

Agenda

Public Meeting of the Trust Board

Date: On 03 August 2017 at 12.30pm – 3.00pm

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

Item	Subject	Presenter	Time	Action
1.	Presentation	Dr Priya Krishnan	12.30pm	Discuss
Opening of the Meeting				
2.	Chair’s Welcome	Chairman	1.00pm	Note
3.	Quorum	Chairman		Note
4.	Register of Interests	Chairman		Note
Meeting Administration				
5.	Minutes of the previous meeting held on 6 July 2017	Chairman	1.05pm	Approve
6.	Matters Arising Action Log	Chairman		Note
Main Business				
7.	Chair’s Report	Chairman	1.10pm	Note
8.	Chief Executive’s Report	Chief Executive	1.15pm	Note
9.	Strategy	Chief Executive	1.25pm	Note
	a) STP Update b) Trust Improvement Plan	20-20		Discussion
10.	Quality	Executive Director of Nursing	1.35pm	Discussion
	a) IQPD b) Safeguarding Adults and Children’s Report			
11.	Performance	Director of Finance	1.55pm	Discussion
	a) Finance Report b) Communications Report	Director of Communications		Discussion

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12.	Governance a) Board Assurance Framework b) Corporate Governance Report	Director of Corporate Governance, Compliance, Legal & Risk	2.15pm	Assurance
13.	People a) Workforce Report b) WRES Report	Director of HR & OD	2.25pm	Assurance
For Approval				
14.	Conflicts of Interest Policy	Trust Secretary	2.40pm	Approval
Reports from Board Committees				
15.	Quality Assurance Committee Report	QAC Chair	2.50pm	Assurance
AOB				
16.	Council of Governors' Update	Governor Representative	2.55pm	Discussion
17.	Any other business	Chairman		Note
18.	Questions from members of the public relating to the Agenda	Chairman		Discussion
Close of Meeting				
19.	Date and time of next meeting: 7 September 2017 Boardroom, Post Graduate Centre, Medway NHS Foundation Trust			

MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Jon Billings Non-Executive Director	<ul style="list-style-type: none"> • Director of Fenestra Consulting Limited • Associate of Healthskills Limited • Associate of FMLM Solutions
2.	Ewan Carmichael Non-Executive Director	<ul style="list-style-type: none"> • Timepathfinders Ltd • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chair of the Medway NHS Foundation Trust Quality Assurance Committee
3.	Stephen Clark Chair	<ul style="list-style-type: none"> • Pro-Chancellor and chair of Governors Canterbury Christ Church University • Deputy Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Business mentor Leadership Exchange Scheme with Metropolitan Police • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chairman of the Medway NHS Foundation Trust • Access Bank UK Limited – Non Executive Director
4.	James Devine Director of HR & OD	<ul style="list-style-type: none"> • Member of the London Board for the Healthcare People Management Association
5.	Lesley Dwyer Chief Executive	<ul style="list-style-type: none"> • Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
6.	Diana Hamilton-Fairley Medical Director	<ul style="list-style-type: none"> • Director of Education Transformation at Guy's and St. Thomas' Hospitals NHS FT • Member of London Clinical Senate Council • Elected Fellows Representative for London South for RCOG • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
7.	Anthony Moore Non-Executive Director	<ul style="list-style-type: none"> • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chair of the Medway NHS Foundation Trust Finance Committee
8.	Joanne Palmer Non-Executive Director	<ul style="list-style-type: none"> • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Director of Lloyds Bank (Fountainbridge 1) Limited • Director of Lloyds Bank (Fountainbridge 2) Limited • Director of Halifax Premises Limited • Director of Gresham Nominee1 Limited

		<ul style="list-style-type: none"> • Director of 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 Target Corporate Services Limited
9.	Karen Rule Director of Nursing	<ul style="list-style-type: none"> • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Mark Spragg Non-Executive Director	<ul style="list-style-type: none"> • Trustee for the Marcela Trust • Trustee of the Sisi & Savita Charitable Trust • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Director of Mark Spragg Limited
11.	Tracey Cotterill Director of Finance	<ul style="list-style-type: none"> • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.

Meeting in Public

Board of Directors Meeting in Public on 06/07/2017 held at Maidstone Suite, Bridgewood Manor Hotel, Walderslade Woods, Chatham

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Mrs T Cotterill	Director of Finance and Business Services	TC
	Mr J Devine	Director of HR & OD	JD
	Mr T Moore	Non-Executive Director	TM
	Mrs J Palmer	Non-Executive Director (part meeting)	JP
	Mrs K Rule	Director of Nursing	KR
	Mr M Spragg	Non-Executive Director	MS
	Mrs J Stephens	Non-Executive Director	JS
	Dr D Hamilton-Fairley	Medical Director	DHF
Attendees:	Ms G Alexander	Director of Communications	GA
	Mrs L Stuart	Director of Corporate Governance, Risk, Compliance & Legal	LS
	Mr C Bradley	Director, 20/20 Delivery (item 9c only)	CB
	Ms K McIntyre	Co-Director of Clinical Operations Families & Clinical Support Services (FCSS) Directorate	KM
	Mr J Lowell	Director of Clinical Operations, Acute and Continuing Care Directorate	JL
	Mr. A Lindsay	Co-Director of Clinical Operations - FCSS Directorate	AL
	Ms N Meadows	Assistant Company Secretary	NM
	Dr. K Mukherjee	Deputy Medical Director (item 15 only)	KM
	Mrs. Stella Dick	Lead Governor	SD
	Mrs. Vivien Bouttell	Governor Board Representative	VB
Apologies:	Mr. Ewan Carmichael	Non-Executive Director	EC
	Mr. Ben Stevens	Director of Clinical Operations, Co-ordinated	BS

		Surgical Directorate	
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Items were taken out of order but the minutes correspond to the agenda

1 Welcome and Apologies for Absence

- 1.1 The Chairman welcomed everyone to the meeting. Apologies were noted as detailed above.

2 Quorum

- 2.1 The Chairman confirmed that a quorum was present.

3 Register of Interests

- 3.1 The Board noted the register of interests.

4 Minutes of the Previous Meeting

- 4.1 The minutes of the meeting held on 1 June 2017 were **APPROVED** as a true and accurate account of the meeting subject to a minor amendment.

5 Matters Arising – Action Log

- 5.1 The Board of Directors **RECEIVED** the Action Log and the following changes and updates were noted:
- 0376 – KN advised that a report on incidents resulting in death would go to the Quality Assurance Committee later in the month and subsequently provided to Board;
- 0377 – Action closed;
- 0382 – Action closed;
- 0383 – Action closed;
- 0384 – Action closed;
- 0385 and 0386 – It was noted that these queries were raised by a governor and that TC needed to respond directly to the governor before the actions could be closed.

6 Chair's Report

- 6.1 The Chairman notified the Board of recent steps taken by the Trust following the tragic fire at Grenfell Tower in London. SC stated that, following requests for information and instructions from NHS Improvement, the Kent Fire and Rescue Service were invited to carry out a review and the Trust had promptly provided NHS Improvement with responses to their enquiries.

6.2 SC noted that further to the above, the Trust ordered an independent review of the building by engineering experts. Samples of the cladding on the building, including on the new ED extension were assessed with positive conclusions made. SC advised that risks were being mitigated by increased vigilance and fire safety training.

6.3 SC commented that work on fire safety will continue relentlessly in the Trust.

7 Chief Executive's Report

7.1 The Chief Executive presented her report which was taken as read. The following points were highlighted:

- The Trust improvement plan covers other priorities and last month the workforce and digital daily huddles were launched. The workforce huddles focus on staffing gaps particularly over the weekend while the focus of the digital huddles is on the use of the ExtraMed system to speed up the discharge process;
- The positive feedback from the successful staff engagement event on 21 June which focused on better workforce involvement with the improvement plan;
- The successful reserves day event on 21 June;
- The visit from the improvement team at Kings College Hospital on 22 June to learn from the Trust's experience of improving flow;
- The three week visit of Professor Clifford Hughes who acted as a Quality Care Advisor and his feedback that since his last visit in 2016 he had noticed a different "feel" on the wards which was more "can do" and positive;
- Glenn Douglas had been appointed as Chief Executive of the Kent and Medway Sustainability and Transformation Partnership (STP), and a transformation commissioning lead is still to be appointed. LD had chaired the delivery board for Medway, North and West Kent on 16 June;
- The NHS Providers Quality Conference on 20 June, which was an interesting event during which LD had the privilege of sharing the Trust's improvement journey.

7.2 LD expressed her gratitude to JD who stood in for her as Acting Chief Executive during her recent period of annual leave.

8 Strategy

STP Update

Kent and Medway Service Models and Hurdle Criteria

8.1 LD noted the Kent and Medway Service Models and Hurdle Criteria that had been developed through the STP and was now being brought into the public domain.

8.2 DHF noted that the bundle was to show the methodology used by the STP for decision making.

- 8.3 DHF advised that the service models and hurdle criteria were:
- i. Local care model
 - ii. Emergency department service delivery board
 - iii. Acute medical services delivery model
 - iv. Stroke service delivery model
 - v. Elective orthopaedic service delivery model
 - vi. Urgent care/elective orthopaedics and stroke hurdle criteria
- 8.4 DHF stated that it is envisaged that public consultation will take place in two waves with the first services to be consulted on being ii, iii and v above. The next step will then be to agree a long list of options against each of the above services and to apply a filtering criteria to develop a shortlist of options which will then be evaluated using the full evaluation criteria.
- 8.5 DHF noted that the STP partner organisations were asked to consider the contents of the bundle and support the service models and the hurdle criteria that will be used to assess the long list of options. She noted that the methodology had been tested and has got support.
- 8.6 Following a concern raised by JB that the status quo needed to be described first before going to the future, DHF confirmed that the case for change was published last year and so there had been a description of the current position.
- 8.7 DHF having satisfactorily responded to further queries raised, SC commented that there was evident confidence in the models and the Board was therefore asked to support the direction of travel.
- 8.8 The Board endorsed the proposals.

Trust Improvement Plan

- 8.9 DC provided an update to the Board on the progress made so far in relation to the Improvement Programme, describing the positive changes and feedback from staff.
- 8.10 DC stated that the Improvement Programme began by focusing on flow to improve ED performance and it was shown that 4 hour performance improved immediately and significantly. DC commented that though in the last month performance was lower than in the early weeks attributable to higher attendances, a 7% increase in performance was still recorded.
- 8.11 DC noted that patients now wait less time from triage to different stages of treatment. DC stated that there was now a significantly lower time in ED as time between Decision to Admit (DTA) and leaving ED had reduced greatly. DC also noted that capacity had increased since the reclaiming of the Sunderland Day Care Centre.

- 8.12 In relation to how the progress made so far could be sustained, DC noted that there was effective devolved responsibility in the organisation with development of standard operating procedures produced to support this. There are systems and processes in place capturing challenges and these are immediately addressed.
- 8.13 DC added that feedback from staff is positive with a “can do” attitude prevailing.
- 8.14 Following a question in relation to referrals triaged to MedOCC which are sometimes bounced back, JL confirmed that complaints in this area had reduced significantly. JL added that all the complaints were being investigated to see if there were any particular problems but the evidence to date did not suggest inappropriate streaming to MedOCC. MS commended the team for the good results but queried if this was at the expense of resources being deployed elsewhere. DC confirmed that decisions are made in terms of resources, explaining that the assessment unit and leadership are directly involved in the change programme. DHF added that there are additional surgical bed spaces which allow for more elective surgeries now.
- 8.15 TC drew the Board’s attention to the need for the financial impact of the focus on patient flow to be evaluated. She noted that a report was going to the Finance Committee regarding the financial implication of the revised flow. SC commented that this is a challenge that the Trust must rise up to as the Trust cannot be seen to be going backwards.
- 8.16 CB informed the Board that the workforce and digital workstreams started in June. He explained that the workforce huddles focus on staffing gaps, particularly over the weekend, while the digital work is targeted at the use of the ExtraMed system to speed up the discharge process and for bed planning. CB noted that the next focus would be on financial improvement.
- 8.17 2020 was acknowledged for the progress made on patient flow. SC advised that the transformational attitude should be maintained.
- 8.18 JP left the meeting.

9 Quality

Integrated Quality and Performance Dashboard

- 9.1 The report and dashboard for May performance was taken as read. KR noted that continued improvement is demonstrated. She noted that the HSMR data was within benchmark limits and that mixed sex accommodation breaches had decreased adding that the Trust was currently working with NHSI on the criteria for single sex accommodation.
- 9.2 In relation to complaints, KR stated that there are discussions at Performance Review Meetings to ensure that complaints are responded to promptly and performance had significantly improved in recent months.

- 9.3 KR noted that the data issues regarding infection control had been corrected. KR confirmed that there were 6 post infection reviews in June. KR referred to the death of a patient in 2015 after the ingestion of hand gels and the review undertaken in March 2017 in relation to this. KR provided assurances that hand gels are now safely stored.
- 9.4 Following a query by LD regarding the duty of candour data, DHF confirmed that the data was incorrect as it is ensured that patients are spoken to in addition to completing the relevant form. It was noted that work was being done to get better compliance and that a new policy for mortality would be brought to the Board in September.
- 9.5 KR noted that there had been an increase in the number of falls with no or low harm in the month of May compared to April. Following a concern raised by JS on the need to share more information on CQUINs, TC confirmed that a report to go to the Finance Committee was being worked on.
- 9.6 Referral to Treatment Time (RTT) performance had seen an increase in performance at 88% and is above the revised trajectory of 79.6%. AL advised that although there was a slight increase in 52 week waits, all patients had plans in place and clinical harm reviews were undertaken to ensure there was no harm. AL advised that specific action plans were in place for specialty problem areas.
- 9.7 AL advised that cancer targets had not all been achieved due to a consultant vacancy which has now been filled. He confirmed that there is a significant improvement now. AL stated that following a slight improvement on the 62 day GP Referrals for Urology and Lower GI, NHSI confirmed that the Trust had met the required standard.
- 9.8 AL noted that diagnostic wait to test patients within 6 weeks continues to improve as procedures causing a slow pace are being reviewed. LD added that the framework within which this is managed is better now. Following a concern raised by TM on RTT, DHF explained that RTT is being pushed although the data reported is always behind.

10 Performance

Finance Report

- 10.1 The Board noted the report. TC stated that the report was in line with the planned deficit, however clinical income levels for Month 2 were below expectation based on 2017/18 planning. TC explained that income trajectory is to be reported better in Month 3. TC noted that activity was slightly down and this resulted in an increased pressure on cash. TC explained that work was being done to identify additional opportunities to generate income.

- 10.2 TC noted that at month 2, Cost Improvement Plan (CIP) delivery was behind plan. TC explained that actions were already being taken to improve this through identifying schemes, efficiency areas, Carter metrics and partnering with a local Trust not in deficit so as to learn from them. 20/20 resource would also be deployed to support this.
- 10.3 TC informed the Board that creditors were pushing as payments were not going through quickly enough. She explained that this situation was being managed.

Communications Report

- 10.4 The Board noted the report. GA provided an update on internal and external communications and engagement activity.
- 10.5 GA made reference to the staff engagement workshop and the successful briefing sessions. GA explained that the workshop included an overview of the improvement plan and progress on flow in particular. In an interactive session where staff were asked how it had felt in the last few weeks, results gave a clear impression that making improvements is more achievable now than in the past.
- 10.6 GA noted that further communications such as written, electronic, blogs, videos, animation and face-to-face on improvement plan progress and specific workstreams was being planned.
- 10.7 GA noted that the team makes the most of every contact locally and regionally in promoting the good works of the Trust, through meetings, interviews etc. and this had been positive.
- 10.8 To reach a wider audience, GA noted that the next Meet the Governor coffee morning is being planned to take place outside of the hospital. She noted that this was a good step as messages are taken out to people rather than expecting people to come to the Trust.
- 10.9 GA informed the Board that the team is in discussion with Medway and Swale CCGs and local authorities to ensure local people have a chance to get involved in discussions about the future of health and social care across Kent and Medway as part of the STP. SC added that the communications engagement working group meets regularly to discuss what needs to be on the STP. It was also noted that case for change and hospital workstreams are also considered.

