarter 1 18/19.

3.2 Trust appraisal rate stands at 85.04% (+8.16%), now above the Trust target of 85% (better), StatMan (statutory and mandatory) training is also above target (at 85.04%, better, +1.62%) – two directorates are meeting the StatMan target (Corporate and Planned Care) and two directorates are meeting the appraisal target (Corporate and Planned Care).

	Planned Care			Unplanned & Integrated Care			Corporate			Estates & Facilities			Trust		
	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend
Turnover rate (8%)	12%	▼		13%	▲		13%	▲		6%	▲		12%	▼	
Vacancy rate (12%)	19%	▲		21%	▲		15%	▲		14%	▲		19%	▲	
Sickness rate (4%)	4%	▼		4%	▲		3%	▲		5%	▼		4%	▼	
StatMan (85%)	87%	▲		81%	▲		91%	▲		73%	▲		85%	▲	
Appraisal (85%)	87%	▼		82%	▲		91%	▼		82%	▲		85%	▲	

(Table 3: Key workforce metrics)

Report to the Board of Directors

4 TEMPORARY STAFFING

4.1 Table 4 below demonstrates the transformation in the contractual workforce profile 2017/18 compared to 2016/17. Substantive as a percentage of the pay bill has increased by 3% and agency has decreased from 19% to 8%.

		2016/17	2017/18
Spend (£)	Agency	40,530,735	17,444,863
	Bank	8,438,690	25,329,117
	Substantive	164,147,453	171,098,554
% Pay bill	Agency	19%	8%
	Bank	4%	12%
	Substantive	77%	80%

(Table 4: Workforce profile based on contractual arrangement)

4.2 The agency cap breaches across all staff groups for March have decreased compared to previous months with approximately 70 price cap breaches per week. Based on agency spend to date, the Trust is now on target to be £4m below the Trust's 2017/18 NHSi agency ceiling cap of £21.6m.

4.3 Temporary nursing demand increased in March compared to February (11,887 shifts requests in March compared to 10,843 shifts requests in February). The fill rate in March remains at 72% despite the increase in demand. Medical locum demand also increased slightly in March compared to February (871 shifts requests in March compared to 851 shifts requests in February) and the fill rate increased by 5% to 67%.

5 CULTURE: UNCONFERENCE PROGRESS UPDATE

5.1 The Unconference was delivered in January 2018 in partnership with Horizons. This formed part of the Better, Best, Brilliant (BBB) Culture and Engagement project and followed on from listening events conducted during December and early January. Seventy people attended the BBB listening events and the unconference event hosted sixty five people.

5.2 The purpose of the unconference was to:

- Identify the behaviours and attitudes that drive an organisation which is innovative and has a continuous improvement culture;
- Explore issues affecting culture by engaging in creative ways of thinking and determining options for the future;

- Design how a 'Brilliant' Medway looks and feels incorporating those behaviours, attitudes and approach to continuous improvement;
- Formulate ideas and actions that will be taken from the unconference and implemented in their working life.

5.3 A climate survey was carried out to highlight the difference between where the Trust is now, in relation to transformation, to the Trust's aspiring transformation climate for the future, results are demonstrated below:

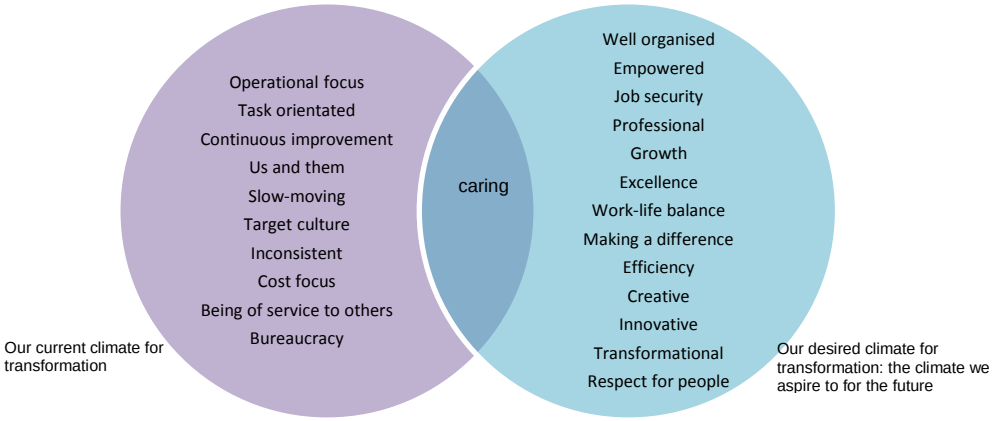


Figure 1: Unconference transformation climate survey

5.4 The Unconference progressed to looking at what we could do to make Medway Brilliant and a number of 'Big Ideas' were generated and were then voted on by those attending. These included recruitment and retention; collaborative working; challenging poor behaviour and staff engagement – follow-up actions as a result include further linkages to the Promoting Professionalism Pyramid project to assist staff across the organisation to challenge poor behaviour; a session is now delivered in the Leadership programme to poor behaviours, and it is now discussed at induction and incorporated into our master classes. Discussions are under way to further develop delivery plans for the other 'big ideas'.

5.5 It was recognised at the event that representation of all staff groups was required to ensure a rich understanding of the organisations culture. The Organisational & Professional Development (OPD) team began to provide 'mini unconferences' in work areas to gather further information. The sessions consisted of: climate survey, breaking the rules, permissions and sharing big ideas. Three subsequent mini-unconferences have been run with a further five scheduled as part of the discovery phase.

5.6 The discovery phase will cease at the end of May 2018 where all the data and information will be collated, from this the project will move to delivery.

5.7 The event has been a vehicle to encouraging a big conversation regarding the culture and continuous improvement of the organisation. It has given staff a voice and platform to express freely how they feel and what they can do to make Medway Brilliant. The next phase will be vital to assure staff they are being listened to and that there ideas and honest conversations are put into action.

5.8 The Trust has also appointed a Head of Culture & Engagement as part of the Trust's transformation team to play a pivotal role in the culture improvements and objectives.

-End

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/03/2018

Agenda item 13b

Title of Report	**Gender Pay Gap Report**
Prepared By:	Alister McClure, Head of Equality & Inclusion
Lead Director	Leon Hinton, acting Director of Operational HR & OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	This report sets out the gender pay gap calculations and supporting statement for 2017. It is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The gender pay gap for the Trust is a mean of 30.62% and a median of 19.56%. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles.
Resource Implications	None identified at this stage
Risk and Assurance	Reputation and Contract Compliance Publication of the gender pay gap along with the supporting statement will remove the risk of non-compliance. Development of an implementation plan will enable the Trust to mitigate the reputational risks associated with a gender pay gap.
Legal Implications/Regulatory Requirements	The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires the Trust publishes its gender pay gap.
Improvement Plan Implication	Workforce equality, including being an employer of choice, is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan.
Quality Impact Assessment	Not applicable
Recommendation	To approve the publication of the Trust's Gender Pay Gap and

Report to the Board of Directors

	supporting statement (as set out is section 6)			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☐	☐	☐

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 This report sets out the gender pay gap calculations for 2017, together with a supporting statement. The report is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

1.2 The gender pay gap for the Trust is a mean of 33.32% and a median of 24.24%. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles. There is some evidence that this pattern is repeated in many other Trusts across the NHS, and relates to professional career paths.

2 BACKGROUND

2.1 Following government consultation, it became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG). Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce (these are published annually on the Trust website). Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

2.2 The new requirement to publish GPG reports is set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The requirements are summarised in section 4 of this report.

2.3 The difference between the gender pay gap and equal pay

2.3.1 **Equal pay** deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

2.3.2 **The gender pay gap** shows the differences in the average pay, across the whole workforce, between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are. In some cases, the gender pay gap may include unlawful inequality in pay but this is not necessarily the case.

2.4 Although each individual NHS Trust is responsible for its own GPG report, the NHS has a nationwide tool to make the relevant calculations.

3 REPORTING REQUIREMENTS

3.1 Employers with 250 employees and over will need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations must be made relating to the pay period in which the snapshot day falls. For this first year, this will be the pay period including 31 March 2017.

3.2 Employers must:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls;
- calculate the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees;
- calculate the difference between the mean (and median) bonus pay paid to male and female employees (NB this calculation is not relevant to this Trust, as staff are not paid bonuses. Clinical Excellence Awards, for example, are fully incorporated into pay.);
- calculate the proportions of male and female employees who were paid bonus pay (again, this is not relevant to this Trust);
- calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

3.3 The Trust is also required to publish a supporting narrative (see section 4 below), which must include an assurance statement, agreed by a senior representative of the Trust, and/or the Executive Group and The Trust Board. The calculations and supporting statement must be published on both the Trust website and a Government portal. Once published, employers are required to implement an action plan to address the gender pay gap.

3.4 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 identify gender as male and female. There is no consideration in the regulations to people to identify as intersex, or gender non-binary. In terms of gender identity (e.g. Transgender status) the advice provided to employers is to ensure that for the purposes of the GPG report, people's gender is recorded according to their HR/Payroll records.