11 Governance

Corporate Governance Report

- 11.1 The paper which provided a brief overview of corporate governance activity and issues arising was taken as read.
- 11.2 LS made reference to the table of corporate policies and the few that still required review and approval. LS advised that the standard of business conduct policy had

been redrafted as a conflict of interest policy and that talks were underway with HR regarding the integration of the recent NHS England statutory guidance on conflicts of interest requirements into the recruitment and data collection process. LS explained that the policy needed to be approved as a primary step and thereafter engagement and communication with staff needed to follow and that it was likely to take 6 to 12 months to fully embed the policy effectively as there had been an absence of training, induction and communications on conflicts of interest for a considerable period of time.

11.3 LS reported that the recently developed corporate governance dashboard was being embedded well in clinical directorates and corporate functions and was featuring on the relevant meeting agendas.

11.4 Following a query by TM in relation to IG breaches under investigation, LS confirmed that the investigations are undertaken quickly as HR support to the process was strong and the Information Commissioner's Office (ICO) had been assured that the Trust had responded appropriately and proportionately to recent serious breaches.

Board Assurance Framework (BAF)

11.5 The Board noted the report. On the methodology and approach to the BAF, LS noted that guidance was provided by both the Department of Health and HM Treasury and the Trust's BAF complied with the guidance.

11.6 LS advised that the BAF was recently audited by KPMG as part of their review of the Trust's risk management and internal control framework and was commended with KPMG noting that deficiencies identified in 2015 had been resolved.

11.7 JD explained that the Executives with responsibility for the risks and controls stated on the BAF undertake a process of scrutiny and review regularly, resulting in the updated document provided to the Board. LD advised that strategic risks should be reviewed and refreshed every 6 months by the Executive collectively.

11.8 The Board noted the BAF and the assurances therein.

12 People

Workforce Report

12.1 The Board took the report as read. JD highlighted the following from the report:

- The international recruitment plan for nursing continues with a total of 176 nurses being processed for posts in the Trust. A further 15 nurses will commence in July from successful EU recruitment. The Trust is also taking part in a collaborative regional procurement approach for international recruitment as part of the STP following selection of two partner agencies.

- The number of starters and leavers are encouraging. The Trust turnover rate and vacancy rate are reducing but compliance with mandatory training decreased slightly.
- A rise in the percentage of pay bill spent on substantive staff, decrease in bank spend but an increase in agency spend by 2% due to Lister ward now being a 24 hour capacity ward.

12.2 Following concerns in relation to performance and non-compliance with mandatory training from JS and TM, JD confirmed that threshold should be met by the end of the year explaining that processes were in place to address deficiencies. JD advised that changes will be seen in relation to compliance as apps are being developed and the frequency of training reviewed.

13 Integrated Audit Committee Terms of Reference

13.1 LS advised that the Terms of Reference follows the NHS Audit Committee handbook template. LS noted that the Terms of Reference had been reviewed in detail by the Integrated Audit Committee and the Committee recommended that the Board approve the revised Terms of Reference.

13.2 The Board **APPROVED** the revised Terms of Reference.

14 Medical Appraisal and Revalidation Board Report

14.1 The Chair welcomed Dr Kirti Mukherjee to the meeting. It was noted that the purpose of the report was to provide an update and assurance to the Board that there is a fit for purpose appraisal and revalidation system for medical staff. The Board was asked to approve the report after which the statement of compliance shall be signed off by the Chair/CEO.

14.2 KM gave an update on the completed annual medical appraisals and the number of revalidation recommendations made for the year ending 31 March 2017. KM noted that for this appraisal reporting year, 289 doctors (trainee doctors excluded) had a completed appraisal. Seven doctors had incomplete appraisals with agreed reasons and two doctors had unapproved missed appraisals which included one who left the Trust and one who was under GMC investigation. KM commented that there are 8 specialty doctors presently doing a highly commendable job of appraising.

14.3 In relation to revalidation recommendations for the year ending 31 March 2017, KM noted that there were 11 positive recommendations to revalidate, 3 were deferred to the next year as there was insufficient evidence for a recommendation to revalidate and 2 are on hold pending GMC investigation.

14.4 KM commented that there had been several improvements since the last report. She explained that the e-appraisal software had been updated hence feedback from appraisees had now become possible. In addition to this, there are regular GMC meetings, monthly disciplinary sessions with progress recorded, regular update

sessions for annual appraisals and the commencement of a revalidation governance group in December 2016.

- 14.5 JB advised that the report though very good was devoid of precision in terms of the statutory duties of the Board for sign off. He suggested a short briefing on this and offered to work together with DHF and KM due to his previous experience in this area. SC noted that there was indeed a need for clarity.

Action: A briefing on the precise statutory duties of the Board is required prior to signing off of the statement of compliance attached to the Medical Appraisal and Revalidation Report.

15 Quality Assurance Committee Report

- 15.1 The Quality Assurance Committee had met on 23 June and DHF, on behalf of EC, asked the Board to note the report.
- 15.2 JB noted that a paper on National Reporting & Learning System (NRLS) organisational patient safety incident reporting is to be brought to Board.

16 Finance Committee Report

- 16.1 The Finance Committee had met on 29 June. The report was taken as read. A further highlight brought to the attention of the Board by TM was focus of the Committee on revenue generation clarity.

17 Audit Committee Report

- 17.1 The Audit Committee had met on 19 June. MS asked the Board to note the report and commended LS for the good progress on addressing the findings of the recent health and safety audit.

18 Council of Governors' Update

- 18.1 VB as Governor Board Representative raised the following queries:

- Whether IT had sufficient resources to apply patches to keep the organisation resilient in case of cyber attacks

TC advised that whilst there were sufficient resources to apply patches, it was the equipment downtime required that was more problematic in terms of scheduling patching.

- Whether TTOs (To Take Out Medication) could be expedited to help the discharge process.

JL explained that Electronic Discharge Notifications (EDNs) are being completed the day before patients are leaving and that this process helps with giving prescriptions quicker.

- Mortality figures were creeping upwards and it was questioned whether was due to a lack of trained staff.

DHF explained that single points do not make a trend. She stated that the position will be seen to go up and down month to month but it is the trend that is important.

19 Any other business

- 19.1 SC acknowledged LS, DC and JS for whom it was their last Board meeting. SC thanked LS and DC for their relentless hard work and dedication. He wished them well in their future endeavours.
- 19.2 SC noted that JS had been a committed public servant throughout her life and latterly a Non-Executive Director in the Trust for the past six years. SC commented that during that time she had showed devotion to Trust issues with her detailed analysis and probing questioning. He thanked her on behalf of the Board, governors and members of the public. JS responded by thanking everybody and advising that she would continue to follow the Trust's progress.

20 Questions from the members of the public

- 20.1 None.

Date of next meeting

The next meeting of the Trust Board will be held on Thursday 3 August 2017.

The meeting closed at 4.50 pm.

Stephen Clark:
Chair

Date:

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB – 0376	04/05/17	9.1.2	IQPR data quality assurance required for SI's resulting in death.	Director of Nursing	06/07/17 – Director of Nursing advised that the annual report on incidents would be provided to the July Quality Assurance Committee meeting	Open
PUB - 0385	01/06/17	21.1	Concern about mobility impaired people getting trapped in corridors when the alarm goes off because the doors are too heavy to open	Director of Finance and Business Services	03/08/17 – Director of F&BS has responded directly to the governor	Open
PUB - 0386	01/06/17	21.2	Car parking for disabled people to be looked into from a holistic point of view	Director of Finance & Business Services	03/08/17 – Director of F&BS has responded directly to the governor	Open
PUB - 0387	06/07/17	15.5	A briefing on the precise statutory duties of the Board required prior to signing off of the statement of compliance attached to the Medical Appraisal and Revalidation Report.	Medical Director		Open

Chief Executive's Report – August 2017

This report provides the Trust Board with an overview of matters to bring to the Board's attention 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

At and around Medway

Our Improvement Plan – Better, Best, Brilliant

We have been continuing with our Better, Best, Brilliant (BBB) Programme which has had a big focus on patient flow through the hospital. We have seen some reduction from our initial improved performance figures however the methodology we are using to support the programme means that we are constantly evaluating and looking at where changes need to be made to achieve a sustained improvement in meeting the four hour performance target of 95% which means that 95% of patients presenting at the emergency department are being seen, treated and either admitted or discharged appropriately within four hours.

We held a critical friends panel last week which allowed doctors and nurses on the ground to feedback and challenge some of the changes put in place to improve patient flow through the hospital. It was a very worthwhile exercise and has allowed us to reflect on the processes we have and look at how they can be developed further to become sustainable and drive further improvements.

We have now also completed four-week intensive pieces of work on digital and workforce. I am pleased to say big improvements have been seen in both areas. Work has now begun on our important financial recovery workstream.

Fire Safety

The Trust has continued to respond to all requests for information from NHS Improvement following the tragic Grenfell Tower fire in London. The Trust was informed that our cladding had been tested by BRE, the appointed agency for testing cladding, and the Trust was not deemed to be one of the NHS Trusts considered to be a high risk. In order to provide additional assurance, our Director of Estates is looking into sourcing independent testing. This will allow us to ensure that we are taking all necessary measures to ensure we are aware of the level of risk and can put in place appropriate mitigations. Following a review we commissioned from Kent Fire and Rescue Service during the summer of 2016, we have continued to implement our fire safety action plan and will remain vigilant to ensure fire safety remains a high priority for the Trust.

Mortality rate continues to fall

One of the indicators that the Trust is monitored on is our mortality rate. This is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. A score of 100 means that the number of deaths is similar to what you would expect. A higher score means more deaths, a lower score, fewer. I am absolutely delighted to say that, thanks to the continued hard work of our staff, our mortality rate is now below 100.

Recruitment

We are seeing increasing evidence that people want to come to work at Medway as their first choice and this is a great position to be in. It has also meant that we are an exception to national trends. For example, nationally there is a shortage of midwives but thanks to our excellent performance in that area we are a preferred choice for many highly-skilled midwives, obstetricians and other supporting roles in our maternity unit and we have been able to recruit successfully into the department. We have made offers of employment to a number of midwives to come and work with us after a successful recruitment campaign and, pending our usual rigorous background checks, we have now filled all of our midwifery vacancies.

There are a number of ongoing recruitment initiatives underway and I also had the pleasure of welcoming 14 nurses from Europe to the Trust and I am looking forward to welcoming more over the coming months. We are also expecting our first cohort of Filipino nurses to commence in post in November 2017. We then expect cohorts of 10 to 12 nurses every eight weeks thereafter. Our UK recruitment drive is also going well at the moment and the Trust held another Nursing Open Day last weekend which we will hopefully begin to see positive results from over the coming weeks. We are also partaking in joint recruitment initiatives as part of the Sustainability and Transformation Partnership.

Medical recruitment is also ongoing and Medical Staffing have engaged with permanent recruitment agencies to recruit for hard to fill medical posts. Three Medical Training Initiative scheme doctors (MTI) commenced in Medicine in July. The Trust has commissioned TMP Worldwide (TMPW) to complete some focused diagnostic work on junior doctor and consultant vacancies and the Trust is utilising TMPW feedback to advertise directly in European Medical Journals, in Greece, Netherlands and Germany. I've also been welcoming our new junior doctors to the Trust which I am very much looking forward to seeing around the hospital.

I was really pleased to have been able to attend the Kent County Show where the Trust was promoting some of the great job opportunities available at the Trust. Ensuring we have the right levels of staff throughout the organisation remains a very important priority.

Supervision and training of junior doctors

We are very proud of our junior doctors and the difference they make to our patients, not only through the daily care they provide but also through initiatives such as MediLead. This great programme develops junior doctors as future leaders in health, improves quality improvement training and increases junior doctors' participation in the quality improvement agenda both within the Trust and across the NHS more widely.

I'm really delighted to say that we have recently received the results from the GMC Trainee Survey and these show that we are rated the highest in Kent, Surrey and Sussex for trainee satisfaction – and we are above the national average. This is great news and a real reflection of the fantastic work done by our clinician supervisors.

Celebrating our patient safety achievements

The Trust held a patient safety conference a few weeks ago which I've had some fantastic feedback about. The event showcased the work we have been doing to improve safety for our patients. Congratulations to Amanda Epps, Lead DSN and Rebecca Watt, Diabetes Clinical Sister for the 'Making variable rate intravenous insulin infusion training mandatory' poster which won the poster prize.

It was also good to see our work recognised on the national stage with five of our projects being shortlisted for the Patient Safety Congress Awards. Our Medical Director, Diana Hamilton-Fairley, was also part of the panel for a fascinating safety debate at the conference. This demonstrates that we are heading in the right direction with the work we are doing.

Inpatient Survey

Although we know we have improved in so many areas, the CQC has published the results of the 2016 Inpatient Survey which are not as good as we would like – in fact they will show that in July last year (when the survey was undertaken) in some areas our results were worse. We have made real progress since then however and are hopeful of better results next time.

Since the survey was carried out, and following our inspection last year, the CQC rated us 'Good' for caring and recommended our removal from special measures. We know that we need to continue to focus on improving the care and the experience of our patients and we are focussed on doing this. For example, we know that many of the concerns from patients are about delays which dramatically affect their experience – this is something we are addressing directly with our work on flow.

Pathology service

I joined Susan Acott, Chief Executive of Dartford and Gravesham NHS Trust, for a visit to the pathology lab at Darent Valley Hospital, along with our Director of Clinical Operations Alistair Lindsay and Pathology Manager Gurjit Lindsay. This followed a similar visit by Susan to Medway recently. We met staff and viewed the facilities as part of preparations to bring our two pathology services together. Following lengthy discussions, the two Trusts have agreed to move to an integrated service, which will have long term benefits for our system. This will be a time of change for some staff, but an exciting opportunity for the service. It was important for me to be able to see and feel assured about where some of our staff will be working in future. I am confident that together our teams will deliver a better service.

Kent and Medway Sustainability and Transformation Partnership

Work is already underway in a number of workstreams throughout the Kent and Medway STP. Particular developments have been made through the productivity workstream with many workstreams already beginning to look at how to develop new ways of working together as a whole system to provide care for the population of Kent and Medway more effectively.

Medway, North and West Kent Delivery Board

On 21 July 2017, I chaired the second meeting of the delivery board for Medway, North and West Kent.

The delivery board sits within the Kent and Medway Sustainability and Transformation Partnership (STP) and complements the work being done by the East Kent Delivery Board.

The terms of reference for the group were approved and further discussions are taking place around the overall governance within the STP. Further discussions are being held around how the services will be aligned in future.

Executive Team

There have been a number of changes to the Board over the last month. We said goodbye to Darren Cattell, our Improvement Director who has now left the Trust and James Devine will now have Trust Improvement as part of his portfolio. We also said farewell to Lynne Stuart, our Director of Corporate Governance, Risk, Compliance and Legal; Katy White will be stepping into the role. We also welcome Sheila Murphy who is the new Trust Secretary who joined us on 26 July.

Non-Executive Director Jan Stephens, who has come to the end of her term of office, will be sadly missed, however the Executive and I are really looking forward to working with our new Non-Executive Director, Adrian Ward who joined us on 1 August.