4 GENDER PAY GAP CALCULATIONS

4.1 Mean and Median Hourly Rates (All staff groups)

Gender	Average (mean) Hourly Rate	Median Hourly Rate
Male	21.7437	16.4418
Female	14.4996	12.4556
Difference	7.2441	3.9862
Pay Gap %	33.32%	24.24%

4.2 Number of employees per quartile

Quartile	Female	Male	Female %	Male %
1 (lower)	880	158	84.78	15.22
2 (lower middle)	920	159	85.26	14.74
3 (upper middle)	910	150	85.85	14.15
4 (upper)	690	370	65.09	34.91

4.3 As reported in section 3 above, the calculation on bonuses is not relevant to this Trust, as staff are not paid bonuses. Awards that may be perceived as bonuses (Clinical Excellence Award, for example) are fully incorporated into pay, and under the definitions of the regulation are pay not bonuses.

4.4 Mean and Median Hourly Rates, separating medical and dental roles from non-medical roles.

Medical and Dental		
Gender	Average (mean). Hourly Rate	Median Hourly Rate
Male	36.2115	36.4409
Female	30.0725	27.2668
Difference	6.1390	9.1740
Pay Gap %	16.95%	25.18%

Non-Medical		
Gender	**Avg. Hourly Rate**	**Median Hourly Rate**
Male	14.3136	12.0973
Female	13.5470	11.9526
Difference	0.7666	0.1448
Pay Gap %	5.36%	1.20%

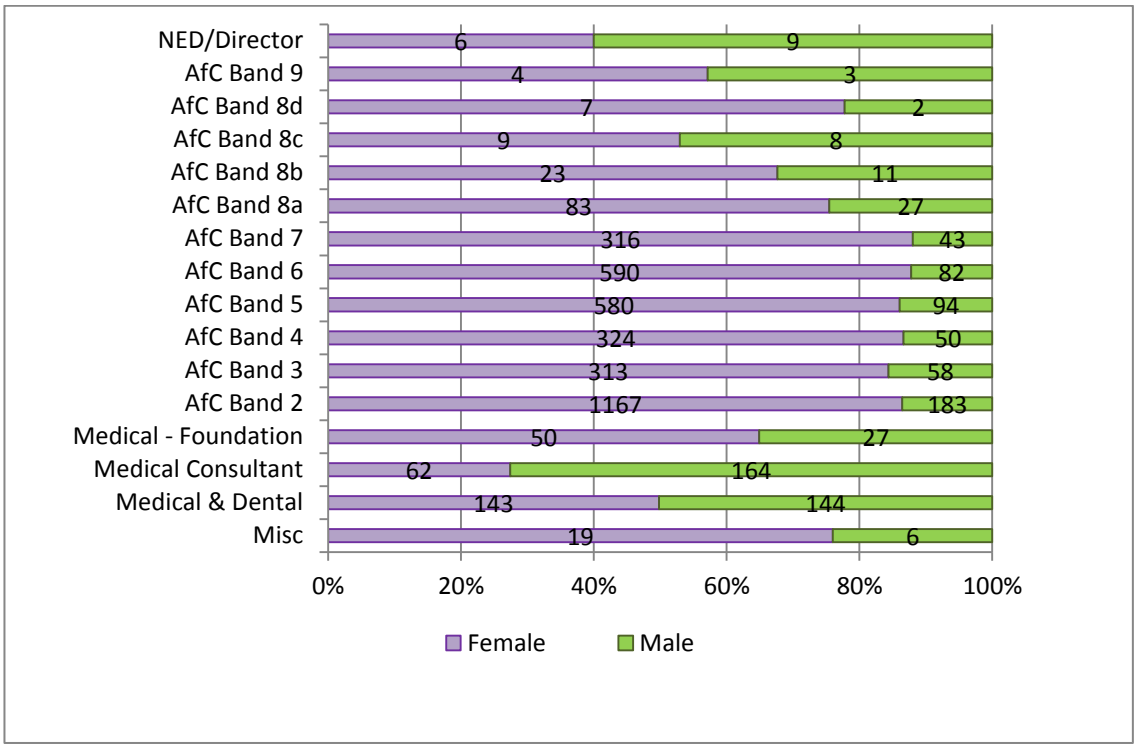
5 SUPPORTING STATEMENT

5.1 The headline calculations for this Trust are a Mean gender pay gap of 33.32% and a Median gender pay gap of 24.24%. However, it is evident that the proportion of men in the workforce increases in the upper quartile, compared to quartiles 1 to 3.

5.2 When calculating the pay gap separately for medical and dental, and non-medical staff, the mean reduces for both groups, and the median reduces for non-medical staff. Indeed, the mean pay gap for non-medical staff (chiefly AfC pay bands) there is very little variation in the mean, at 5.36%, and the median is 1.2%.

5.3 The gender pay gap issue for the Trust comes when we combine medical and non-medical grades, as the number of men in the medical workforce, particularly consultants, is significantly higher than the number of women. The graph below illustrates, from the Trust's workforce demographics report 2017, that amongst medical consultants, men comprise over 75% of the workforce. In Agenda for Change (AfC) pay bands, women form over 80% of the workforce. This means that, compared to women, a greater proportion of men are in higher paid roles. Another potential matter to consider is the fact that the Trust has not outsourced some services, such as catering and housekeeping, which have a higher proportion of women in lower pay bands.

Report to the Board of Directors



5.4 Discussions with neighbouring trusts and with NHS Employers have revealed that there is a similar pattern across Acute Trusts in England. On the one hand, there is reasonable confidence that, owing to Agenda for Change and medical pay reviews, the NHS is providing equal pay (men and women paid equally to carry out the same jobs, similar jobs or work of equal value). However, it is evident that in medical roles there are significantly more men progressing to the most senior levels resulting in a gender pay gap.

5.5 Further work is needed to understand the reasons for the differences in progression for men and women, especially in medical and dental roles. There is also little that the Trust can do in the short term to remove the gender pay gap, precisely because the issue affects professions that have long term career pathways.

5.6 The important issue with gender pay gap analysis is not only to know the data and understand the reasons for the gaps, but to be able to develop plans to address the gap. Reliable benchmarking with other organisations has not yet been possible, as this is the first year for gender pay gap reports. Noting that the gender pay gap issue is common to many other acute trusts across the NHS, it will be important to explore with partners across the NHS what practical changes can be made. Ideas currently under consideration include:

- Continuing to keep pay structures under proper review, to ensure that equal pay is maintained;
- Improving the professional pathways for women in medical roles to encourage more female medics into consultant and other senior roles;
- Working with Medical Schools/Universities to explore how medical graduates choose the direction of their careers;
- Reviewing the international dimension of medical recruitment, recognising the pattern of male dominance in medical roles across the world. This must include practical steps to encourage more women medics from international recruitment;
- Reviewing how well the Trust manages women's progression after career gaps/maternity;
- Reviewing how well the Trust is managing the progression into senior medical roles for women who work part-time;
- Active promotion of current policies on flexible and family-friendly working, workforce planning and career development opportunities and career pathways for all staff.

5.7 **Assurance statement.** The gender pay gap for Medway Foundation Trust has been prepared using the NHS Electronic Staff Record (ESR) gender pay gap calculator. The Trust has also used the ACAS guidance to calculate and verify the result.

6 PUBLICATION

6.1 Subject to approval by the Trust Board at its meeting in March 2018, the gender pay gap and supporting statement will be published on the Trust website and the Government portal before 31 March 2018. The next steps (set out in 4.5 above) will be developed into an implementation plan.

6.2 It is recommended:

6.2.1 that the gender pay gap (section 4 of this report) together with the supporting statement (section 5), be approved for publication.

6.2.2 that the Trust works with partners across the NHS to develop the next steps (5.5 above) into a detailed implementation plan.

6.2.3 that benchmarking be undertaken with other NHS trusts and with UK employers whose gender pay gap will published on the Government portal.