Away from Medway

STP ratings

STPs across the country have been rated in four categories from 'outstanding' to 'needs most improvement'. Kent and Medway is in one of the middle categories, 'making progress'. It is the first time the STPs have been given public ratings.

Medway CCG rated 'good'

Medway CCG has been rated 'good' in its annual assessment by NHS England. The rating for 2016/17 moves the CCG up two grades from last year's 'inadequate'.

In the annual assessment, the CCG was praised for the Medway and Swale Centre for Organisational Excellence (MASCOE), which is about taking a whole system approach to drive improvement, recognising in particular the work that has been undertaken in falls prevention.

Areas of strength and good practice also included putting considerable effort into primary care and developing increasingly positive relationships with partners, most notably Medway Foundation Trust and Medway Council. The CCG's leadership was also recognised for playing an important role in leading the Sustainability and Transformation Plan thinking on local and out-of-hospital based care.

Vascular network

In July Diana Hamilton-Fairley attended a meeting of the Kent and Medway Vascular Network – the first time teams from East Kent and Medway had met to discuss and agree how they are going to work together as a network to provide vascular services that meet the national standards.

Vascular surgeons, specialist vascular nurses, interventional radiologists, radiographers and nurses and anaesthetists from both sites came together at a really positive meeting. The

actions needed to take this forward were agreed for the short, intermediate and longer term in an atmosphere of collegiality and enthusiasm. The business case for the network is being developed for approval by November and the teams plan to hold another awayday early in 2018. In the meantime they are going to combine their multi-disciplinary teams, agree the guidelines and Standard Operating Procedures for the network and adjust the on-call rotas for treating emergency patients. This is a really encouraging step forward.

Report to the Board of Directors

Board Date: 3rd August 2017

Agenda Item:

9a

Title of Report	STP Update
Presented by	Lesley Dwyer, Chief Executive
Lead Director	Lesley Dwyer, Chief Executive
Committees or Groups who have considered this report	N/A
Executive Summary	<p>The purpose of this report is : For the Board to note the progress being made across the Kent and Medway STP.</p> <p>Key points are :</p> <ul style="list-style-type: none"> • Two delivery boards have been established and are working towards how services can be developed in line with the wider Kent and Medway Sustainability and Transformation Plan • Plans for public and patient engagement are underway. • Further stakeholder engagement events are planned.
Resource Implications	N/A
Risk and Assurance	N/A
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	The Board is asked to note the contents of the report.
Purpose & Actions required by the Board :	<div> <div>Approval <input type="checkbox"/></div> <div>Assurance <input type="checkbox"/></div> <div>Discussion <input type="checkbox"/></div> <div>Noting <input checked="" type="checkbox"/></div> </div>

STP Update – August 2017

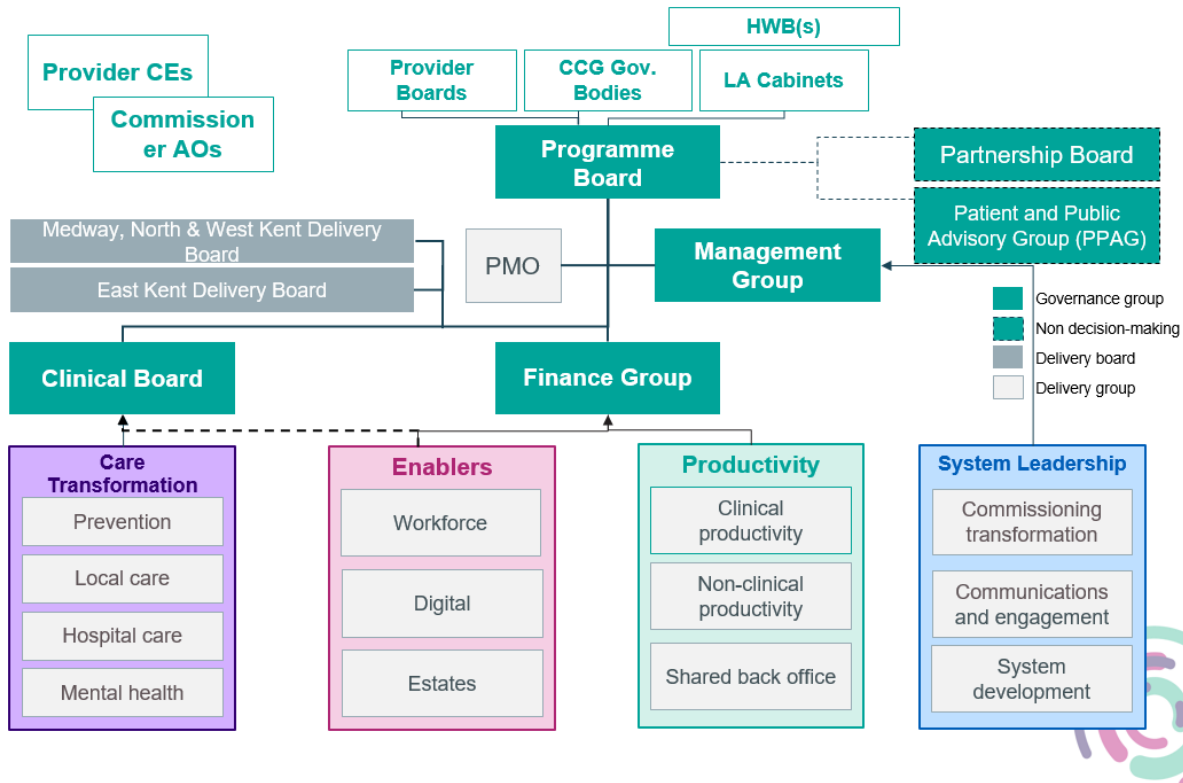
EXECUTIVE SUMMARY

- A great deal of work has taken place since publication of Kent and Medway's Case for Change document in March 2017.
- Two workstreams in particular have taken much of the focus – looking at Hospital Care and Local Care. There has also been considerable work to see how these workstreams fit with others such as mental health, system transformation, workforce, use of new digital technology, and productivity.
- The East Kent Delivery Board has been established for some time and their plans are more advanced for more integrated social care, primary and secondary care services in East Kent.
- A newly formed Medway, North and West Kent (MNWK) Delivery Board has so far had two meetings and is beginning the work of setting out how services could be improved for MNWK, in line with the wider Kent and Medway Sustainability and Transformation Plan.
- Recognising the need to engage patients and the public as these plans develop, a series of 10 events for East Kent and West Kent are already underway, with more for Medway and North Kent due to take place over August and September.
- Those leading the STP have consistently recognised the very wide range of stakeholders who need to be kept informed and involved in this significant programme of service redesign and change. As a result, further events are planned in the Autumn to inform and engage local voluntary sector organisations, district councils, Westminster MPs representing Kent and Medway constituencies, and staff working in all STP partner organisations.

STP GOVERNANCE

- The STP's governance structure is most neatly summarised in the diagram below

Governance



LATEST PROGRAMME BOARD UPDATE

- At its June meeting the STP Programme Board received an update from the hospital care workstream which is focusing as a priority on urgent and emergency, acute medical and elective orthopaedic services in east Kent; and stroke and vascular services across the whole of Kent and Medway. These services have been assessed as most in need of change to make sure they consistently meet national quality standards. Kent and Medway currently have some of the worst outcomes for stroke in the country and work continues with focus around proposals to develop hyper acute stroke units to offer more concentrated specialist care in the critical first 72 hours after a stroke.
- The work in east Kent continues with the development of a model of care based on Sir Bruce Keogh's clinical model for urgent and emergency care. The emerging proposal is to establish a major emergency centre with specialist services; an emergency centre and a medical emergency centre, creating a sustainable model across all three of the main EKHUFT hospital sites. This proposed model of care, and hurdle criteria to apply to a long list of options, has been discussed widely, including with the South East Clinical Senate. Patients and the public are being

asked for their views on the model of care at a series of listening events in June and July, building on previous discussions and engagement activity. Hurdle criteria were discussed with patients and the public at a series of events in the Spring of this year. Next steps are for the proposed service models and hurdle criteria to be taken to CCG Governing Bodies and Trust Boards across Kent and Medway for approval. They will also be shared formally with Kent Health Overview and Scrutiny Committee and Medway Health and Adult Social Care Overview and Scrutiny Committee, building on earlier discussions and briefings. Governance structures for consultation are also being put in place (for example, through the creation of CCG joint committees) to facilitate joint decision-making amongst the CCGs on these particular service issues. The Board were also made aware that the Clinical Board has recommended a sub-committee be set up to consider stroke prevention and rehabilitation.

- There was a discussion on priority areas to support the smooth-running of the programme, including reviewing governance arrangements, recruitment of a full-time programme office team to support the workstreams and the recruitment of a Director for System Transformation to lead the system transformation workstream. Leaders in both commissioning and provider organisations across Kent and Medway generally agree there should be a strategic commissioning function for Kent and Medway. Its role would focus on strategic planning, resource allocation and commissioning those services which serve a large population and operate on a Kent and Medway wide basis. This function would work alongside local commissioning for local populations – through local accountable care systems. The System Transformation workstream has recently been set up to look at this in more detail.
- The Board received an update on engagement activity to date, and recommendations from the Patient and Public Advisory Group around engagement, including aligning a PPAG member to each workstream now recruitment of members was complete with more capacity in place to enable this level of support. It was agreed that engagement around local care was as important as engagement around emerging proposals for hospital care.

URGENT CARE CONSULTATION AND THE MEDWAY MODEL

- Medway is currently consulting on provision of urgent care services in Medway, specifically proposals to create a new urgent care centre at Medway Maritime Hospital; improvements to NHS 111 and extending access to GP services seven days a week. The public will be asked for their views on receiving urgent care (ie. immediate medical help or advice) in situations that are not life-threatening.
- The public will also be invited to discuss the Medway Model – a new partnership approach to delivering care and supporting wellbeing designed to help people stay healthy longer, offering joined up health and social care services closer to, or at home.

These integrated local care services will bring together expertise from primary care, social care, the local authority and mental health working in partnership.

- The newly formed MNWK Delivery Board has been tasked to develop and implement a system care strategy for Medway, North and West Kent that supports the Five Year Forward View's triple aims to deliver improved health and wellbeing for the community; better quality health and care services for patients; on a financially sustainable basis. The work will bring together local care, hospital care and other plans to ensure comprehensive coverage of all health and care services for the MNWK area within the context of the strategic framework established through the Kent and Medway STP.
- The MNWK Delivery Board sits within the Kent and Medway Sustainability & Transformation Partnership (STP) governance. Building on the strategic framework provided by Kent and Medway STP, the MNWK Delivery Board is the vehicle for developing and delivering the STP strategy for this local geography. As with all STP planning and modelling the MNWK Delivery Board aims to involve the local community, patients and staff as this work progresses.

EARLY FEEDBACK FROM LISTENING EVENTS

- The six listening events that have taken place in East and West Kent so far have already given us valuable early feedback from patients, the public and staff members who attended. Issues like transport, staff recruitment and retention, joining up social care and healthcare services, and placing greater emphasis on prevention and supporting those with mental health problems are likely to be common themes across Kent and Medway. A full report and analysis from the listening events will be available later in the year.
- **Themes we have heard so far include**
 - 1..1 Recruitment and use of staff/workforce
 - 1..2 Care Homes – ensuring where they are and that they are included in this
 - 1..3 Communication to all
 - 1..4 Finance – is the resource enough?
 - 1..5 The importance of working with voluntary and community organisations and their future sustainability
 - 1..6 Transport – and the difficulties of travel to services
 - 1..7 The importance of family and friends in a patients recovery
 - 1..8 Support for the model meaning more care closer to home
- **Attendees want to see**
 - 1..1 Better communication at all levels and with everyone

- 1..2 Partnership with organisations working together in a more joined up approach
- 1..3 Coordinated IT system
- 1..4 More personal care
- **Mental Health**
 - 1..1 More education is needed for all
 - 1..2 More support services especially for family members
 - 1..3 Signposting
 - 1..4 Prevent gaps in service
 - 1..5 Smoother transition from one team to another for a patient
- **Prevention/Health Improvement**
 - 1..1 More funding for prevention
 - 1..2 Information needs to be local
 - 1..3 Start prevention messages with children
 - 1..4 Prevent mixed messages from clinicians

FUTURE EVENTS OF RELEVANCE

- Two public engagement events focusing on the provision of urgent care in Medway.
- 9th August, 6:30 – 8:30pm, Priestfield Stadium, Redfern Avenue, Medway, ME7 4DD
- 5th September, 6:30 – 8:30pm, St Georges Hotel, 8 New Road, ME4 6BB
- One engagement event to discuss the Medway Model
- 13th September 13:30 – 16:30, Holiday Inn, Rochester, Maidstone Road, ME5 9SF
- West Kent listening events
- Sevenoaks, 8 August, 9:30 am to 12:30 pm Mehew Hall, Sevenoaks Community Centre, Cramptons Road, TN14 5DN
- Weald of Kent, 29 August, 1pm to 4pm, Kilndown Village Hall, Church Road, Kilndown TN17 2SF
-

Board Report

Report date: 03 August 2017

Agenda Item

9b

Title of Report	Better, Best, Brilliant – Our Trust Improvement Programme
Presented by	James Devine, Executive Director of HR&OD and Improvement
Lead Director	Lesley Dwyer, CEO
Committees or Groups who have considered this report	Executive Group
Executive Summary	<p>The Board approved the Business case for the appointment of 2020 Delivery to support the Trust in the Better, Best, Brilliant Improvement Plan.</p> <p>2020 Delivery have been working to the Trust Executive and importantly with Trust staff and Stakeholders to identify and support improvement initiatives.</p> <p>The Executive Group has previously focused all Trust and 2020 effort on improving Patient Flow which is number 1 in our list of 13 improvement work streams. In the last month the Workforce and Digital work streams have shown progress and are focused initially on how we improve flow by reducing our staffing gaps and an increased use of existing technology (Extramed).</p> <p>We had seen some reduction from our initial improved performance figures in weeks 7 (86.5%), week 8 (82.9%) and week 9 (87.5%); however, we are beginning to see improvements back toward the required target of 95% in week 10 of the programme (94.3%) – however, the important step is toward sustaining performance at or above the target. The methodology we are using to support the programme means that we are constantly evaluating and looking at where changes need to be made to achieve a sustained improvement in meeting the four hour performance target. To do this, we are focussing on embedding and communicating the new flow model; standardisation of processes in flow-critical areas; co-ordination of flow- critical activity; and improving discharge processes and reducing length of stay.</p> <p>As part of the BBB programme, we are now also supporting the financial recovery workstream and specifically the cost improvement programmes.</p>

	<p>In addition, in August, we launch our green belt training for managers across the Trust who will lead the delivery of 16 improvement projects.</p> <p>The Board is asked to note progress and the further work outlined.</p>
Resource Implications	As outlined in the presentation.
Risk and Assurance	<p>The core risk is continued non delivery of the 4 hour ED standard. Risk mitigation and assurance so far is attached in the presentation, there remains more work to do.</p> <p>Sustainability of the improvement workstreams is a risk and all actions contain elements for medium to long term sustainability.</p>
Legal Implications/Regulatory Requirements	<p>None at this point.</p> <p>There is the clear expectation that further improvement in services standards and ratings in made. This programme will enable us to do that. If we do not then further regulatory action will follow.</p>
Recovery Plan Implication	As above.
Quality Impact Assessment	All actions continue to follow an appropriate QIA process
Recommendation	The Board is asked to note the progress made in the report and the further work required.
Purpose & Actions required by the Board :	<div> <div>Approval <input type="checkbox"/></div> <div>Assurance <input checked="" type="checkbox"/></div> <div>Discussion <input type="checkbox"/></div> <div>Noting <input type="checkbox"/></div> </div>

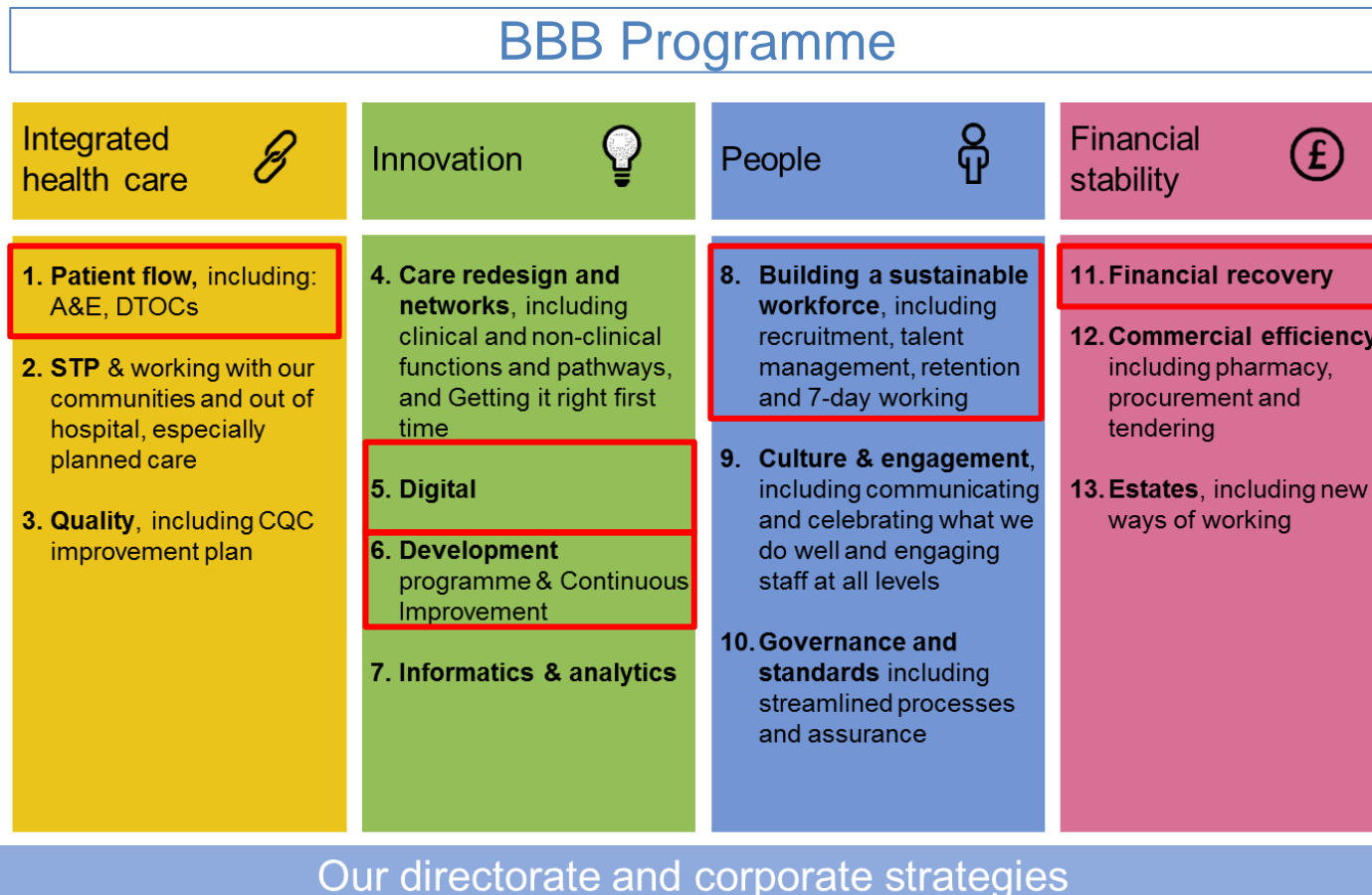
Better, Best, Brilliant

Our improvement programme

Board Update 3rd August 2017

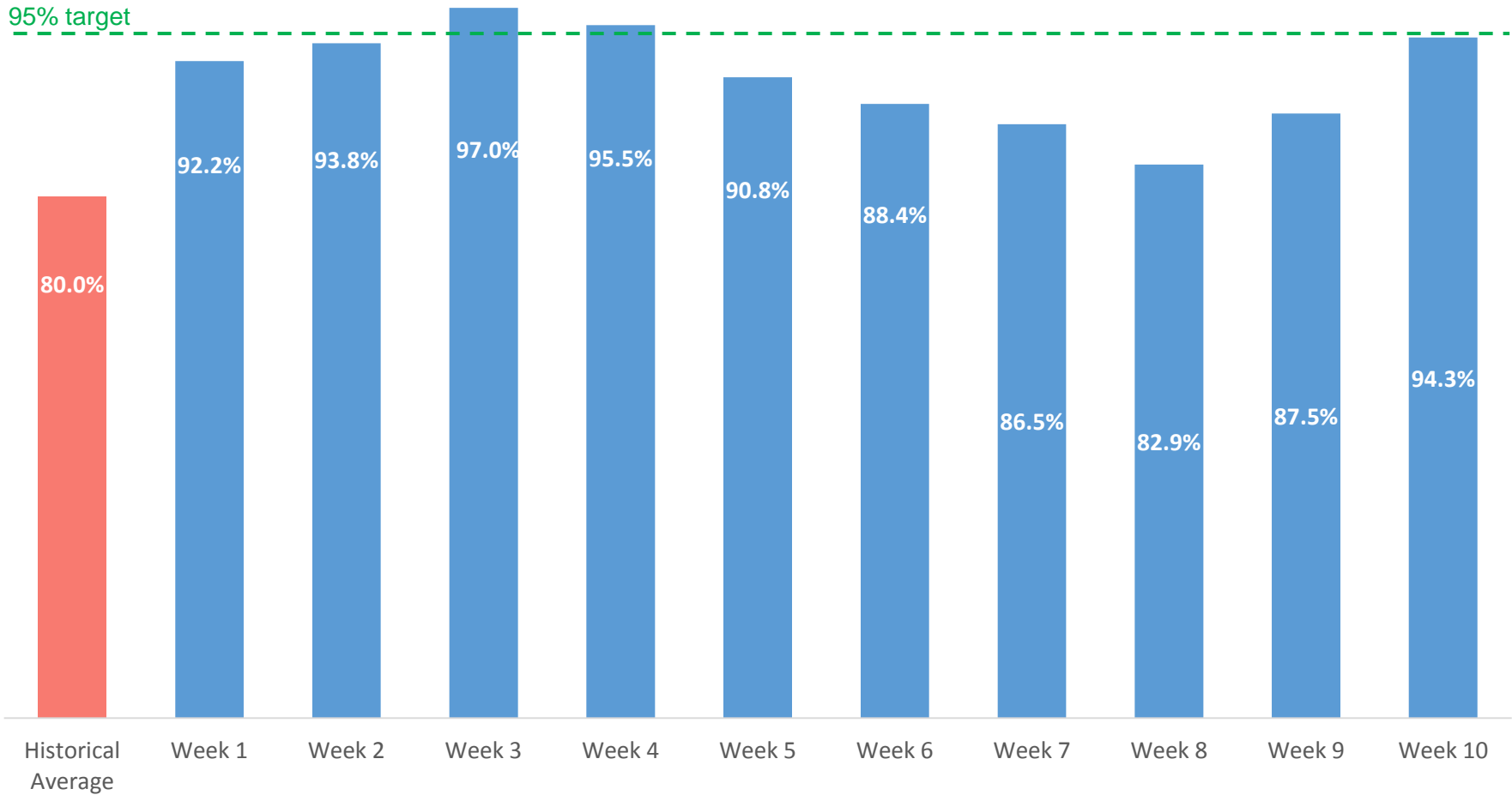
In the last month, the programme has kicked off two more improvement teams, financial recovery and development, and continues to focus on patient flow, workforce and digital

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After a dip in 4 hour performance immediately following Flow Month, we have seen a recovery towards our 95% target

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We now want to ensure that performance is sustained and are focussing on a number of key areas

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Embedding and communicating the new flow model

- Development and communication of **clear admission pathways and protocols**
- Development of **ambulatory care pathways and protocols** to reduce admissions and improve patient experience

Standardisation of processes in flow-critical areas

- Introduction of a **standardised check-list for board rounds, ward rounds and CCC huddles**
- Development of 'standard work' one-pagers to **define expected roles and responsibilities**
- Development of **clear protocols for escalation** when pressures on flow increases
- Ensuring the **correct use of estimated date of discharge**, driving progress in patient care

Coordination of flow-critical activity

- **Weekend preparation starting on Wednesday** through the CCC, including identification of patients for weekend discharge and strengthening criteria-led discharge
- Ensuring use of ExtraMed to allow **live accurate data on bed status**

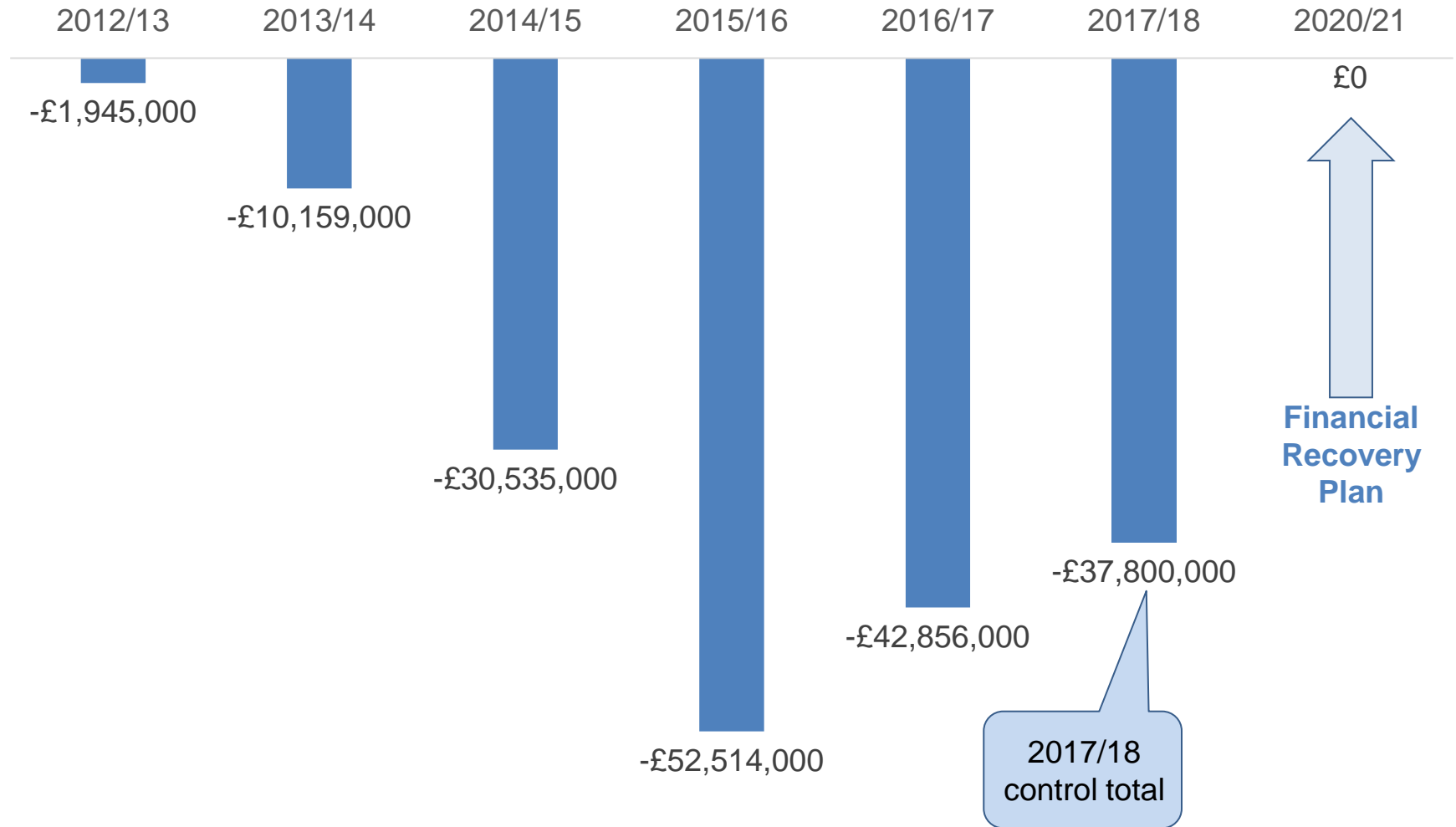
Improving discharge processes and reducing length of stay

- Development and communication of **criteria-led discharge protocols**
- **Review of the EDN and TTO process**, understanding whether this can be re-structured to **support earlier discharge** e.g. pharmacy-completed TTOs
- Identification of the **drivers of prolonged length of stay**

Having already started reducing the financial deficit, we are setting out a detailed plan to return to balance

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MEDWAY NHS FOUNDATION TRUST DEFICIT BY YEAR



Detailed Cost Improvement Plans (CIPs) are in place with further improvement opportunities being actively sought

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- **CIPs of £10.1 million have been identified for 2017/18**, equating to £7.5 million on a risk-adjusted basis
- We are focussing on a number of key areas to support delivery of **further cost improvement opportunities by 2020/21**:
 - Maximising clinical and non-clinical income
 - Removing unwarranted variation, employing best practice from Carter and RightCare, and reviewing Reference Costs and Corporate Benchmarking
 - Improving financial viability of specialties
 - Reducing staffing costs, particular through review of productivity and use of temporary staffing
 - Undertaking better procurement
 - Maximising digital productivity
 - Ensuring better use of estates

We are currently kicking off 14 further Improvement Projects supported by training and mentoring

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Improvement Team	Project	Project Lead
Patient flow	Improve imaging efficiency	Sarah Smith
Patient flow	Redesign of the elective flow pathway	Sam Chapman
Patient flow	Improve discharge processes to reduce length of stay on Wakeley and Dickens from 2.3 days to 1.5 days sustainably, and then roll out working practice to other medical wards	Katherine Smith
Quality	Tissue viability – improving quality and reducing incidents	Amara Collins-Oke
Quality	Model ward including nutrition	Julie Murray and Kerri Eilertsen-Feeney
Sustainable workforce	Design and implement a performance review framework	Jill Lane
Sustainable workforce	Design and implement new roles to support the nursing workforce, specifically within elderly care	Pauline Brooker and Chandrawtee Elder
Culture and engagement	Improve our culture relating to themes on bullying and harassment from the staff survey	Neil Adams
Digital	How do we improve our compliance of having the nationally recognised demographic details of patients for the purpose of reducing correspondence errors and therefore mitigating commissioning challenge?	Jo Lambert
Development	Improve the two week nurse induction	Lisa Webb
Informatics and analytics	Develop the scope and project plan for the most suitable approach to a robust data warehouse that supports the information requirements across the organisation. Identify and deliver improvements to the data warehouse within a six month period which will enable sustainable and robust processes and allow the development of self-service reliable report writing through SSRS	Lianne Mellor
Commercial efficiency	Identify some key areas of non-pay expenditure suitable for an organisation wide approach to deliver cost savings eg single contract for photocopiers, mobile phone/data contract	Dan Small
Financial recovery	Develop specialty efficiency reporting and benchmarking, utilising Carter Efficiency, service line contribution, and PLICs	Anil Patel
Financial recovery	Support the development of an Aligned Incentive Contract to underpin the delivery of system wide efficiencies	Tracey Easton