-End

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: Thursday, 03 May 2018 Item No: 13c

Title of Report	**Staff Survey 2017 Results and Improvement Plan**
Prepared By:	Kay Abbs, AD of Workforce development and OD
Lead Director	James Devine, Deputy Chief Executive Officer and Executive Director of HR&OD
Committees or Groups who have considered this report	Trust Executive
Executive Summary	1.1 The overall response rate for Medway for the 2017 Staff Survey was 40%. This was a reduction on the 2016 rate of 9.5%. However, 40% is equal to the National Acute Trust average and higher than our 2015 response rate of 37%. 1.2 For Medway, of the 32 key findings in the survey, 14 worsened statistically and 18 remained unchanged. 1.3 National results (which cover all organisations that participated in the survey) report an average response rate of 45% and, of the 32 key findings in the survey, 21 worsened and 11 improved. 1.4 Medway's overall staff engagement index (this score is created from 3 key findings – recommendation of the trust as a place to work or receive treatment; staff motivation at work and staff ability to contribute to improvement at work) declined by 3% from 3.76 to 3.66. This is lower than the National Acute Trust average of 3.79 and slightly worse than the Kent Acute average which declined by 1%. 1.5 The majority of areas within the Trust have recorded a reduction in positive scores. 87 questions were asked in this survey. 62 results (71%) deteriorated compared to 2016, 19 results (22%) remained unchanged and 6 results (7%) improved. 1.6 The 2017 NHS Staff Survey for Medway indicates that levels of staff engagement have reduced, compared to the 2016 survey. However, further analysis against the 3

Report to the Board of Directors

	year trend and compared to Kent Acute Trust averages indicate that the organisations position is improving, and it can be extrapolated that the results for the 2016 survey were significantly higher due to the organisations combined effort to exit special measures.
Resource Implications	None
Risk and Assurance	None
Legal Implications/Regulatory Requirements	None
Improvement Plan Implication	Supports the Better, Best, Brilliant Programme 8 (Building a Sustainable Workforce)
Quality Impact Assessment	None
Recommendation	To note and accept the recommendation as per item 9.1.
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☐ **Discussion** ☒ **Noting** ☐

Report to the Board of Directors

2 EXECUTIVE OVERVIEW

2.1 The overall response rate for Medway for the 2017 Staff Survey was 40%. This was a reduction on the 2016 rate of 9.5%. However, 40% is equal to the National Acute Trust average and higher than our 2015 response rate of 37%.

2.2 For Medway, of the 32 key findings in the survey, 14 worsened statistically and 18 remained unchanged.

2.3 National results (which cover all organisations that participated in the survey) report an average response rate of 45% and, of the 32 key findings in the survey, 21 worsened and 11 improved.

2.4 Medway's overall staff engagement index (this score is created from 3 key findings – recommendation of the trust as a place to work or receive treatment; staff motivation at work and staff ability to contribute to improvement at work) declined by 3% from 3.76 to 3.66. This is lower than the National Acute Trust average of 3.79 and slightly worse than the Kent Acute average which declined by 1%.

2.5 The majority of areas within the Trust have recorded a reduction in positive scores. 87 questions were asked in this survey. 62 results (71%) deteriorated compared to 2016, 19 results (22%) remained unchanged and 6 results (7%) improved.

2.6 The 2017 NHS Staff Survey for Medway indicates that levels of staff engagement have reduced, compared to the 2016 survey. However, further analysis against the 3 year trend and compared to Kent Acute Trust averages indicate that the organisations position is improving, and it can be extrapolated that the results for the 2016 survey were significantly higher due to the organisations combined effort to exit special measures.

3 BACKGROUND AND CONTEXT

3.1 The Medway National Staff Survey 2017 took place between 9th October and 1st December 2017 and was conducted by the independent survey contractor, Quality Health, on behalf of the Trust.

3.2 The NHS National Staff Survey questionnaire covers five themes relating to the working environment and individual's experience of the workplace:

- Your Job
- Your Managers
- Your Health, Wellbeing and Safety at Work
- Your Personal Development and
- Your Organisation.

The questions associated with each of these themes are determined nationally and consistency between the questions included in successive surveys enables comparisons and trend analysis year on year.

3.3 There are two types of Key Finding:

- Percentage score, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
- Scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these summary scores the minimum score is always 1 and the maximum score is 5.

3.4 This report includes weighted results from the full report, which provide a more accurate representation, as opposed to unweighted results which are provided in the first initial report.

3.5 The full report can be accessed by following the link 2017 Full Results.

3.6 It should also be noted that the survey was conducted during a period of significant change at the Trust. Over eight immediate organisational changes had recently happened or were actively running, and significant changes to services had been announced for the forthcoming year. In addition, the Trust had only been able to take limited actions based on the 2016 results. During the 2016 staff survey period the organisation was working towards being removed from special measures. This may have had the effect of engendering a united, defined purpose for staff which resulted in a more engaged workforce for that period of time. This may be a contributing factor to the lower 2017 engagement results as staff moved from a defined end point (March 2017) to a period requiring continuous improvement and an increased financial deficit.

4 OVERVIEW OF MEDWAY RESULTS

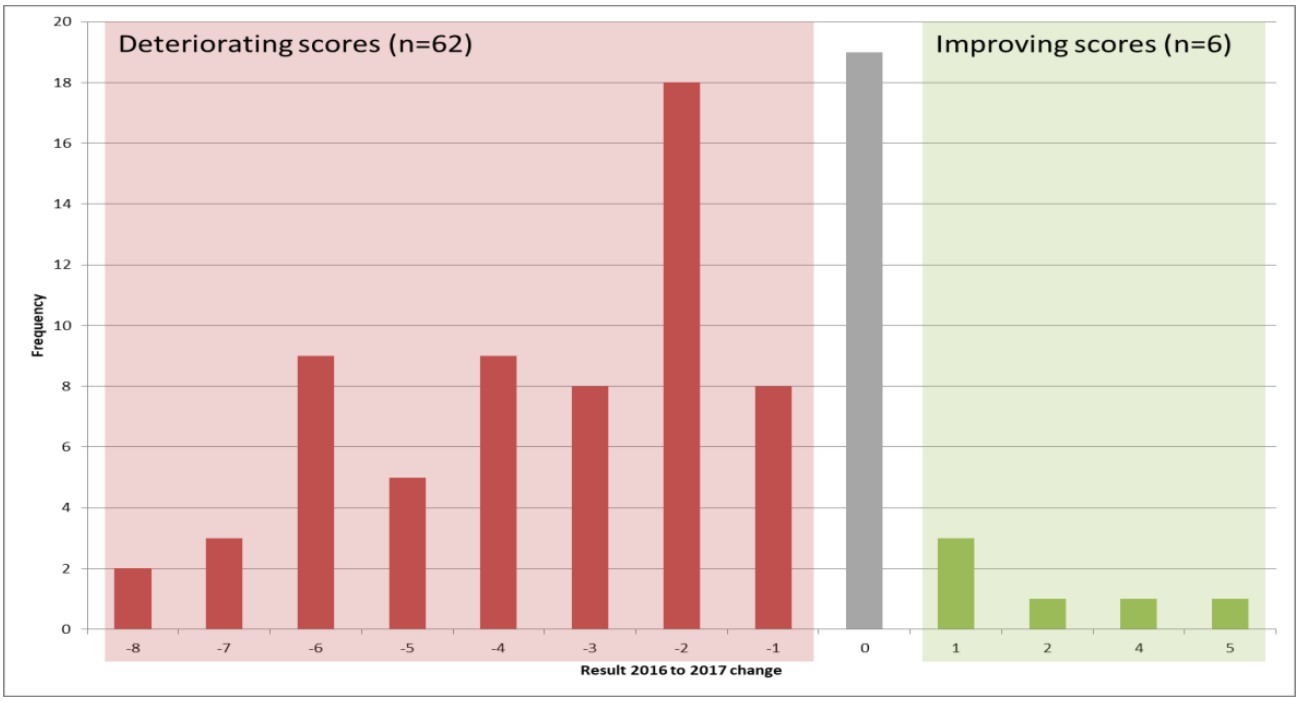
4.1 All staff employed by the Trust on 1 September 2017, a total of 4459, were invited to participate in the survey. 1773 staff took up the opportunity which resulted in a response rate of 40%. It should be noted that the national average response rate across the NHS for Acute Trusts is 40%.

4.2 Of the 32 key findings in the survey 14 worsened statistically and 18 remained unchanged.

4.3 The overall staff engagement index (this score is created from 3 key findings – recommendation of the trust as a place to work or receive treatment; staff motivation at work and staff ability to contribute to improvement at work) for Medway declined by 3% from 3.76 to 3.66. This is lower than the National Acute Trust average of 3.79 and slightly worse than the Kent Acute average which declined by 1%.

4.4 The questions asked in the survey were identical for both 2016 and 2017 and therefore allow us to draw a direct comparison. By comparing positive scores of both data sets they indicate deterioration in staff satisfaction. 62 questions had a deteriorating score ranging between 1 and 8 percentage points lower than 2016; 19 questions showed no change and 6 questions had an improved score ranging from 1 to 5 percentage points higher.

Chart 1 below shows changes in percentage points in comparison to 2016.



(Chart 1: 2016 to 2017 results comparison)

4.5 Table 2, below, shows the variance between 2016 and 2017 by the frequency of improving or deteriorating scores. All themes apart from 'Health, Wellbeing and Safety at Work' indicate a reduction in satisfaction with no improving scores. The average variance demonstrates that the theme of 'Your Organisation' has experienced the most severe deterioration with an average of -5.4% to questions across the organisation. Overall, across all themes, the average variance between survey years is -2.4% as a result.

Report to the Board of Directors

Survey Theme	Deteriorating		Improving		No change
	Frequency	Average Score Change	Frequency	Average Score Change	Frequency
Your job	25	-3.7			2
Your managers	6	-4.0			5
Your health, wellbeing and safety at work	16	-2.8	6	2.3	8
Your personal development	8	-2.6			4
Your organisation	7	-5.4			
Grand Total	**62**	**-3.5**	**6**	**2.3**	**19**

(Table 2: Thematic score change 2016 to 2017)

4.6 The 5 areas where we compare most favourably against national results

- KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse
- KF12. Quality of appraisals
- KF24. Percentage of staff / colleagues reporting most recent experience of violence
- KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months

4.7 The 5 areas where we compare least favourably against national results

- KF31. Staff confidence and security in reporting unsafe clinical practice
- KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- KF3. Percentage of staff agreeing that their role makes a difference to patients / service users
- KF15. Percentage of staff satisfied with the opportunities for flexible working patterns
- KF7. Percentage of staff able to contribute towards improvements at work

4.8 The 5 areas where staff experiences have deteriorated most since 2016

- KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
- KF31. Staff confidence and security in reporting unsafe clinical practice

- KF2. Staff satisfaction with the quality of work and care they are able to deliver
- KF8. Staff satisfaction with level of responsibility and involvement
- KF15. Percentage of staff satisfied with the opportunities for flexible working patterns

5 OVERVIEW OF THE NATIONAL PERSPECTIVE ON 2017 RESULTS, AS DESCRIBED BY NHS EMPLOYERS

5.1 487,227 NHS staff took part in the survey which equates to a response rate of 45%.

5.2 The results show a service under strain. Staff report that they are working under more pressure and feel less able to deliver a good quality service. They feel less enthusiastic about their jobs and more dissatisfied with pay. Across a range of indicators they report worse experience than in 2016. Some progress has been made in some areas such as increased support from managers and more confidence that the organisation takes action on health and wellbeing.

5.3 Of the 32 key findings in the survey 21 worsened and 11 improved.

5.4 There were some clear trends across the survey. Indicators linked to staff assessment of quality and experience of work reflected the intense pressures on the NHS. There were mixed results for staff engagement and health and wellbeing. There were positive trends in results for measures of people management, for example on appraisal and the role of line managers.

5.5 Staff perception of the quality of care they are able to deliver worsened. By contrast the measure of whether staff would feel willing to recommend the care provided by their organisation remained stable.

5.6 On staff engagement the overall index of engagement fell. This was due largely to a fall in the index of motivation (from 3.92 to 3.90) arising from falls in questions on whether staff are enthusiastic about and look forward to going to work. The key finding on staff involvement also fell from 70% to 69%.

5.7 On health and wellbeing some of the measures on individual staff health worsened, for example rising levels of stress and the percentage or staff attending when unwell (53%). However, there was an improvement in the measures on line manager support and organisational action on health and wellbeing.

5.8 There was a sustained improvement in almost all measures of support from line managers leading to a rise in the overall indicator. There were also small improvements in the areas of quality of appraisal and training. The indicator on staff confidence to raise concerns remained stable at 3.67.

6 COMPARISON INFORMATION

6.1 Table 3 below provides analysis of the data for Medway's results from 2015, 2016 and 2017, identifies the key changes and compares it to the changes identified in other Kent Acute Trusts.

Report to the Board of Directors

Indicator	Result			MFT Changes		Kent Acute Changes	
	2017	2016	2015	2016 to 2017	2015 to 2017	2016 to 2017	2015 to 2017
Response Rate	40%	49%	37%	-9%	3%	0%	0%
Key Finding 1. Staff recommendation of the organisation as a place to work or receive treatment	3.49	3.66	3.45	-5%	1%	-2%	-3%
Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver	3.85	3.99	3.87	-3%	0%	-1%	-3%
Key Finding 3. Percentage of staff agreeing that their role makes a difference to patients / service users	87%	89%	86%	-2%	1%	0%	-1%
Key Finding 4. Staff motivation at work	3.89	3.93	3.90	-1%	0%	-1%	-2%
Key Finding 5. Recognition and value of staff by managers and the organisation	3.34	3.43	3.27	-3%	2%	0%	1%
Key Finding 6. Percentage of staff reporting good communication between senior management and staff	25%	31%	21%	-6%	4%	0%	0%
Key Finding 7. Percentage of staff able to contribute towards improvements at work	66%	69%	63%	-3%	3%	-1%	-1%
Key Finding 8. Staff satisfaction with level of responsibility and involvement	3.83	3.91	3.81	-2%	1%	0%	0%
Key Finding 9. Effective team working	3.71	3.76	3.66	-1%	1%	1%	0%
Key Finding 10. Support from immediate managers	3.68	3.71	3.59	-1%	2%	0%	1%
Key Finding 11. Percentage of staff appraised in last 12 months	84%	83%	84%	0%	0%	0%	0%
Key Finding 12. Quality of appraisals	3.15	3.25	3.07	-3%	2%	0%	2%
Key Finding 13. Quality of non-mandatory training, learning or development	4.00	4.05	3.96	-1%	1%	0%	-1%
Key Finding 14. Staff satisfaction with resourcing and support	3.24	3.33	3.20	-3%	1%	-1%	-2%
Key Finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns	46%	51%	48%	-5%	-2%	1%	1%

Report to the Board of Directors

Indicator	Result			MFT Changes		Kent Acute Changes	
	2017	2016	2015	2016 to 2017	2015 to 2017	2016 to 2017	2015 to 2017
Key Finding 16. Percentage of staff working extra hours	72%	73%	75%	-1%	-3%	-1%	-2%
Key Finding 17. Percentage of staff feeling unwell due to work related stress in last 12 months	37%	34%	38%	3%	-1%	1%	2%
Key Finding 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	54%	52%	62%	2%	-8%	1%	-5%
Key Finding 19. Organisation and management interest in and action on health and wellbeing	3.46	3.57	3.35	-3%	3%	1%	1%
Key Finding 20. Percentage of staff experiencing discrimination at work in the last 12 months	14%	12%	13%	2%	1%	2%	2%
Key Finding 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	78%	86%	80%	-8%	-2%	0%	1%
Key Finding 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	15%	16%	15%	-1%	0%	1%	1%
Key Finding 23. Percentage of staff experiencing physical violence from staff in last 12 months	3%	3%	3%	0%	0%	0%	1%
Key Finding 24. Percentage of staff/colleagues reporting most recent experience of violence	68%	66%	53%	2%	15%	3%	16%
Key Finding 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	29%	28%	28%	0%	1%	1%	0%
Key Finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	30%	28%	30%	2%	0%	0%	-1%
Key Finding 27. Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	47%	43%	23%	4%	24%	-3%	7%

Report to the Board of Directors

Indicator	Result			MFT Changes		Kent Acute Changes	
	2017	2016	2015	2016 to 2017	2015 to 2017	2016 to 2017	2015 to 2017
Key Finding 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	31%	30%	30%	1%	1%	-3%	0%
Key Finding 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	89%	92%	88%	-3%	1%	1%	0%
Key Finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.59	3.65	3.49	-2%	3%	0%	1%
Key Finding 31. Staff confidence and security in reporting unsafe clinical practice	3.51	3.64	3.48	-4%	1%	-1%	0%
Key Finding 32. Effective use of patient / service user feedback	3.61	3.68	3.53	-2%	2%	-1%	0%

(Table 3: 2015 – 17 Trend data and comparison to Kent Acute Trusts)

6.2 Analysis of the data indicates that the improved results that Medway achieved overall in the 2016 survey could be seen as an anomaly and do not follow the 3 year trend or the trend in the other Kent Acute Trusts. What is important to note is that 2016 appears to be both a Medway and a Kent wide anomaly. When comparison is made between 2015 and 2017 Medway has improved in a large number of areas.

6.3 When comparing the Kent Acute Trust data the picture is not the same and the same improvements are not seen. Results across other Kent Acute Trusts have largely deteriorated between 2015 and 2017 and also between 2016 and 2017.

6.4 On face value the results for Medway for 2107 show a decrease in satisfaction in 27 KF areas with a zero or small increase in 5 areas. If this is compared to the 3 year trend the figures are reversed with an increase in satisfaction in 27 areas and a decrease in 5.