Best of care
Best of people

NHS

Medway

NHS Foundation Trust

Next steps for the Improvement Programme include completing the Financial Recovery Plan and scoping a workforce review

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Patient Flow

- Continue to **embed and communicate the new flow model**
- **Standardisation of processes** and development of standard work

Financial Recovery

- Complete the **Trust Financial Recovery Plan**
- Work on **further opportunities for additional cost savings** and confirm the multi-year CIP pipeline

Development Programme

- Deliver further *Leadership* and *Introduction to Improvement* training sessions in order to train staff on a **consistent improvement methodology**
- Launch the green belt development programme, **kicking off 14 improvement projects supported by training and mentoring**

Digital

- Continue to **shift flow management onto ExtraMed**, removing spreadsheet and paper-based processes
- Ensure **all agency nurses and doctors are trained on ExtraMed**

Workforce

- Continue to focus upon **ensuring safe staffing** and supporting flow, retention and recruitment and the efficient and effective use of staff through the newly established medical and nursing workforce groups
- Scoping and supporting a **workforce review**

Report to the Board of Directors

Board Date: 2nd August 2017

Agenda item:

10ai

Title of Report	Integrated Quality Performance Dashboard - Update
Presented by	N/A
Lead Reporting Director	Executive Team
Committees or Groups who have considered this report	Draft to Quality Assurance Committee Draft to Quality Improvement Committee
Executive Summary	<p>To inform Board Members in the form of a flash report of June's performance across all functions and key performance indicators. A full report will be presented to the next Board.</p> <p>Key points are:</p> <ul style="list-style-type: none"> • The Trust did not achieve the four hour ED target for June but performance has increased from 87.73% in May to 91.05% in June. The main reasons for this as outlined by the Operational Teams are; <ul style="list-style-type: none"> ○ June saw the continuance of the Better, Best, Brilliant (BBB) Flow work stream ○ The discharge lounge is now seeing up to 40 patients per day through allowing a better patient experience and a much earlier provision of bed availability improving flow and performance ○ Lister ward remains as a 24hr acute medical unit to increase flow in the evening. Subsequently the medical admission 4 hour performance remains almost consistently over 80%. ○ Bed occupancy remains steady at 94.48% for June compared to 94.44% in May. • The Trust has reported a total of 0 12 hour breaches in June. • HSMR data reported in this month's IQPR is for the period from April 2016 to March 2017 and is the provisionally year end figure. This is currently 99.43, which is below the national benchmark. The year-end position will be finalised and refreshed with the next Dr Foster update. • This month saw a 42.31 % increase in the number of Mixed Sex Accommodation breaches, these totalled 37 in June. The Trust is currently reviewing the source and methodology of the MSA reporting since the adoption of the Extramed System, and the increased use of Lister Ward as

	<p>an assessment unit.</p> <ul style="list-style-type: none"> • RTT performance has improved to 82.42% from 80.80%, This is below the national standard of 92% however this remains above the agreed trajectory, • Cancer targets have not all been achieved. The 2 week wait performance increased by 5.47% to 73.64%. This was predominantly due to the historical clinic capacity issues in Skin as a result of ongoing Consultant vacancy. • There was a 4.05% increase in the number of falls in June (77) when compared to May (74). • 62 complaints were reported in month, a slight decrease on May's 63 and number of complaint returners has dropped by 2 since the previous month
Resource Implications	N/A
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Supports the Recovery Plan in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report as appropriate
Recommendation	N/A
Purpose & Actions required by the Board :	<div> <div>Approval <input type="checkbox"/></div> <div>Assurance <input type="checkbox"/></div> <div>Discussion <input type="checkbox"/></div> <div>Noting <input checked="" type="checkbox"/></div> </div>

Integrated Quality and Performance Report




July 2017

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



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June's Story	3-4
Executive Summary	5-12
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Caring	18
Responsive	19
Well Led	20
Enablers	21

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



9978

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Patients visited our ED , which has **decreased by 2.0%** on the previous month, with performance **improving** to **91.05%** seen within 4 hours, compared to 87.73% . **2258** Patients were admitted, with an **increase** in conversion rate of **22.63%**

There were **5644** total patient admissions June, and **5626** patients were discharged.



to **94.48%**.

Bed Occupancy **improved** by **0.04%** in June



3178

patients arrived at ED via ambulance which is a **3.67% decrease** on last month

40.0%

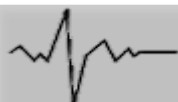
Of ambulance patients were seen in under 15 minutes

June's Story....



445 Babies were

delivered in the month of June (43 more than May) with Emergency C-Section rate with a slight **increase** of **2.16%** from the previous month to **19.33%**



HSMR is **99.43** and within expected parameters (93.81 – 105.29). This has been the lowest rate for the Trust.



80% of staff have had an Performance Review compared to **83%** in May



26170 Patients attended an outpatient appointment with **9.35%** DNA rate improved with a decrease of **0.05%** on last month



There were **77** total falls in June, compared to **74** in May



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RTT Overall Incomplete Pathways for June was **82.42%** which improved by **1.62%** on previous month. We remain on our improvement trajectory. The trust also reported **21 x 52** week waiters which decreased by **12** compared to May

31 day subsequent treatment surgery cancer target has dropped below the target at **87.50%** in May (reported one month in arrears)

2 Week Wait symptomatic breast dropped below the target of **93%** in May with performance of **81.72%** - deteriorated by 4.64%

2 Week Wait cancer performance for May was **73.64%** (reported one month in arrears) . This is a **5.47%** improvement on April's performance

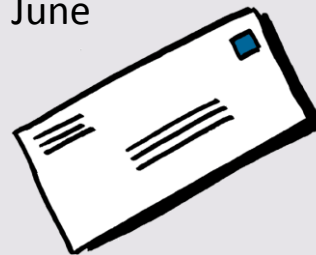


June's Performance....



96.15% of patients waited under 6 weeks for diagnostic tests in the month of June, this has deteriorated by **0.38%** since May's reported performance

We received **62** complaints in June, decreasing slightly from those received in May by **1**. The number of complaint returners fell from **6** in May to **4** reported in June



There were **37** Mixed Sex Accommodation breaches in June which is a **42.31%** increase on May's performance



Infection Control

MRSA Screening - FCS (Maternity Services) had a deteriorating position for MRSA screening. One patient not rescreened after 7 days as an inpatient, corrective actions implemented. Note: Low denominator due to most women having an inpatient stay of less than 7 day. Impact of one missed screen has a significant impact on performance.

C Diff post 72 hours - Increased incidence of Clostridium Difficile Associated Diarrhoea (CDAD), 6 cases reported in June resulting in a breach of trajectory for Q1. Of the 8 C diff post infection reviews undertaken so far, three cases were deemed unavoidable, with 2 of these categorized as level 3 lapses of care. If we breach end of year target all level 3 breaches will incur a fine of £10.000 per case.

Serious Incidents

As at 30 June 2017 there are a total of 137 open Serious Incidents (SIs)

Open SIs within allocated timeframe - **54**

Open SIs breaching the allocated timeframe – **83**

Of the 83 breaching 37 SIs have been presented to the CCG (represented in 7 final reports). Additional information has been requested in relation to these 7 final reports prior to closure of the 37 SIs; this is currently being progressed

The Quality Team are currently working with Directorates to agree a trajectory for closure of the SIs breaching the allocated timeframe.

Root Cause Analysis (RCA) training will commence in July 2017 to increase the pool of eligible SI investigators and commence the SI academy.

New SIs reported on STEIS in June 2017– **21**

6 SIs were presented at the CCG Closure panel in the June 2017 – of these 1 was a virtual closure and 5 had closure declined; additional information and assurance was required prior to closure.

Pressure Ulcers

Grade 4 acquisition in a patient with spinal compromise. RCA completed, learning identified and enhanced support and teaching put in place by TVN team

NICE Technology Appraisals - June 2017

There were 6 TAs published in June 2017, 5 of which relate to cancer, and 1 pathology. None of these have been assessed, with a 90 day deadline of 30 September 2017. The guidelines have been distributed to the Families and Clinical Support Services Governance team for dissemination to relevant clinicians.

Year to date (excluding June 2017)

There have been 6 TAs published since April 2017 of which 5 are relevant to the Trust. The TAs have 90 day deadlines of 31 July for the 4 published in April and 31 August for the 1 published in May. These guidelines relate to Pharmacy (x2), Rheumatology, General Surgery and Dermatology, and have been distributed to the relevant governance teams for dissemination.

NICE Clinical Guidelines - June 2017

There were 10 CGs published in June 2017, 9 of which are relevant to the Trust, relating to ED, Emergency & Elective Gynaecology, Rheumatology, the Acute & Continuing Care Directorate and Trust Wide. One of these was assessed as being fully implemented, and the remaining 8 remain as not assessed currently, with a 90 day deadline of 30 September 2017. The guidelines have been distributed to the relevant directorate governance teams for dissemination to clinicians.

Year to date (excluding June 2017)

There have been 13 CGs published since April 2017 of which 12 are relevant to the Trust. The guidelines have 90 day deadlines of 31 July for the 3 published in April and 31 August for the 9 published in May. These guidelines relate to Trauma & Orthopaedics (x2), Respiratory, General Surgery, Gastroenterology (x2), Diabetes, Colorectal (x2) and Trust Wide (x4) and have been distributed to the relevant governance teams for dissemination.

NICE Quality Standards - June 2017

There were 5 Qs published in June 2017, relating to Cancer, Gastroenterology and Trust Wide (x3). These currently remain as not assessed, with a 90 day deadline of 30 September 2017. The guidelines have been sent to the relevant directorate governance teams for dissemination to clinicians.

Year to date (excluding June 2017)

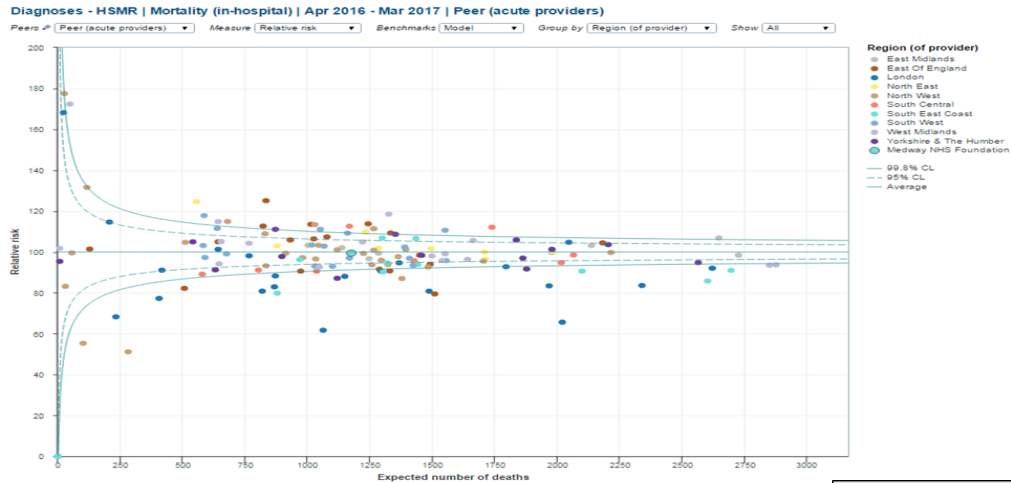
There have been 2 Qs published since April 2017, which have 90 day deadlines of 31 July for the 1 published in April and 31 August for the 1 published in May. These guidelines relate to Trauma & Orthopaedics and Osteoporosis, and have been sent to the relevant governance teams for dissemination.

All guidelines published since April 2017 currently remain within the 90 day deadline for response and implementation. All of the outstanding guidelines published since January 2015 continues to be escalated to Specialty, Program and Directorate level on a monthly basis.

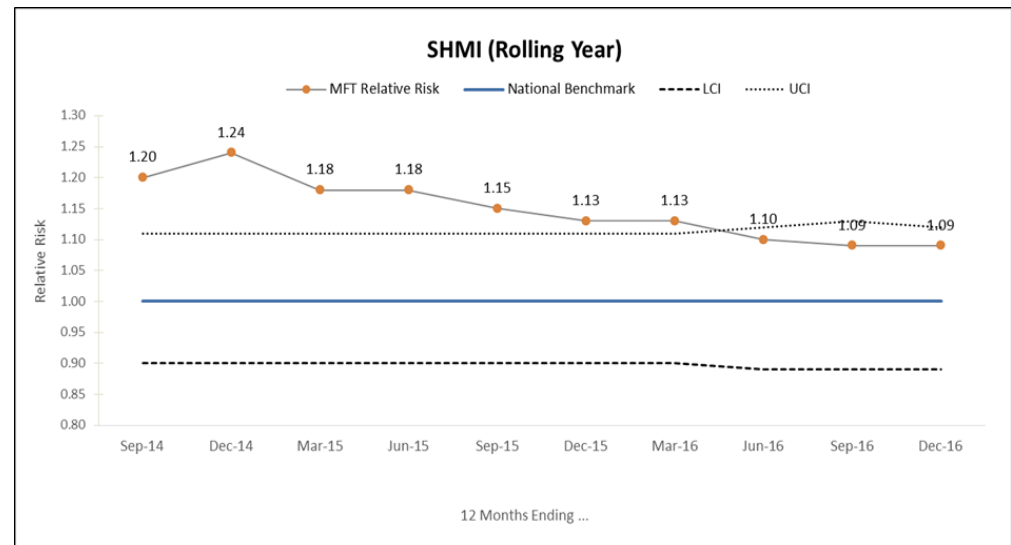
Other news

The NICE & NCEPOD Facilitator continues to work on the historic reviews, and is now attending Directorate, Specialty and Governance meetings to achieve this. This work will be continued now to ensure full response and implementation wherever possible within 90 days.

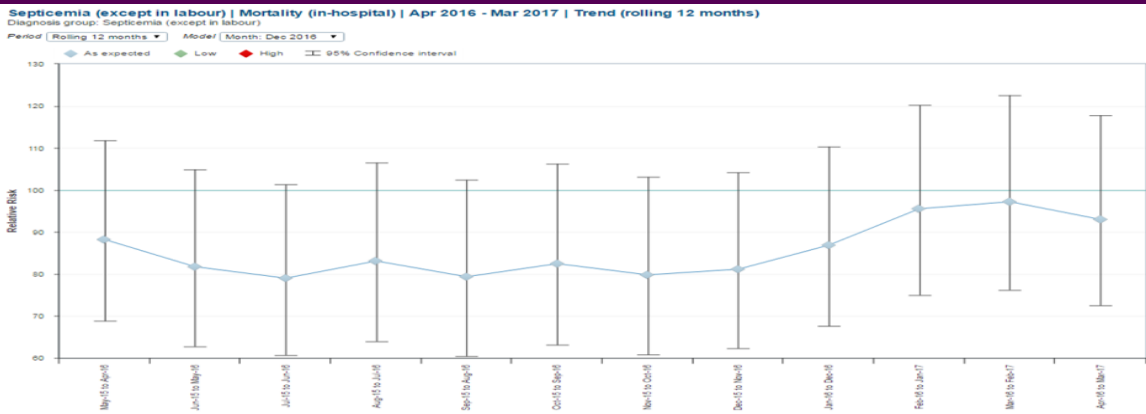
The Hospital Standardised Mortality Ratio (HSMR) is currently 99.43 (for the period from April 2016 to March 2017) and is below the national benchmark. The current figure is the provisional year end data for 2017. This will be finalised and refreshed with the next Dr Foster update (20 July 2017). The current peer comparison and rolling HSMR trend are demonstrated in the following graphs.



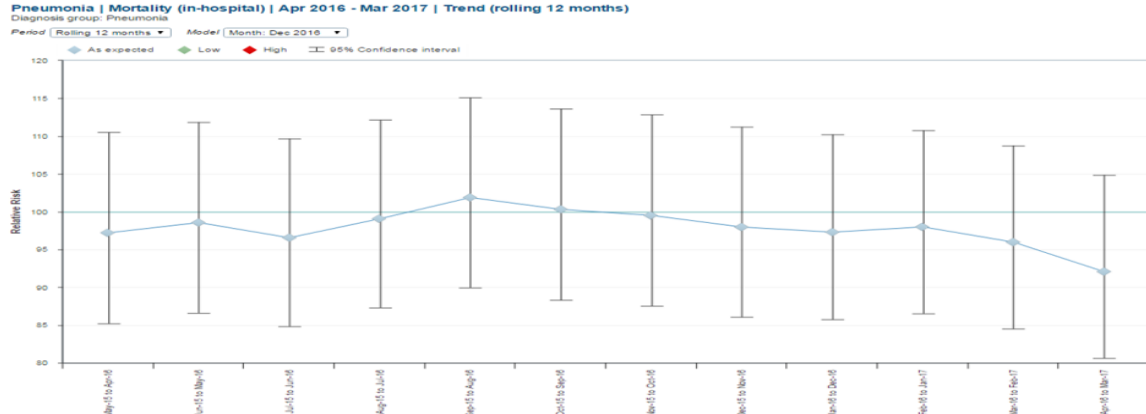
The latest SHMI value for the period January 2016 – December 2016 was published on 22 June 2017. The value remains the same at 1.09 (for the period from January 2016 to December 2016) which is within the expected range. The rolling year trend is demonstrated below.



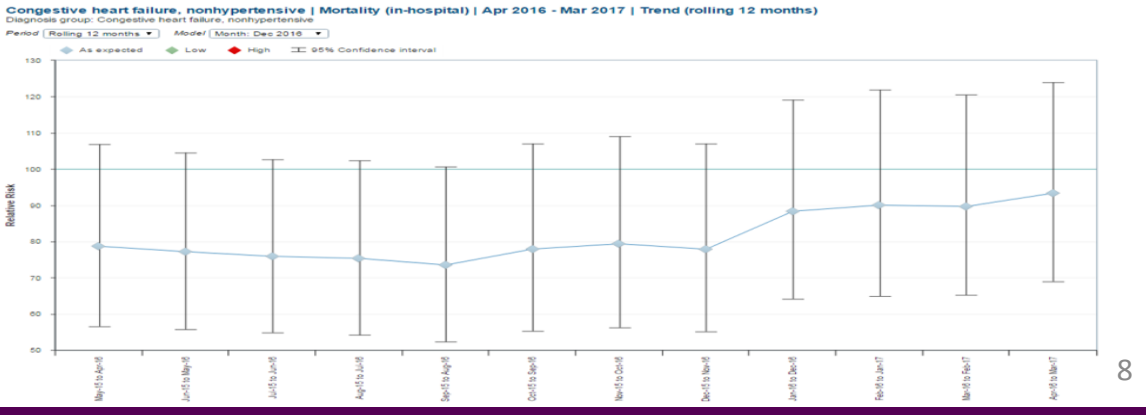
The HSMR for Septicaemia is currently below the national benchmark (100) at 94.07.



The HSMR for Pneumonia is also below the national benchmark (100) at 91.98.



The HSMR for Congestive Cardiac Failure is currently below the national benchmark (100) at 90.94.



Effective Page 15

Please see Effective section for QTR 4 CQUIN 16/17 Tracker

Caring Page 16

The Trust is currently reviewing the source and methodology of the MSA reporting since the adoption of the Extramed System and the increased use of Lister Ward as an assessment unit. This work is further supported by the South East project group led by NHS England

Responsive Page 17

● RTT

Performance against the incomplete 18 weeks standard has improved on the previous month. Performance for June was 82.4% against the national standard of 92% however this remains above the agreed trajectory, currently one month ahead, for delivery of the standard by the end of January 2018.

The total number of patients waiting more than 18 weeks on an open pathway has reduced by 451 patients from the previous month.

The numbers of patients waiting over 52 weeks for treatment has decreased from 33 in May to 21 in June. Patients waiting longer than 52 weeks are reviewed clinically with no incidence of moderate or severe harm identified.

● ED

The Trusts Emergency Department's (ED) performance, against the national 4 hour standard, for June was **91.05%**. June saw a 3.32% improvement on performance compared to May 2017 and was 3.95% below Medway Foundation Trust (MFT) planned trajectory of 95% for the month. The Trust has subsequently revised its trajectory to deliver 95% performance from June 2017.

This markedly improved performance was driven by a number of individual factors. -

- June saw the continuance of the Better, Best, Brilliant (BBB) Flow work stream. The BBB work began to focus on unblocking the trusts urgent care flows thus allowing staff to provide care in the manner and place where it would be optimised. The work focused on eliminating blocks within pathways and increasing patient facing time for clinical staff.
- The BBB rapid improvement initiative therefore resulted in a marked and immediate effect on the in-month performance against the 4 hr standard.
- The ED streaming process is still averaging **around 40% of patients** being redirected to a more appropriate place of care within the primary care setting. The team's current performance is now in line with the best performing units nationally.
- The BBB work refocused the locus of control for the organisations flow to the Clinical Coordination Centre (CCC) and utilised 3 daily huddles as the main vehicle for rapid improvement.
- Lister ward remains as a 24hr acute medical unit to increase flow in the evening. Subsequently the medical admission 4 hour performance remains almost consistently over 80%.
- There is continual monitoring of the length of stay on the acute admissions wards to ensure patients spend no more than 48 hours. This, again, is a key metric of the CCC discussion.
- The surgical bed base rapid reconfiguration has resulted in a larger Surgical Assessment unit with co-located specialties which is taking more patients through within 4 hours of arrival to the ED.
- The discharge lounge is now seeing up to 40 patients per day through allowing a better patient experience and a much earlier provision of bed availability improving flow and performance..
- All of the facilities and clinical support services have reviewed their processes which effect patient flow and as a result have assisted with patient treatment times and added immense value to the wider BBB initiative.
- ExtraMed Patient Flow Management System is now more established which has continued the step change in the way the CCC team and colleagues can manage patient flow within MFT.
- The MFT Business Intelligence team rapidly developed a BBB dashboard so that staff could have sight of key performance indicator's in real time and therefore react where required to support flow. This is utilised as a key component of the CCC metrics and discussion

June 2107 saw a **2%** reduction in attendances compared to May but an 8% increase on the same time last year. MFT remains consistently one of the top performer's in the region for ambulance handover with 40% of offloads within 15 minutes for June despite seeing the largest number of conveyances in the region (3179).

Cancer

- **2WW - The Trust failed to achieve the GP 2 week wait predominantly due to the historical clinic capacity issues in Skin as a result of ongoing Consultant vacancy. The Trust also failed with the 2 week wait symptomatic breast standard for a further month as a result of patients choosing an appointment outside of 2 weeks.**
 - Dermatology consultant vacancy is now filled and skin 2ww compliance has improved significantly in June
 - 22/33 of the 2 week wait breaches were booked within the target 48 hours from receipt of referral
 - Monthly audits are being established to investigate the reasons for late bookings and information provided to tumour site management
 - Monthly audits are being established to investigate how many days into the 2 week wait pathway first appointments are being offered
- **31D –The Trust achieved the first definitive treatment standard with performance of 100%**
- **31D Subsequent surgical – The Trust failed to meet this standard with 3 breaches in total .Two breast breaches were as a result of consultant leave and 1 skin breach was due to the patient changing the surgical date which was undertaken as an outpatient minor operational procedure and cannot therefore be adjusted for patient availability on the National Cancer Database**
 - NHSI are investigating on behalf of MFT if adjustments are possible for outpatient treatments
- **62D - The Trust failed to achieve compliance with the GP 62 day referral standard and 62 day screening standard.**

The 62 GP standard performance was 74.24%, failing both the 85% standard and the 83.5% improvement trajectory. However, forecast performance for June looks much improved

The 62 day screening failed due to 1.5 breaches, 1 breast due to theatre capacity/consultant leave and 0.5 lower GI due to diagnostic delays

There were 25.5 breaches against the GP 62 day referral standard with 3 breast, 1 haematology, 1 head & neck, 9.5 lower GI, 0.5 lung, 0.5 sarcoma, 4.5 Skin, 1 upper GI and 4.5 Urology breaches

Pathway breaches were varied due to complex pathways, theatre & diagnostic capacity, consultant leave, patient choice and fitness for treatment, late referrals by Medway from originating Trusts. Delays in the skin pathway due to 2ww capacity contributed to the late referrals to treating Trusts

There were 9 breaches over 104 day and 12 breaches between 62 & 76 days for which Medway is a National outlier

Voluntary turnover (across all staff groups) decreased slightly to 9.7% (-0.3%) remaining largely static and above the tolerance level of 8%. Sickness absence (at 3.84%) remains slightly below the tolerance level of 4% and is also a slight decrease from the previous month (-0.02%). Ratios of long-term sickness to short-term sickness remain largely static between months.

In June, we continued to see a net increase in staffing (more starters than leavers) by +17 FTE. The number of leavers of the last three months remains lower than the year to date average.

Temporary staff (specifically agency) has seen three consecutive, significant decreases by -9.2% comparing June to March – now standing at 16.9%. This continues to be a result of supporting temporary staff to substantive positions and successful recruitment campaigns.

Data Quality Validation Update

The Data Quality Team is currently supporting the ED Department by identifying data items entered late or incorrect onto the Symphony System. The reporting mechanisms are currently being set up to ensure this information is available to the ED Team for them to address the issues immediately. Highlighting and correcting these issues sooner will enable performance reports to be monitored and agreed in a timelier manner, allowing managers to subsequently address any areas of concern, either within the ED department or other hospital departments.

Referral To Treatment (RTT) update:

The DQ Team continues to support the Operational Divisions with managing and monitoring their 18 week RTT position. Monitoring daily RTT reports where patients have not been validated after hitting trigger points, such as:

1 outpatient appointment since last validation

Patient over 15 weeks since last validation

Additionally, the DQ Team monitors patients that have waited over 52 weeks for treatment, ensuring these are accurate through validation and sign off with the divisions. This information is fed back to Business Intelligence.

Furthermore, the DQ Team are reviewing the 18 week decision making training in consultation with Service Managers and Training. This will then be delivered to staff involved with RTT and patient pathways, enhancing subject matter knowledge and assisting the Trusts RTT position.

Other DQ related work:

The team continue to validate data quality issues of patient records, identified through the Data Quality dashboard. Regular engagement with Directorates and partners is on-going.

3. Safe

	Monthly Target	RAG Status	Trend					Data Quality	Alignment		
			Apr-17	May-17	Jun-17	Movement	YTD avg		Carter	SOF	Quality Account / Column
1.1.3.2 NRLS Organisational Reporting Rate (6 monthly)	40	G	40.63								
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	4.00	5.00	2.00	↓	4.2				✓
1.1.6 Incidents resulting in severe harm (per 1000 bed days)	0.30	R	0.60	0.20	0.49	↑	0.24				✓
1.1.7 Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	0.97	1.70	1.41	↓	1.7				✓
1.1.10 Incidents with moderate or severe harm with duty of candour response	100%	R	4.5%	0.0%	0.0%	↔	13.6				✓
1.1.14 Pressure ulcers (grade 2) attributable to trust	10	G	10.00	6.00	7.00	↑	10.2				✓
1.1.15 Pressure ulcers (grade 3&4)	0	R	1.00	0.00	1.00	↑	1.1				✓
1.1.17 Patient falls with moderate or severe harm (per 1000 bed days)	0.2	R	0.07	0.07	0.21	↑	0.1				
1.1.18 Falls per 1000 bed days	6.63	G	4.90	5.02	5.41	↑	5.2				
1.1.19 Number of falls to fracture (per 1000 bed days)	0.2	G	0.00	0.07	0.14	↑	0.1				
1.1.20 NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00		↔	0.0		✓		
1.1.21 % Duty of Candour with first letter	Datix system being reconfigured to allow accurate data capture.										
1.2.2 New VTEs - point prevalence in month	0.36%	G	0.4%	1.30%	0.20%	↓	0.7%			✓	
1.2.7 Emergency c-section rate	<15%	R	17.0%	17.2%	19.3%	↑	17.7%				
1.3.1 MRSA screening of admissions	95%	R	97.7%	96.3%	86.0%	↓	94%				✓
1.3.2 MRSA bacteraemia (trust – attributable)	0	G	0.00	0.00	0.00	↔	0		✓		
1.3.3 C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	R	0.00	3.00	6.00	↑	2		✓	✓	
1.4.1 Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	99.43 (93.81-105.29)						✓	✓	
1.4.1.2 Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	105.75 (94.64-117.79)						✓		
1.4.2 Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.09 (0.89-1.12)						✓	✓	

Commentary

Please see Executive Summary

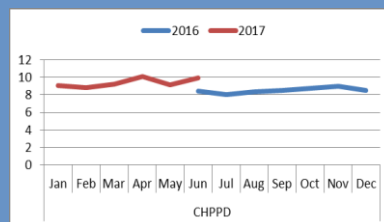
Actions

Please see Executive Summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

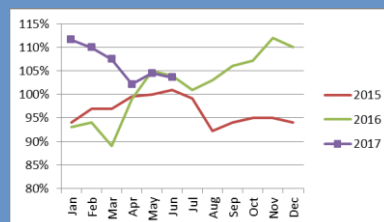
We have continued to see good performance remaining over the target of 8 for June.



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

Safe Staffing

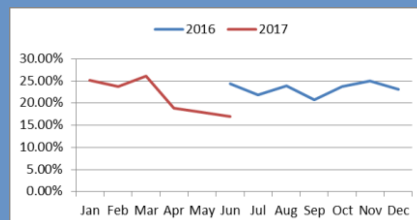
There has been a small decrease in the amount of actual hours worked vs plan, but we continue to perform above 100%.



Staff issues are being risk assessed multiple time daily. Nursing days are being held with good turnout which has led to more recruitment in the pipeline.

Temporary Staffing

The Trust remains below target for Temporary Staffing, however since January we have seen a month on month decrease.



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

Staffing Levels – Nursing & Clinical Support Workers

Page 59 of 303.