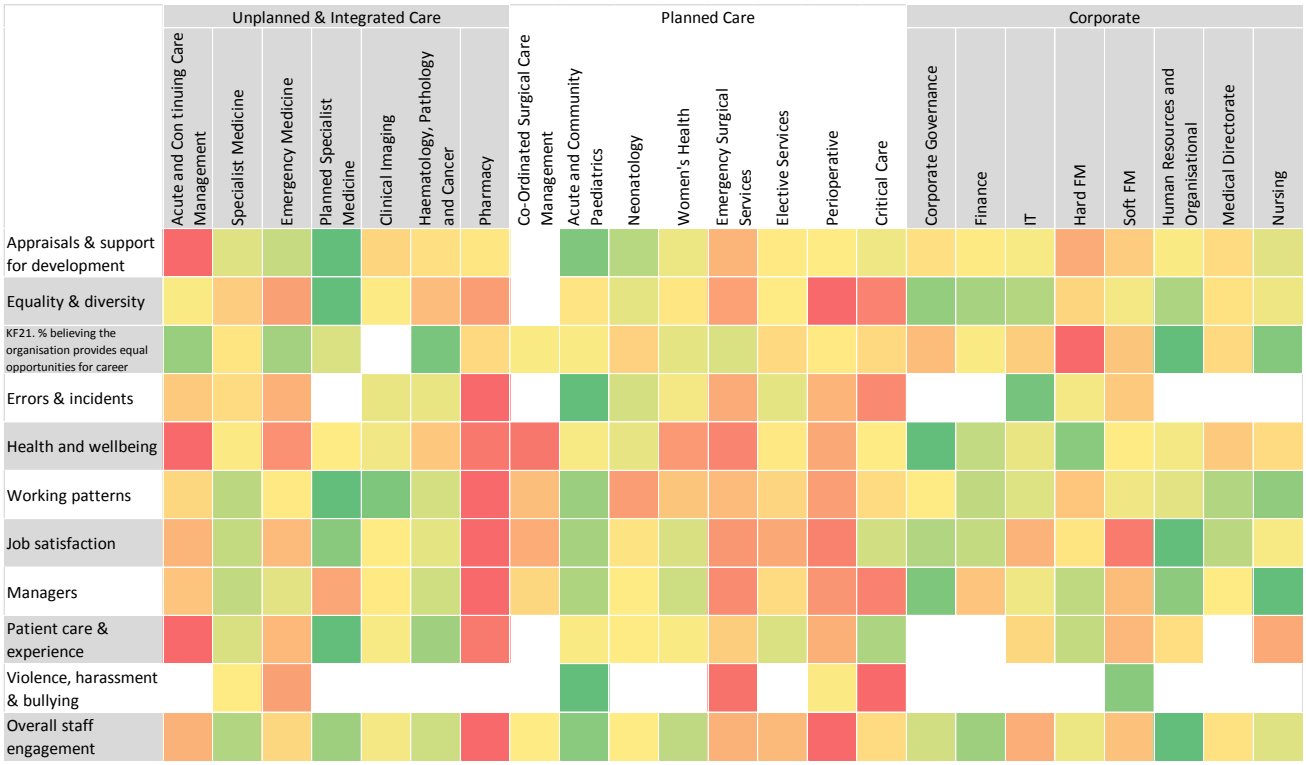
6.5 Examples of the improvements that Medway can identify when analysing the 3 year trend are

- the response rate has increased by 3%
- KF6, the percentage of staff reporting good communication between senior management and staff has increased by 4%
- KF16, the percentage of staff working extra hours has decreased by 3%
- KF18, the percentage of staff attending work in the last 3 months, despite feeling unwell because they felt pressure from their manager, colleagues or themselves has decreased by 8%

- the reporting of the most recent experiences of violence, KF 25, has increased by 15% and
- the percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse has increased by 24%. (This indicates that staff are more confident in reporting incidents rather than there is an increase in incidents)

6.6 Whilst the points noted above are some mitigation for the 2017 results it does not present the detailed picture which will provide the Trust with the information it needs in order to plan for improvement.

6.7 Table 4, below, is a more detailed analysis of the weighted data which allows for a departmental wide assessment of the results to be made. It is this information which will be used by the HR Business Partners (HRBPs), in conjunction with the full report, to develop improvement plans in partnership with departmental and directorate leads. The ratings are composite numbers of the results and grouped into key development areas. Whilst they don't match the key themes of the survey by question type as described in point 3.5, they offer the Trust key areas to focus on for development and are instrumental in the improvement work the HRBPs will be taking forward.



(Table 4 - Departmental breakdown of results)

6.8 The results for Pharmacy, Emergency Surgical Services and Perioperative indicate that staff within those departments are the least satisfied in the organisation. The results for Specialist medicine, Planned Specialist Medicine and Acute and Community Paediatrics indicate that they are the most engaged. However, there are no areas which indicate there is satisfaction across the board.

7 RESPONDING TO MAIN AREAS OF CONCERN

7.1 The table at Appendix A demonstrates some of the development and improvement work which has already been identified as needing to be addressed in the initial phase of improvement. This also incorporates the areas identified in our 5 areas where we compare least favourably and where we have seen the greatest deterioration in staff experience.

7.2 It is also recognised that there is a need to re-engage with staff and to allow them to become involved in the improvement work so they feel a part of the solution.

7.3 In order to maintain momentum on the improvements required the following actions will take place.

- An Improvement 'Task Force' has been set up which is Chaired by the Associate Director of Workforce Development and OD. The group is formed of representatives from across the Trust, together with the Chair of Staff Side. The focus of this group is to take an organisational wide approach, build on the work generated from the Culture and Engagement Strand of the Better, Best, Brilliant (BBB) programme and focus on improvements which should positively impact on the wider organisation. The group will report to the Executive and Board, through the Deputy CEO. The aim is that bespoke projects will be generated by the group and the model set up by 2020 will be followed. This will entail the project lead taking responsibility for a time-bound improvement initiative and reporting back to the group via a 'viva-style' presentation. The aim of this approach is that it will allow more detailed analysis of issues to be conducted initially; involve a wider pool of 'improvers'; develop skills; offer support and guidance and have timelines for pieces of work to be delivered.

- The Human Resources Business Partners (HRBPs) who work directly with the Directorates, will focus on, and drive, the local improvements required. These improvement pieces of work will be decided based on the discussions they have with directorate and departmental leads. As these projects are more discreet and departmentally focussed they will be fed back to the 'Task Force' so there is again momentum, and to ensure there is no duplication or conflicting actions. The aim of these interventions being managed locally is so, again, staff can become involved in making the changes they want to see. The Organisational and Professional Development Team (OPD) should be commissioned to support

pieces of work to assist teams in the improvements they want, and need, to make.

- The aim of this two fold approach it to develop a response to the staff survey which is more stable and covers more than a twelve month period. It also follows the Trusts improvement methodology, allows for cross service working, includes staff in improvement work, links with the Transformation Team and provides a better vehicle for governance and accountability.

- The swim chart at Appendix B sets out indicative timescales for implementation of the response and subsequent reporting

7.4 The Trust-wide results, and proposed response, will continue to be communicated to, and discussed with, staff. We aim to engender a culture where staff engagement is everyone's responsibility and it is vital that we work with managers and staff in a collaborative way.

8 CONCLUSION

8.1 The 2017 staff survey results may not be, on face value, as 'good' as the one for 2016. However, the detailed analysis and comparison of the three-year trend indicates that Medway may not be in such a poor position as the raw results describe.

8.2 However, this does not mean that the organisation can lose momentum in its quest to be 'Brilliant' and the commitment, potential, creativity and capability of our staff are central to our successful operation.

8.3 Engaged staff have a sense of personal attachment, pride and are motivated to give their best to an organisation. The action plan and interventions that we plan to develop and embed should result in a series of tangible benefits for both the organisation and the individual.

9 RECOMMENDATION

9.1 The Trust Board is asked to note the contents of this summary report and support the proposal (7.3) to focus on Trust-wide organisational and local responses in addressing the highlighted areas for improvement.

Report to the Board of Directors

APPENDIX A: INITIAL PHASE OF DEVELOPMENT

2017 Committed Areas for Development	Related Survey Questions	2016	2017	Comparator
Develop the Health and Wellbeing (H&W) agenda and support staff to ensure they take appropriate rest if unwell	My organization takes positive action on H&W I have experienced musculoskeletal problems I have come to work despite not feeling well enough	89% 24% 56%	85% 26% 58%	90% 27% 56%
Strengthen the anti-bullying (B&H) campaign and build on the work started in 2016 and further development of workplace listeners	In the last 12 months I personally experienced B&H from Managers Other Colleagues	 17% 21%	 18% 21%	 14% 19%
Promote Vision, Values and Behaviours	I get recognition for good work I get support from my immediate manager I get support from my work colleagues Values were discussed as part of my appraisal	51% 66% 82% 83%	47% 64% 80% 83%	52% 67% 81% 77%
Develop our leadership capability, focusing on improving staff communication and relationships with leaders and managers across the Trust through the continued development of leadership programmes	I am trusted to do my job My manager gives me clear feedback I am involved in deciding on changes I am able to make improvements Communication senior management and staff is effective Senior managers act on feedback	91% 59% 49% 54% 37% 30%	90% 59% 44% 50% 31% 23%	92% 60% 52% 55% 39% 31%
Increase opportunities for professional development	I received training and development My manager supported me to receive training and development	71% 93%	68% 89%	72% 91%
Introduce effective Conflict Resolution training for staff and communicate the Trust policy on zero tolerance of violence	Physical violence was reported In the last 12 months I have personally experienced from the public… physical violence B&H	67% 15% 28%	69% 14% 27%	69% 16% 29%
Devise an improved system for reporting errors, near misses and incidents.	The last time I saw an error, near miss or incident, I or a colleague report it	94%	93%	95%
Ensure all internal developmental and educational opportunities are advertised openly for all	My training helped me to stay up-to-date with professional requirements	87%	84%	88%