Directorate	WARD	Bec	Day				Night				Day		Night	
			Registered Staff		Care Staff		Registered Staff		Care Staff		Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Average fill rate - registered staff (%)	Average fill rate - care staff (%)
			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				
Acute & Continuing Care	Bronte Ward	18	1487	1238	1100	1111	1058	1057	700	747	83%	101%	100%	107%
Acute & Continuing Care	Byron Ward	26	1397	1383	921	1814	956	1351	979	1560	99%	197%	141%	159%
Acute & Continuing Care	CCU	4	697	675	0	0	690	691	0	12	97%		100%	
Acute & Continuing Care	Gundulph	25	1962	1136	1540	1303	1254	1144	1298	1232	58%	85%	91%	95%
Acute & Continuing Care	Harvey Ward	24	1122	1167	1559	1320	1013	1005	1013	900	104%	85%	99%	89%
Acute & Continuing Care	Keats Ward	27	1614	1225	1236	1309	957	1200	990	1111	76%	106%	125%	112%
Acute & Continuing Care	Lawrence Ward	19	1091	982	861	949	675	776	675	696	90%	110%	115%	103%
Acute & Continuing Care	Milton Ward	27	1551	949	1117	2067	1013	983	967	1533	61%	185%	97%	159%
Acute & Continuing Care	Nelson Ward	24	1486	1306	1133	1157	979	994	649	659	88%	102%	102%	102%
Acute & Continuing Care	Sapphire Ward	28	1696	1015	2381	1906	968	957	1325	1318	60%	80%	99%	99%
Acute & Continuing Care	Tennyson Ward	27	1506	1028	1218	1456	1001	979	1013	1027	68%	120%	98%	101%
Acute & Continuing Care	Wakeley Ward	25	1902	1434	1511	1455	1294	1239	1339	1348	75%	96%	96%	101%
Acute & Continuing Care	Will Adams Ward	26	1561	1084	1113	1450	913	1072	979	1199	69%	130%	117%	122%
Co-ordinated Surgical	Arethusa Ward	27	1810	1741	1110	1581	1276	1407	1069	1426	96%	142%	110%	133%
Co-ordinated Surgical	ICU	9	3602	3211	0	0	3352	3071	0	0	89%		92%	
Co-ordinated Surgical	Kingfisher SAU	14	1938	1435	1379	1633	1287	1465	660	891	74%	118%	114%	135%
Co-ordinated Surgical	McCulloch Ward	29	1382	1674	1105	1959	957	1429	990	1308	121%	177%	149%	132%
Co-ordinated Surgical	Medical HDU	6	1426	1266	348	306	1035	1002	345	333	89%	88%	97%	97%
Co-ordinated Surgical	Pembroke Ward	27	1724	1967	1036	1944	968	1782	990	1615	114%	188%	184%	163%
Co-ordinated Surgical	Phoenix Ward	30	1911	1508	1554	1560	1276	1473	1298	1307	79%	100%	115%	101%
Co-ordinated Surgical	SDCC	26	1854	1576	1397	905	572	528	572	473	85%	65%	92%	83%
Co-ordinated Surgical	Surgical HDU	10	2168	2145	389	295	1616	1921	0	0	99%	76%	119%	
Co-ordinated Surgical	Victory Ward	18	887	865	671	1113	847	814	528	715	97%	166%	96%	135%
Women & Childrens	Delivery Suite	15	2828	2818	492	675	2868	2861	492	468	100%	137%	100%	95%
Women & Childrens	Dolphin (Paeds)	34	3099	2886	752	1077	2415	2299	334	460	93%	143%	95%	138%
Women & Childrens	Kent Ward	24	1057	1046	414	408	708	710	660	660	99%	99%	100%	100%
Women & Childrens	NICU	25	3438	3990	127	127	3410	3935	0	23	116%	100%	115%	
Women & Childrens	Ocelot Ward	12	840	848	513	508	708	719	360	360	101%	99%	101%	100%
Women & Childrens	Pearl Ward	23	1071	1299	652	642	1080	1083	336	336	121%	98%	100%	100%
Women & Childrens	The Birth Place	9	1080	1018	360	360	1080	1024	360	324	94%	100%	95%	90%
Trust total		638	51,183	45,914	27,985	32,386	38,224	40,966	20,919	24,039	89.7%	115.7%	107.2%	114.9%

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG	Trend							Data Quality
			Status	Apr-17	May-17	Jun-17	Movement	YTD avg	Trend		
1.5.2	Vacancy Rate (Overall)	8%	R	26.82%	25.86%	25.48%	↓	26.05%	<div><div></div><div></div><div></div></div>		
1.5.3	Total Vacancies (WTE)	TBC		471.24	400.00	394.00	↓	421.7	<div><div></div><div></div><div></div></div>		
1.5.4	Vacancy Rate (Band 5)	TBC		36.97%	36.16%	36.02%	↓	0.4	<div><div></div><div></div><div></div></div>		
1.5.5	Vacancy Rate (Band 6)	TBC		24.94%	24.10%	22.47%	↓	0.24	<div><div></div><div></div><div></div></div>		
1.5.6	Vacancy Rate (CSW)	TBC		19.16%	18.78%	17.87%	↓	0.2	<div><div></div><div></div><div></div></div>		
1.5.7	Nursing Starters	TBC		14	15	16	↑	15.0	<div><div></div><div></div><div></div></div>		
1.5.8	Nursing Leavers	TBC		18	12	10	↓	13.3	<div><div></div><div></div><div></div></div>		
1.5.9	CSW Starters	TBC		16	14	14	↔	14.7	<div><div></div><div></div><div></div></div>		
1.5.10	CSW Leavers	TBC		12	6	11	↑	9.7	<div><div></div><div></div><div></div></div>		
1.5.11	Rolling annual turnover rate	8%	R	10.00%	9.95%	9.73%	↓	0.1	<div><div></div><div></div><div></div></div>		
1.5.16	Safe Staffing	94.00%	G	102.1%	104.5%	103.6%	↓	103.4%	<div><div></div><div></div><div></div></div>		
1.5.17	CHPPD	8.00	G	10.09	9.17	9.93	↑	973%	<div><div></div><div></div><div></div></div>		

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

Commentary	Actions
<p>The Trust has reviewed our current use of the assessment days, and as such all band 6 and below roles are now being recruited through one standardised process.</p> <p>The Trust is currently reviewing job adverts with a view to ensure these are individualised based on the area of recruitment.</p>	<p>Continue to recruit in line with these processes.</p>

4. Effective

	Monthly Target	Status	Trend						Alignment			
			Apr-17	May-17	Jun-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN	CQUIN
2.5.4 Emergency Readmissions within 28 days	5%	R	11.9%	13.3%	12.9%	↓	12%			✓		
2.5.4.1 Emergency Readmissions within 28 days Under 65	5%	R	9.7%	11.9%	12.4%	↑	11%					
2.5.4.2 Emergency Readmissions within 28 days 65 +	5%	R	14.3%	14.9%	13.5%	↓	15%					
2.6 Discharges before noon	25%	R	13.78%	20.59%	20.56%	↓	15%		✓	✓		

CQUIN	CCG Reconciliation Notes Q4	Q1 CQUIN Achievement	Q2 CQUIN	Q3 CQUIN Achievement	Q4 CQUIN Achievement	Year end 2016/17 financial payment
NHS Staff and Wellbeing Physical, Mental & Physio	Q4 Achieved	Achieved	Not applicable	Not applicable	Achieved	£428,400
NHS Staff and Wellbeing food	Q4 Achieved	Not Achieved	Not applicable	Not applicable	Achieved	£342,720
NHS Staff and Wellbeing flu	Q4 Achieved	Not applicable	Not applicable	Not applicable	Achieved	£428,400
Sepsis 2a	Q4 Achieved 5% Not achieved 5%	Partial (20%)	Not Achieved	Partial (5%)	Partial (5%) Not achieved 5%	£64,260
Sepsis 2b	Q4 Achieved 7.5% Not achieved 7.5%	Achieved	Not Achieved	Achieved	Partial (7.5%) Not achieved 5%	£133,875
Antimicrobial Resistance 5A -	Q4 Achieved	Not Achieved	Not Achieved	Achieved	Achieved	£85,680
Antimicrobial Resistance 5B -	Q4 Achieved	Not Achieved	Not Achieved	Achieved	Achieved	£21,420
Joint Formulary	Audit report has not been submitted that evidences required reduction in FP10 prescriptions.	Achieved	Achieved	Not Achieved	Not Achieved	£133,661
Medicines Reconciliation	Q4 Achieved 20% Not achieved 25% 15% No data received to evidence number of charts sampled. 10% No evidence of actions taken	Not Achieved 15%	Not Achieved 15%	Partial (15%) achieved Not achieved 10%	Partial (20%) achieved Not achieved 25%	£63,488
Review of patients on Oral Nutritional Supplements	Q4 Achieved	Achieved	Achieved	Not Achieved	Achieved	£200,491
Reduction in Community Acquired Pressure Ulcers	Q4 Achieved	Achieved	Achieved	Achieved	Achieved	£267,322
Discharge Before Midday	Not achieved as data supplied by Trust evidence that improvement is at 16.66% against a target of 35% for payment	Achieved	Not Achieved	Not Achieved	Not Achieved	£53,464
Paediatric outpatient referral management system	Q4 Achieved	Achieved	Not applicable	Not applicable	Achieved	£267,322
Development of Electronic Discharge Note	Quarter 4 not achieved. Despite an enormous effort by the EDN CQUIN lead at MFT, the Q4 milestones have not been achieved. (with 2 milestones being outside of the organisation's control)	Achieved	Achieved	Achieved	Not Achieved	£213,857
Paediatric asthma and wheeze pathway	Q4 Achieved 65% Not achieved 15% This is based on 9.2% reattendance	Achieved	Not applicable	Not applicable	Partial (65%) Achieved Not achieved 15%	£181,779

5. Caring

		Monthly Target	RAG Status	Trend						Alignment		
				Apr-17	May-17	Jun-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / COUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	83%	G	88.8%	86.7%	87.9%	↑	86%		✓		
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	65%	G	82.8%	84.8%	82.4%	↓	78%		✓		
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	79%	G	99.0%	98.9%	99.1%	↑	99%		✓		
3.1.3	Mixed Sex Accommodation breaches	15	R	33.00	26.00	37.00	↑	28.7		✓		
3.4.1	Number of Complaints	45	R	53.00	63.00	62.00	↓	50		✓		
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	85%	R	49.0%				43%		✓		
3.4.3	Number of complaint returners	↓	G	1.00	6.00	4.00	↓	6.3		✓		

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

6. Responsive

	Monthly Target	Status	Trend						Alignment		
			Apr-17	May-17	Jun-17	Movement	YTD avg	Data Quality	Carter	SDF	Quality Account / COUIN
4.1.1 RTT – Incomplete pathways (overall)	92%	R	76.97%	80.80%	82.42%	↑	77.50%		✓		
4.1.2 RTT - Treatment Over 52 Weeks	0	G	33	33	21	↓	21				
4.2.3 A&E 4 hour target	95%	R	80.77%	87.73%	91.05%	↑	79.95%		✓		
4.3.1 Cancer – 2 week wait (1 month in arrears)	93%	R	68.17%	73.64%		↑	82.04%				
4.3.2 Cancer - 2 Week Wait Breast (1 month in arrears)	93%	R	86.36%	81.72%		↓	90.57%				
4.3.3 Cancer - 31 day first treatment (1 month in arrears)	96%	G	97.03%	97.22%		↑	94.24%				
4.3.4 Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	R	100.00%	87.50%		↓	92.20%				
4.3.5 Cancer – 31 day subsequent treatments - drug (1 month in arrears)	98%	G	100.00%	100.00%		↔	98.91%				
4.3.6 Cancer - 62 day consultant upgrade (1 month in arrears)	N/A		60.00%	80.00%		↑	78.60%				
4.3.7 Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	R	84.71%	74.24%		↓	79%		✓		
4.3.9 Cancer – 62 day screening (1 month in arrears)	90%	R	83.33%	80.00%		↓	88%		✓		
4.4.1 Diagnostic waits - under 6 weeks (1 month in arrears)	99%	R	95.16%	96.53%	96.15%	↓	93%		✓		
4.5.8 Patients seen by a stroke consultant within 24 hours (Dec to Mar figures reported)	95%	R	48.00%	71.00%		↑	52%				✓
4.6.1 Average elective Length of Stay	<5	G	1.99	2.27	2.40	↑	2.5				✓
4.6.2 Average non-elective Length of Stay	<5	R	7.01	8.40	9.19	↑	6.7				✓
4.6.6 Average occupancy	90%	R	96.67%	94.44%	94.48%	↑	94%				✓

**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	Apr-17	May-17	Jun-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / COQIN
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	62%	R	57.7%			↔	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	79%	R	73.1%			↔	73.0%			✓	
5.3.7	Rolling annual turnover rate	8%	R	10.1%	10.0%	9.7%	↓				✓	
5.3.7.1	Executive Team Turnover Rate			7.1%	7.1%	0.0%	↓	3%			✓	
5.3.8	Overall Sickness rate	4.0%	G	3.90%	3.86%	3.84%	↓	3.9%				
5.3.9	Sickness rate – Short term	3.0%	G	2.1%	2.1%	2.0%	↓	2.6%			✓	
5.3.10	Sickness rate – Long term	1.0%	R	1.8%	1.8%	1.8%	↔	1.3%			✓	
5.3.11	Temporary staff % of pay bill	15%	R	18.9%	17.9%	16.9%	↓	22.4%			✓	
5.3.14	Starters	N/A		53	56	62	↑	72.7				
5.3.15	Leavers	N/A		53	39	45	↑	55.6				

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

8. Enablers

		Monthly Target	Status	Trend						Alignment			
				Status	Apr-17	May-17	Jun-17	Movement	YTD avg	Data Quality	Carier	SOF	Quality Account / Column
7.2.1	APC – NHS number completeness (2 month in arrears)	99%	G		99.2%				99.0%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	99%	R		96.1%				96.5%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	11	R		225	112		↓	96.9		✓		✓
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		119	99		↓	308.6		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	1%	G		0.5%	0.4%		↓	1.3%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	103.50	G		6	6		↔	243.21				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	0.00	R		2.00	2.00		↔	3.21				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	949	R		1861	1222		↓	1647.4		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	50%	R		100.0%	100.0%		↔	91.0%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	0.25	R		0	6		↑	5.4		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	13.25	G		2	1		↓	18.4		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	0.01	R		0	0		↔	0%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	2	R		2	14		↑	5.9		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	1.25	G		0	0		↔	2.3		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	1.25	R		2	14		↑	4.3		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	1	R		0	3		↑	5.2		✓		✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Report to the Trust Board (Public)

10b

Date: 3 August 2017

Agenda Item:

Title of Report	Annual Safeguarding Report 2016/2017
Presented by	Prepared by Bridget Fordham, Head of Safeguarding Presented by Karen Rule, Director of Nursing
Lead Director	Karen Rule, Director of Nursing
Committees or Groups who have considered this report	Quality Assurance Committee
Executive Summary	<p>The report reviews the safeguarding work from 1 April 2016 to 31 March 2017, giving assurance that the Trust has discharged its statutory and regulatory responsibilities to safeguard the welfare of adults & children.</p> <p>Over the course of the year the Adult and Children's work plans were brought together to maintain a focused vision through a new reporting and governance structure with a singular aim to ensure patients and public were safeguarded in accordance with legislation and that the staff at MFT were equipped with the knowledge, skills, confidence and competence required to achieve this.</p> <p>The Safeguarding resources were reviewed and a team established that can take the Safeguarding agendas forward, strengthening our credibility with external agencies and partners, withstanding scrutiny from governing bodies and reassuring the public and Trust board of our commitment to respond to safeguarding concerns promptly and openly, above all working towards prevention of abuse.</p>
Resource Implications	Nil
Risk and Assurance	Reputational and Regulatory risk should the Trust not fulfil its statutory and regulatory responsibilities
Legal Implications/Regulatory Requirements	<p>Compliance with statutory duties for safeguarding adults & children</p> <ul style="list-style-type: none"> • Care Act 2014 • Section 11 of the Children Act 2004 • Mental Capacity Act 2007. • Deprivation of Liberty Safeguards 2009 <p>Compliance with regulatory duties for safeguarding adults & children</p> <ul style="list-style-type: none"> • Fundamental standard (5) – safeguarding from abuse • Regulation 12: Safe care and treatment.