Report to the Board of Directors

APPENDIX B: TASKFORCE TIMESCALES

April 18 | May 18 | September 18 | December 18 | March 19

Estimated duration	1-2 weeks	6 months	2-6 months	2-4 weeks
Key activities	• Establish team-working relationships • Set priority projects • Share plan with organisation • Global communications	• Follow project improvement methodology to drive projects • Communicate with staff • Review progress via Medway Observations and feedback from staff • Communicate improvements to staff • Prepare for 2018 survey	• Launch 2018 survey • Continue to executive improvement plan	• Share results with organisation • Continue with improvement plan and refocus where necessary
Key meetings	• First taskforce meeting • HRBPs discuss with directorate leads	• Monthly taskforce meetings • Regular meetings with HRBPs and directorates	• Meetings with staff to engage with survey	• Taskforce meeting to decide key actions from 2018 survey • Workforce to share results with staff
End products	• Agreed key organisational and local improvement projects • Connect with 2016 action plans	• Improvement in staff engagement	• Continuous improvement in culture and engagement • Survey completion	• Iterative process for action plan product

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018

Agenda item 14

Title of Report	**Membership Strategy 2018/19**
Prepared By:	Sheila M Murphy
Lead Director	Sheila M Murphy
Committees or Groups who have considered this report	Council of Governors
Executive Summary	Updated Membership Strategy
Resource Implications	None
Risk and Assurance	None
Legal Implications/Regulatory Requirements	None
Improvement Plan Implication	None
Quality Impact Assessment	None
Recommendation	Note
Purpose and Actions required by the Board :	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

Membership Strategy 2018/19

Proposed and agreed by the Council of Governors:	**11 April 2018**
Approved by Trust Board:	
Review date:	April 2019

CONTENTS

MEDWAY NHS FOUNDATION TRUST

MEMBERSHIP STRATEGY

1. INTRODUCTION

This document describes Medway NHS Foundation Trust's strategy to attract, retain, engage and develop a representative and diverse membership. As a public benefit organisation we believe this type of membership will enable us to deliver better health care services that are more appropriate to a wide range of people.

Our aim is that Medway NHS Foundation Trust becomes an exemplar membership organisation and that our membership is truly reflective of our community in terms of gender, age, disability, sexuality, ethnic background and faith.

2. MEMBERSHIP

Membership of Medway NHS Foundation Trust comprises members of the Medway community, Swale Community and beyond, and Trust staff.

We believe that having a strong, active membership will mean that Medway NHS Foundation Trust will be better equipped to deliver services that are cognisant of the needs of people in Medway. This will be achieved by:

- Actively engaging with members and listening to what they have to say
- Consulting with members about important developments and changes
- Developing an effective Governing Council

Public membership is available for any individual member of the public aged 16 and over who lives in Medway, Swale or the rest of England and Wales. Members are invited to "opt in" by completing an written or electronic application form.

We are eager to involve our current and past patients and their carers and other members of our local community. We are also keen to involve those who live outside our community and who wish to become involved because they live within easy travelling distance, have some current or past connection with the Trust or may use health care services provided by the Trust.

Local Demographics

The demographics of the local population are set out below.

Medway and Swale have a younger population than average for England, but older people are now living longer and more independently. This means there will be an increasing demand for health and social care for older people and at the same time high demand for services for children and young people compared to other areas.

The population of Medway and Swale is predominantly white, being 89.64% and 96.55% respectively although ethnic minority communities are diverse and include several groups whose first language is not English.

The population of Medway is expected to reach 275,100[1] in 2017, with a growth forecast up to 237,800[1] expected by 2033. The population of Swale is expected to reach 113,100[1] in 2017 with a growth forecast up to 126,900[1] expected by 2033.

[1] Kent County Council Strategy Forecast (October 2014)

The Trust has calculated the population for Medway and Swale[1] to determine the percentage in each area. This percentage has then been set as the target percentage for the Trust's membership in Medway and Swale. The table also highlights the current membership total reached, converted to a percentage:

	Population	Percentage split of combined population	Membership as at 05/03/18	As %
Medway	218,700	68.7%	6671	79.02%
Swale	113,100	31.3%	1771	20.98%

Although the Trust's services are available to the whole of Swale, it is noted that not all Swale residents would automatically attend Medway Maritime Hospital or receive services that it provides in the community. There appears to be a natural geographical divide where residents were more likely to travel to Canterbury. It would be predominately people from Newington, Lower Halstow, Iwade, Sittingbourne and the Isle of Sheppey that would use Medway Hospital.

Staff Membership - Staff are eligible to become staff members if they have a permanent contract, a 12 month or longer fixed term contract, have an honorary contract or are employed by the Trust although they work with other NHS organisations locally. Staff will automatically become members unless they opt out.

Staff members may be disqualified on the same basis as public members. In addition a staff member may be asked to temporarily cease membership activities during any period of suspension under the Trust's code of conduct and associated staff policies and professional codes.

Corporate Membership

For other organisations such as local businesses who would like to be involved more closely with the Trust, it is likely that areas of fundraising, training and volunteering may provide appropriate opportunities to harness their interest. There is no opportunity within
Foundation Trust status to offer corporate membership.

Membership Targets

The Trust set itself a target of recruiting 10,500 members within the first three years authorised as a Foundation Trust. This target was achieved in September 2011. The absolute minimum number of public members is defined in our constitution as 400.

	Membership Totals as at 10 March 2016	**Membership Totals as at 8 February 2017**	**Membership Totals as at 15 March 2018**
Medway	6779	6902	6671
Swale	1841	1864	1771
Rest of England & Wales	2272	2359	2249
Public	10 892	11125	
Staff		4411	4452
Total		15,536	15,143

A cleanse of the membership database was undertaken in 2018 to remove people who no longer wished to be a member. This has resulted in a small drop in numbers. We therefore need to maintain our efforts to recruit new members.

In order to ensure the public membership is representative of the population it serves, the information provided below detailed targets within each constituency based on gender, age and ethnicity, together with details of current membership percentages for those who disclosed the relevant information. The ethnicity targets are based on the 2011 Census data (27/3/2011) from the Office of National Statistics (ONS) © Crown Copyright. The gender and age targets are based on 2017 forecasted population data provided by Kent County Council Strategy Forecast (2014):

Medway Constituency

Gender	Target	Current Membership - As at 15/03/2018
Male	49.38%	29.43%
Female	50.62%	68.33%
Unknown		2.24%
Age	**Target**	**Current Membership - As at 15/03/2018**
16	1.56%	0.03%
17-21	7.89%	1.45%
22 – 30	90.51%	12.91%
31- 40		9.95%
41 - 50		10.72%
51 - 60		11%
61 - 70		11.27%
71 - 80		10.99%
81 – 90		5.77%
91+		0.55%
Unknown		25.36%
Ethnicity	**Target**	**Current Membership - As at 15/03/2018**
White	89.64%	69.54%
Mixed	1.96%	1.09%
Asian or Asian British	5.16%	4.74%
Black or Black British	2.52%	3.42%
Other Ethnic Groups	0.72%	0.28%
Unknown		20.93%

Swale Constituency

Gender	Target	Current Membership - As at 15/03/2018
Male	49.02%	33.09%
Female	50.98%	64.88%
Unknown		2.03%
Age	**Target**	**Current Membership - As at 15/03/2018**
16	1.51%	0.08%
17-21	6.83%	0.79%
22 – 30	91.67%	6.38%
31- 40		8.98%
41 - 50		13.33%
51 - 60		12.25%
61 - 70		14.17%
71 - 80		16.09%
81 – 90		6.88%
91+		0.39%
Unknown		20.66%
Ethnicity	**Target**	**Current Membership - As at 15/03/2018**
White	96.55%	79.05%
Mixed	1.16%	0.68%
Asian or Asian British	1.10%	1.19%
Black or Black British	1.03%	1.52%
Other Ethnic Groups	0.16%	0.06%
Unknown		17.5%

The details above highlight that further recruitment is required in various categories and the aim will be to improve the diversity of the public membrship over the next 12 months.

Whilst the Trust has not set a target for the Rest of England and Wales constituency, the membership figures are also analysed and recorded. The percentages listed below are based on the total public membership across all three public constituencies, where the relevant information has been disclosed:

Rest of England and Wales Constituency

Gender	**Current Membership - As at 15/03/2018**
Male	29.21%
Female	61.18%
Unknown	9.61%
Age	**Current Membership - As at 15/03/2018**
16	0%
17-21	1.65%
22 – 30	19.48%
31- 40	9.25%
41 - 50	9.16%
51 - 60	7.6%
61 - 70	6.09%
71 - 80	4.67%
81 – 90	1.56%
91+	0.18%
Unknown	40.36%
Ethnicity	**Current Membership - As at 15/03/2018**
White	49.31%
Mixed	1.82%
Asian or Asian British	7.96%
Black or Black British	6.09%
Other Ethnic Groups	0.53%
Unknown	34.29%

The **Council of Governors** consists of 14 public (9 from Medway, 4 Swale, 1 rest of England and Wales), 5 staff and 6 partner governors. Staff representatives may be disqualified on the same basis as public members or have their membership temporarily suspended during any period of formal suspension under the Trust's code of conduct and associated staff policies and professional codes.

The 4 places on the Council of Governors for partner organisations comprise:

- Local Authority (represented by a member of the Medway Health and Wellbeing Board) x 1
- Local Authority (represented by a member of the Kent Health and Wellbeing Board) x 1
- Charities x 1 (seat currently represented by Medway Hospital League of Friends)
- Universities of Medway x 3

3. MEMBERSHIP RECRUITMENT

Our aim is to recruit a wide range of members, which represent the local community which the Trust serves. We do this by:

- Raising awareness of membership in all the qualifying communities within Medway and Swale
- Providing a simple, accessible and publicised process for becoming a member
- Ensuring that the composition of the membership reflects the diversity of the local communities
- Recognising and using members as a valuable resource
- Developing both external and internal publications to promote membership
- Targeting recruitment at specific groups or areas, for example, community groups, education institutions
- Displaying leaflets and application forms in areas of the hospital that have the greatest footfall

- High profile advertisement on site and on the Trust's internet
- Engaging staff and volunteers in recruiting public members
- Engaging health economy partner organisations
- Using local media to promote the campaign
- Developing the Trust's electronic interface with the public e.g. pop up reminders
- Holding membership recruitment drives by Governors in the Hospital foyer and across Swale.

The recruitment and engagement plan is attached as appendix A.

4. ENGAGING MEMBERS

We aim to focus on the quality and level of involvement of our members. We acknowledge that members will desire different levels of involvement, depending on their needs and reason they became members. It is important to ascertain at the outset what these levels of involvement are likely to be and to regularly check this is as members' circumstances change. Early information is collected via the membership application form.

The Trust also distributes a quarterly newspaper called News@Medway which is available for people and members to pick up at from newsstands at various locations within Medway Hospital as well as at Medway Council Hubs. The newspaper is also available electronically on the Trust's website and members who have registerd to receive e-communications from the Trust receive notification of each News@Medway edition as well as a regular e-bulletin from the Trust Chairman.

The Annual General Meeting provides an opportunity for members to meet governors (their representatives) and senior staff of the Trust. It provides a good opportunity for the Foundation Trust to market itself to increase membership.

Members' Meetings also take place at least six times a year, the purpose of which is to inform, consult and engage with members.

The Trust issues a **membership card** on which key information about the Trust is provided. The intention here is to promote a sense of belonging. In addition, from time to time the Trust holds member **focus groups** on particular issues.

We have developed a members' section on the main website www.medway.nhs.uk via which members are able to make comments and ask questions.

Members are required to abide by the Trust's code of conduct and public service values. Members may be disqualified if:

- They have perpetrated a serious incident or violence in the past five years, towards any hospital or healthcare facilities or against any of the Trust's staff, Non Executive Directors, Council of Governors, in accordance with the relevant Trust's policy for withholding treatment from violent/aggressive behaviour
- They have been confirmed as a "persistant complainant" in accordance with the relevant Trust's policy
- Breached the Trust's code of conduct

5. MEMBERSHIP DEVELOPMENT

A detailed membership development strategy is outlined below:

- To increase the quality and level of participation in the Medway NHS Foundation Trust's democratic structures to enable the Trust to achieve its objectives and to ensure good governance.
- To increase the number of active, informed members who are representative of the local communities.
- To encourage more members to stand for election to the Medway NHS Foundation Trust Council of Governors.
- To adopt electoral processes which encourage the participation of all active members.
- To strive for the Medway NHS Foundation Trust Membership and Council of Governors to be diverse in their composition.
- To ensure the culture of membership is attractive to potential new generations of activists.

- To enable elected representatives to fulfil their designated roles and responsibilities and facilitate their participation in influencing decisions.
- To foster a partnership approach between members and management to encourage constructive working relationships and dialogue.
- To provide appropriate learning and development opportunities to members to facilitate their fulfilment of their roles and responsibilities.
- To provide appropriate learning and development opportunities to employees to further their understanding of the NHS Foundation Trust's values and principles as a public benefit corporation and membership organisation.

6. MANAGING THE MEMBERSHIP

The Trust has a responsibility to communicate with members. To this end the Trust and its Council of Governors will champion and promote membership as widely as possible.

Resourcing the Membership Strategy
We need to adequately resource our membership function and to ensure that it is appropriately integrated with the organisation. This requires a commitment to providing membership services over the long term, developing them as required and supporting skills development.

Appendix A

Medway NHS Foundation Trust
Membership Recruitment and Engagement Plan

Aim	Action	Lead	Timescales
Increase membership, particularly in underrepresented categories	• Design and deliver at least 4 members' events per year in response to current issues, including the an event on the quality accounts. • Explore venues which are consistent with underrepresented categories • Invite membership via advert on the Trust's website	Trust Secretary	Ongoing
Engage members in Medway NHS FT's annual plan and activities	• Produce and deliver News@Medway via collection points and email • Produce and deliver regular e-bulletins • Provide information via the Trust's website • Engagement at the regular members' events • Promote participation in the annual Governor elections • Invite members to participate in in-house focus groups or committees, as appropriate.	Communications Team/Trust Secretary	Ongoing
Ensure that the Council of Governors' development needs are identified and addressed as part of an annual development plan	• Coordinate and facilitate an induction programme for new Governors	Trust Secretary	Annual

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 27/04/2018

Report to:	**Trust Board**	**Date of meeting: 3 May 2018**		**1**
Presented by:	**Jon Billings** **Non-executive Director**	**Prepared by:**	**Jon Billings** **Chair, Quality Assurance Committee**	
	The papers and full minutes will be available to review on BoardPad			

Matters for escalation or highlighting	• The QAC received proposals for an updated quality dashboard to replace IQPR. Following discussion, QAC agreed the proposed set of metrics with some amendments. It also agreed the principle that the report should move away from RAG 'traffic-light' format in favour of statistical process controls charts showing variation over time within agreed limits. • QAC noted that while still within expect limits at 107.6, the HSMR has shown an upward trend over recent months. This has been acknowledged by the Mortality Committee, and although not considered to be due to concerns about clinical care, it will be kept under close review. • The QAC received and discussed a draft submission on the Maternity CNST Safety Actions. Given the timescales for submission, it is proposed this will circulated to QAC out of committee for review and signed off on behalf of the Board by chair's action subject to advice from the co-directors of quality.
Other matters considered by the committee:	• IQPR – including an update on Duty of Candour governance and performance • Quality Priorities for Quality Account • Report from QIG • Mortality dashboard • Directorate Assurance Reports • 2018/2019 programme of work
Key decisions made/ actions identified:	• New Quality Dashboard to be adopted from June 2018 • HSMR drivers to be kept under close review by Mortality Committee and any findings reported to QAC
Risks:	• The key quality and safety risks on the risk register mainly relate

	to workforce – there will be a regular focus on this at the QAC from now on.
Assurance:	Forward was programme agreed subject to a few amendments. Directorate and programme assurance reports will be standardised and full leadership teams will present these to the QAC in future. Ward and department visits by QAC will be coordinated to align with cycle of assurance reports.

Key Issues Report

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Integrated Audit Committee held on 22/02/2018

Report to:	**Board of Directors**	**Date of meeting:**	**01/03/2018**
Presented by:	**Mark Spragg. Chair Integrated Audit Committee**	**Prepared by:**	**Tracey Cotterill. Director of Finance & Bus Svcs**

1

Matters for escalation

1. The committee considered the going concern declaration for the annual report and accounts and felt that it would be sensible to seek expert advice to ensure that the Directors were able to make the appropriate statements regarding going concern, reflecting the financial position and the organisational risk.
2. The Information Governance toolkit requires 95% of staff to be IG trained in order to be compliant. The Trust is working with staff to reach this target.
3. Terms of reference were agreed at the committee and will be included in the next Board papers.

Other matters considered by the group:

1. Audit reports were received on Cyber Security (Amber/Green rating), Information Governance Toolkit (Amber/Green rating) and Temporary Staffing (Amber/Red rating). The committee asked for future updates on the trends in adherence to procedures for temporary staffing, recognising the proportion of spend in this area.
2. Progress against the Internal Audit plan was reviewed.
3. Progress against the Local Counter Fraud Services Plan was reviewed. It was noted that the guidance on new standards has been released with only minor changes. This will inform the self-assessment toolkit which is expected imminently. There was an update on cases currently in progress.
4. External Auditors presented the sector development update. It was noted that the Audit report will include more information on use of resources and value for money (vfm) and the Trust performance scores adversely in all the areas. There was considerable discussion about context for the performance, not just relying on deficit to determine vfm.
5. Terms of reference for the committee were considered and approved.
6. Losses & Special Payments for the period 1st November 2017 to 31st January 2018 were presented.

	7. The single tender waivers report was presented for information, and is extended in compliance with the SFIs to report on direct awards from the framework. It was noted that the spend on STWs has increased recently, and the committee were assured that the controls were in place. 8. The quarterly declaration of gifts and hospitality was presented. 9. The reference cost methodology was approved, noting that there is a substantial change for 2017/18 collection to PLICs approach. This will be compulsory from 2018/19 but the Trust has decided to use the 2017/18 collection for its first submission. 10. AOB – item raised re IFRS 16 – lease accounting, and ensuring that any investment decisions reflected on changes 11. AOB – whistleblowing – it was noted that one of the NEDs has been asked to take on this responsibility following the departure of the previous lead, Jan Stephens.
Key decisions made/ actions identified:	1. Approved the proposed approach for the calculation of reference costs. 2. Approved the terms of reference for the committee
Risks:	The risks associated with all items on the agenda were considered, and in particular the risks relating to temporary staffing processes, going concern and value for money in the Audit statement.
Assurance:	Assurance was provided on; 1. Expenditure on waivers and framework awards is being appropriately managed and controlled to minimize risk of fraud. 2. The Cyber Security control framework audit showed that the Trust has appropriate processes in place 3. Information Governance Toolkit audit provided assurance on the design and operation of IG controls in place to support the 17/18 self-assessment. 4. Improvements have been made in the control of temporary staffing expenditure, and further enhancements to controls are planned.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Finance Committee held on 29/03/2018

Report to:	**Board of Directors**	**Date of meeting:**	**03/05/2018**	**1**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tracey Cotterill, Director of Finance**	

Matters for escalation

1. The draft annual plan was submitted on 8th March but as yet there has been no feedback from NHSI.
2. Going Concern. The committee reviewed the proposed going concern statements for inclusion within the Annual Report and Accounts. The draft will be reviewed at the Board meeting in May.
3. The forecast outturn remains unchanged at M11 as the determination was received after the month end was reported to NHSI. There is some risk to the forecast outturn position as a result. There are 6 further items being considered under the expert determination.
4. The draft STP budget for 2018/19 was discussed and this will be presented to Board for consideration.

Matters considered by the group:

5. The standard reporting pack was presented and the included activity information was considered – it was agreed to include previous year information for comparison going forward.

   Key items brought to the committees attention included:

   - Forecast remains as reported at M10, noting that the report was prepared prior to the results of the first expert determination.
   - Cash – whilst at the end of February the cash position was still challenging, additional revenue support has been received in March.
   - It was also noted that the large loan due for repayment in March 18 had been rolled forward for a further year. It was agreed that there would be a new appendix included in the pack for schedule of loans.
   - The Better Payment Practice Code is a new addition to the pack, and now that the cash position is improving, we should see better performance against the 30 day terms.
   - Creditor days were still struggling in February, but there has been a focus on utilisation of the additional cash receipt to settle the aged balances in March.

- Debtors analysis has been expanded to show aged debt by year, and a further paper is in the pack to consider bad debt write off and provision.
- CIPs are forecast to deliver £7m against the plan of £12.6m

6. Contract performance was discussed, particularly in relation to challenges and the expert determination. The first expert determination found in favour of the CCG based on contractual notice, but noted that in their opinion the CCG were aware, and that the Trust should now serve a service variation for the new specification to the CCG, which could be effected during 18/19 as there is no requirement for cost neutrality on service variation. If the CCG reject the proposed pathway then the Trust will need to ask them to provide an alternative specification.
7. It was noted that the current contract is a 2 year contract, and therefore 18/19 changes could only be effected by a contract variation.
8. STP. The committee was updated on the back office shared services plans. The anticipated financial contribution of £296k for 2018/19 was discussed, and the committee noted the Board's previous concerns to achieve return on investment.
9. The committee discussed the new accounting standard for provision for doubtful debts. A paper was presented which highlighted the planned approach to bad debt write off and bad debt provision for the year end, and that this is consistent with the approach adopted and approved by the auditors for 2016/17 year end. It was noted that from 1st April the new standard would apply and the provision would then need to increase. This will be in agreement with the External Auditors, and the Trust will adopt the methodology within the Government Accounting Manual.
10. The proposed bad debt provisions and write offs will lead to £1.5m impact on the financial position, but this has been partially offset by reductions achieved in negotiating creditor balances and review of accruals.
11. The committee was updated on the ED build. Phase 1 is due to complete during April. The committee was advised that there had been a meeting with IHP earlier in the week attended by clinical staff. The phasing was discussed at the meeting and a revised programme agreed which would enable the Trust to opt for a pause in the build over the Winter period if required. The new phasing will ensure that the current number of beds is maintained throughout, and that the option to temporarily go to full capacity of 54 spaces next Winter was available.
12. North Kent Pathology Service update received and noted that staff TUPE'd across to NKPS on 28th February and the joint venture partner contracts have now been signed.
13. Procurement performance was reviewed. It was noted that the KPIs

	for the national dashboard are changing, and these will be reflected within the next report. 14. Board Assurance Framework – The risk relating to cash was changed. It was advised that the risks relating to 17/18 would be closed and new risks opened relating to 18/19. 15. AOB – The committee entered private session to consider the papers on Going Concern and the draft Annual Plan for 2018/19.
Risks:	16. The Income position contains a number of risks including the outcome of arbitration and the challenges being raised by the commissioner. This could also impact income plans for 2018/19 17. Risks for 2017/18 will need to be closed over coming weeks, and new risks opened for 2018/19. 18. Planning for 2018/19 – no feedback has yet been received from NHSI on the draft plan submitted on 8th March 2018. 19. The implications of adopting the Going Concern concept for the annual report and accounts needs to be understood by Board members.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Finance Committee held on 26/04/2018

Report to:	**Board of Directors**	**Date of meeting:**	**03/05/2018**	**1**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tracey Cotterill, Director of Finance**	

Matters for escalation

1. Feedback from the regulator on the draft annual plan submitted on 8th March was discussed. The proposed revision to the plan was discussed and the committee endorsed increasing the CIP plan by £6m to give a planned deficit of £46.8m for 18/19.
2. The outturn pre STF was adverse to the revised forecast by £8m, in part due to the Expert Determination outcome, and in part due to further pressures on pay costs.
3. The draft STP budget for 2018/19 was discussed and this will be presented to Board for consideration.
4. Radiology business case for equipment replacement was approved.
5. ED development was discussed and it was noted that there has been further delay to the completion of phase 1.
6. In private session the committee recommended the Board approve the loan resolution.

Matters considered by the group:

7. The standard reporting pack was presented and the included activity information was considered – it was noted that the detailed activity information would be expanding into the directorate elements of the report.

   Key items brought to the committees attention included:

   - Outturn was adverse to the M9 reforecast by £8m, noting that the report was prepared prior to the completion of the draft annual accounts so slight changes to the numbers.
   - Additional STF in the amount of £1.8m was awarded to the Trust on 20th March 18, bringing total STF to £4.2m.
   - There was considerable discussion around forecasting and assurance of controls at directorate level where programmes are adverse to plan.
   - The committee was updated on the latest grip and control measures on bank and agency bookings and daily reporting on bookings.
   - Discussion followed regarding the balance sheet, and it was noted that the revaluation of the estate had increased the

asset value and revaluation reserve by £12m. This meant the Trust ended the year with a negative balance sheet in the amount of £9m.

- Cash – it was noted that a higher balance is required at month end to meet the payments that will fall due in the first 2 weeks until the contractual payment is due from the CCG.
- Debtors and Creditors balances were both improved when measured against the opening balance.
- CIPs delivered £7m against the plan of £12.6m

8. Contract performance was discussed, particularly in relation to challenges and the expert determination. There were 6 further items considered under the expert determination and the outcome of those was applied to 17/18 contract. The CCG and Trust have agreed a final position for 17/18. The Committee wanted to express its thanks to the Finance and BI team for their work on this.
9. STP. The committee was updated on the back office shared services plans. The anticipated financial contribution of £396k for 2018/19 was discussed, and the committee noted return on investment information provided by the productivity workstream.
10. It was noted that the 18/19 CCG contract had been agreed with a block arrangement for the year.
11. The feedback on the draft plan was considered and the impact of adding a £6m stretch target to improve the planned deficit was discussed. It was noted that the 17/18 outturn pre STF is £66m, the draft plan was for a deficit of £53m, the revised plan proposed is for a deficit of £47m, based on increasing the CIP plan from £15m to £21m.
12. The committee was updated on the ED build and the continued delays to completion of phase 1.
13. Procurement performance was reviewed and there was discussion re the introduction of tail end management and standardization of products.
14. Board Assurance Framework –It was advised that the risks relating to 17/18 would be closed and new risks opened relating to 18/19.
15. AOB – The committee entered private session to consider the board resolution for delegated authority to draw loans in 2018/19.

Risks:

16. Risks for 2017/18 will need to be closed over coming weeks, and new risks opened for 2018/19.
17. Planning for 2018/19 – Increased CIP target creates a risk to delivery of the plan.