	<ul style="list-style-type: none"> Regulation 13: Safeguarding service users from abuse and improper treatment
Recovery Plan Implication	The work of the Safeguarding team contributes to the achievement of the Trust CQC improvement plan
Quality Impact Assessment	Not required
Recommendation	The Board is requested to note the contents of the report and the assurance provided in relation to the statutory and regulatory duties of the Trust in relation to Safeguarding
Purpose & Actions required by the Executive Group :	<div> <div>Approval <input type="checkbox"/></div> <div>Assurance <input checked="" type="checkbox"/></div> <div>Discussion <input type="checkbox"/></div> <div>Noting <input checked="" type="checkbox"/></div> </div>

Safeguarding Adults and Children's Annual Report 2016-2017

Bridget Fordham

HEAD OF SAFEGUARDING

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1 EXECUTIVE SUMMARY

- 1.1 It is a statutory requirement to present an Annual Report to the Trust Board showing how the Trust has met its safeguarding responsibilities.
- 1.2 The purpose of this report is to inform members of the Trust Board of the Safeguarding activities in Medway NHS Trust (MFT) during 1st April 2016 to 31st March 2017. It aims to provide assurance of compliance with the local multi-agency guidelines for safeguarding adults and compliance with statutory and regulatory duties.
- 1.3 All providers of health services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably skilled and supported. Within the CQC regulation framework two regulations are now specific to safeguarding within the Trust: Regulation 12: Safe Care and Treatment and Regulation 13: Safeguarding service users from abuse and improper treatment.
- 1.4 The Care Act 2014 brought about significant changes in the statutory duties health and social care have towards safeguarding adults. In July 2016 some amendments were made to clarify and provide further guidance.
- 1.5 The Care Act places adult safeguarding on a statutory footing and puts new legal duties on agencies to work more closely together and share information.
- 1.6 Chapter 14.7 of the Care Act guidance states “Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult’s wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.

- 1.7 The Trust has a commitment and a duty to safeguard adults at risk as stipulated in Outcome 7 of the Care Quality Commission Regulations. To achieve this goal the organisation has to ensure robust systems and policies are in place and are followed consistently, to provide training and supervision to enable staff to recognise and report incidents of adult abuse, to provide expert advice and to reduce the risks to vulnerable adults at risk of being abused.
- 1.8 The NHS England document Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework published in July 2015 provides details of the governance and assurance requirements and also recommends levels for resources and responsibilities for safeguarding.
- 1.9 The requirement of Acute Trusts to safeguard and promote the welfare of children as set out in section 11 of the Children Act 2004 and Working Together (2015) are monitored by the Care Quality Commission (CQC) NHS England and the Clinical Commissioning Groups (CCG).
- 1.10 The Counter Terrorism and Security Bill received Royal Assent on Thursday 12th February 2015. The Channel duty, placing Channel on a legislative footing as part of the Act, came into force on 12th April 2016. It ensures all health Trusts “have due regard, in the exercise of its functions, to prevent people from being drawn into terrorism”, i.e. strengthening the existing NHS Contract Prevent agenda to a statutory duty.
- 1.11 This report will present evidence that MFT is fulfilling its statutory and regulatory duties in the increasing national and local safeguarding agenda’s.

2 2016/2017 HIGHLIGHTS

- 2.1 During April 2016 a priority for Safeguarding Adults was to deliver the Remedial Act Plan (RAP) attached at **Appendix 1** from the Clinical Commissioning Group (CCG) and to action the Care Quality Commission (CQC) must do / should do recommendations from their report in February 2016. A separate review of

Safeguarding Children across Medway was also undertaken by the CQC which led to a further action plan for MFT. This plan is attached at **Appendix 2**.

- 2.2 Over the course of the year the work plans were brought together to maintain a focused vision through a new reporting and governance structure with a singular aim to ensure patients and public were safeguarded in accordance with legislation and that the staff at MFT were equipped with the knowledge, skills, confidence and competence required to achieve this.
- 2.3 The Safeguarding resources were reviewed and over the year recruitment has taken place to establish a team that can take the Safeguarding agendas forward, strengthening our credibility with external agencies and partners, withstanding scrutiny from governing bodies and reassuring the public and Trust board of our commitment to respond to safeguarding concerns promptly and openly, above all working towards prevention of abuse.
- 2.4 The use of databases to log all safeguarding adult concerns, allegations and outcomes allows us to look at themes and trends, areas of concern related to quality and / or clinical practices internally and also allows us to recognise and raise concerns about external services and providers where patterns or themes emerge. We now work very closely with our local authority colleagues, meeting regularly to ensure that no cases are missed or left unresponded to.
- 2.5 The Mental Capacity Act (MCA) continues to be an area requiring support and guidance. There has been renewed training and simpler forms introduced for staff to undertake a capacity assessment. During their inspection the CQC noted an improvement in staff understanding.
- 2.6 A database tracks all Deprivation of Liberty Safeguards (DoLS) urgent authorisations made within the Trust and allows us to monitor standard authorisations granted from the local authority. We were able to supply data during the CQC inspection that surpassed their expectations.
- 2.7 The experience for those with a Learning Disability (LD) has been enhanced with the introduction of the Learning Disability Liaison Nurse. This year has seen the

introduction of Learning Disability Champions across the organisation. There has been a review of pathways for those with an LD diagnosis from emergency admission routes, elective admissions and outpatient visits and in departments such as imaging (specifically CT and MRI). The LD nurse works collaboratively with families, carers, external agencies and local authorities to ensure that care needs are considered throughout the patient journey.

- 2.8 MFT had been considered to be disengaged from partner agencies and local authorities prior to 2016. There had been a lack of response to participate in the safeguarding multi agency work locally. This has been addressed however it remains a challenge to fulfil participation at all Boards and Subgroups due to the extraordinary amount of meetings involved.
- 2.9 The NHS has a statutory responsibility to comply and engage with 'Prevent'. This involves the formulation of policy and procedure, the training of staff and importantly having appropriate mechanisms in place to ensure that concerns are noted and shared. During the past year the training of staff has been a priority and continues to be so. Attendance at PREVENT training continues to be high and we have seen a number of staff discuss concerns.
- 2.10 Both Serious Adult Review (SAR) and Serious Case Review (SCR) for children have been commissioned to be undertaken by the multi-agency Safeguarding Boards this year. We have participated in these with the submission of an Independent Management Review (IMR) in these cases. These multi-agency reviews remain to be approved by the Safeguarding boards prior to their publication.
- 2.11 Safeguarding activity for Adults, Children and Maternity has grown significantly over the past year. There has been an increase in activity across Medway of those experiencing Domestic Abuse (DA), Gang activity has increased and is impacting on the welfare of children and young adults. Drug and Alcohol addiction, poverty, mental health and the high number of prisons locally impact upon the services MFT provide.
- 2.12 In addition to this we now know that a number of vulnerable and isolated people have been housed in Medway from London boroughs due to cheaper housing. As

they are funded from other local authorities they are not always known to health visiting, school nursing or social care. A serious case review was undertaken by Medway Safeguarding Children's Board during the year into the death of a young mother and her daughter. This case is not yet published but will highlight such concerns.

- 2.13 Engagement from all disciplines in the safeguarding investigation process has proven challenging at times, there has been a reluctance to engage in Section 42. In addition managing the external expectations and intense scrutiny in addition to carrying out an increasing workload of safeguarding activity on a day to day basis has impacted on the timeliness and delivery of our priorities.
- 2.14 A review of the training and levels staff should be expected to achieve has been undertaken and this will ensure staff are aware of their responsibilities for the coming year.
- 2.15 The lack of standard authorisation by local authorities for those detained under a Deprivation of Liberty Safeguard remains a concern however this is a similar position nationally. This has been escalated to the Trust Board and externally to our regulators.
- 2.16 Local issues across Kent and Medway show an increase in the nature of the diversity of Safeguarding. Our services need to be responsive to meet the challenges faced and a focus to promote prevention of abuse in all of its formats. Additionally recognising and responding to all disclosures in a compassionate and caring manner.
- 2.17 Ultimately the Trust Board requires assurance that the organisation is fulfilling its obligations to make arrangements to safeguard and promote the welfare of children and vulnerable adults. The Trust remains compliant with its statutory and regulatory duties and is committed to developing a joined up approach to safeguarding all our patients whatever their age.

3 ACTION PLANS

- 3.1 On 16th March 2016 MFT were served a contract performance notice (CPN) from Medway CCG in response to previous poor adult safeguarding performance. On 30th March 2016 the CQC visited the Trust and following interviews with the new adult safeguarding lead an action plan to assure the CQC and CCG was implemented to address the concerns raised.
- 3.2 A review of health services for Children Looked After (LAC) and Safeguarding across Medway in February 2016 took place and the report published in June 2016 gave a number of recommendations specific to MFT. Over the course of the year the action plans were merged and the Trust introduced a Head of Safeguarding post to lead on this work.
- 3.3 The RAP was closed at the final meeting on the 7th February 2017 it was agreed that the RAP had been completed to the standard required and the contract performance notice was therefore closed.
- 3.4 Following the CQC inspection in November and December 2016, the report published in February this year noted that Safeguarding training targets were not being met consistently across the trust for all staff groups. A must do action is to ensure that all staff have appropriate mandatory training, with particular reference to adult safeguarding level two and children safeguarding level two where compliance was below the hospital target of 80%. However they acknowledged that staff understanding of mental capacity was much improved.
- 3.5 A number of reviews have taken place with learning and development to ensure that those staff that require particular level training are profiled for it correctly. This has led to a further drop in compliance and increased training has been put in place to support achieving this.
- 3.6 It was also recognised that support to vulnerable patients such as those with learning disabilities had been significantly improved.
- 3.7 The CQC did however identify that the following should be addressed.

- The Trust should ensure the electronic flagging system for safeguarding children in the children's emergency department is fully embedded into practice.
- A review of safeguarding paperwork should take place to ensure it can be easily identified in patient's records.
- Ensure there is a system in place to identify Looked After Children (LAC) in the children's emergency department.

These actions have continued to be addressed within the 2017/18 action plan.

3.8 A number of documents have been written to support staff with changes in practice and procedure which reflect current legislation and changes for Safeguarding Adults. In particular the changes brought about by the introduction of the Care Act 2014 have led to the introduction of Making Safeguarding Personal (MSP). Safeguarding referrals must demonstrate that the patient has been consulted, where appropriate and a desired outcome is established. This is not the case where the person lacks capacity to make such decisions or even recognise that they have suffered abuse and / or neglect. Family should be consulted in these cases as appropriate.

3.9 Standard Operating Procedure (SOP) documents have been produced for:

- Safeguarding Adults – Making Safeguarding Referrals
- Safeguarding Adults – Process for Applying for Deprivation of Liberty Safeguards
- Management of Allegations against Trust Staff Involving a Vulnerable Adult or a Child procedure

3.10 Other documents also developed this year are:

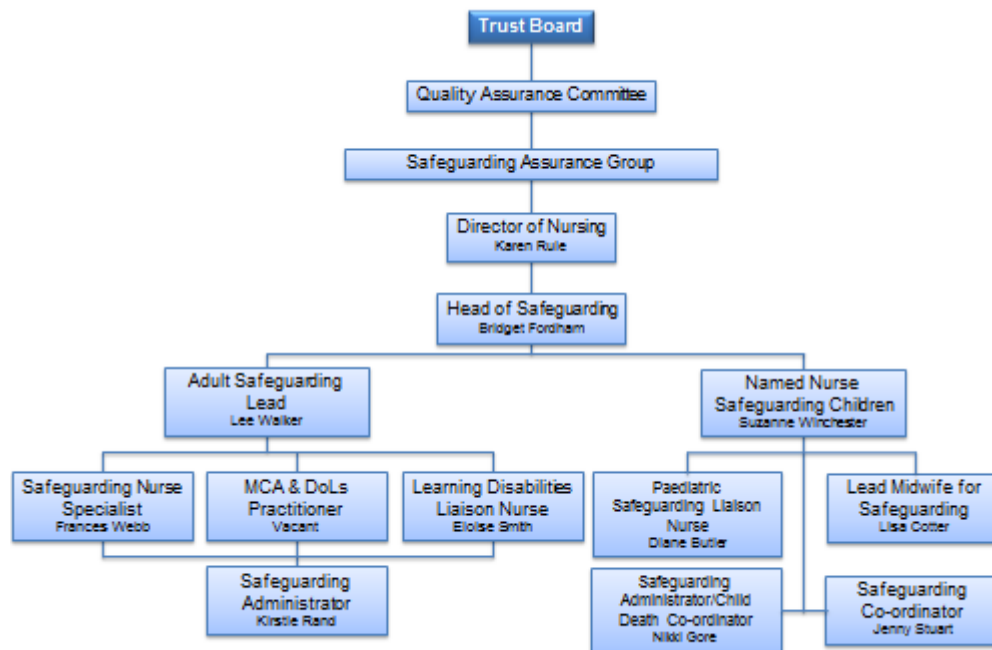
- Trust Safeguarding Strategy
- Safeguarding Adults Training Strategy
- Safeguarding Children's Training Strategy

- PREVENT Guidelines

- 3.11 There is now a Trust intranet Safeguarding Adults page with direct links to all forms and documents available with a plan to merge the Children's page with this to create a Trust wide resource for safeguarding over the coming year.

4 RESOURCES AND GOVERNANCE

- 4.1 All health providers are required to have effective arrangements in place to safeguard vulnerable children and adults at risk and to assure themselves, regulators and their commissioners that these are working. These arrangements include safe recruitment, effective training of all staff, effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, a Named Nurse a Named Midwife and a Named lead for MCA/DoLs.
- 4.2 Recruitment into new safeguarding posts to increase the resources across children's and adults teams has been successful, however the recruitment has proven challenging within the adult posts and for much of the year these new posts have been filled with agency interim staff.
- 4.3 We have now successfully recruited a Specialist Safeguarding Adults Nurse and a Safeguarding Adults lead (yet to take up position). The children's team also recruited a new Paediatric Safeguarding Liaison Nurse and a new Safeguarding Midwife.



- 4.4 The governance arrangements for Safeguarding have evolved over the past year as the new team and structure commenced. In addition to the team members identified above the Trust has designated doctors for Adult and Children's safeguarding.
- 4.5 A monthly Children's and Adults Safeguarding Group is now held for operational issues. These meetings involve a representative from each directorate along with Learning Disabilities Nurse, Harm Free Nurses, Security, LAC team, School Nursing and both Safeguarding teams.
- 4.6 This meeting allows for discussions on actions to achieve work plan objectives, discuss challenging cases collaboratively, identify matters that impact upon safeguarding and ensure that those present are able to share information related to their areas of practice. It is also used to share learning from investigation outcomes, cascading information from meetings attended and review current safeguarding activity, providing peer support and debriefing as required.
- 4.7 A quarterly Safeguarding Assurance Group is chaired by the Director of Nursing. Representatives are invited from the CCG and local authorities. This meeting allows us to seek and provide assurance as to the progress of work plans, review of

strategic documents and policies and to provide assurance and responses to national recommendations from enquires and reports.

- 4.8 A number of external multi-agency meetings support our internal governance. It had been a criticism of the local boards for both children and adults that there had been a lack of engagement from MFT in previous years.
- 4.9 Over the past year we have engaged in both the Kent and Medway Safeguarding Adults board and the Medway Safeguarding Children's Board, presenting our progress to achieving both our RAP plan and the CQC actions. In doing so this provided our external partners reassurance of our commitment to do all we can to safeguard the adults and children that use our services.
- 4.10 Kent Safeguarding Children's Board has representation from MFT only via its subgroups. In addition to these subgroups, there are a number of subgroups from the other Boards. The number of meetings at which participation from MFT is expected has proven challenging to manage and engage fully over the past year.
- 4.11 On completion of the Kent and Medway Safeguarding Adults Board (KMSAB) Self-assessment Framework and undertaking the peer review required it was clear that huge progress has been made to achieve the standards set out by the Board. This is attached at **Appendix 3**.
- 4.12 The Trust meets its statutory requirements with regard to the carrying out of Disclosure and Barring Service (DBS) checks. All clinical staff employed at the Trust undergo a DBS check prior to employment and those working with vulnerable adults undergo an enhanced level of assessment.

5 SAFEGUARDING ADULTS ACTIVITY

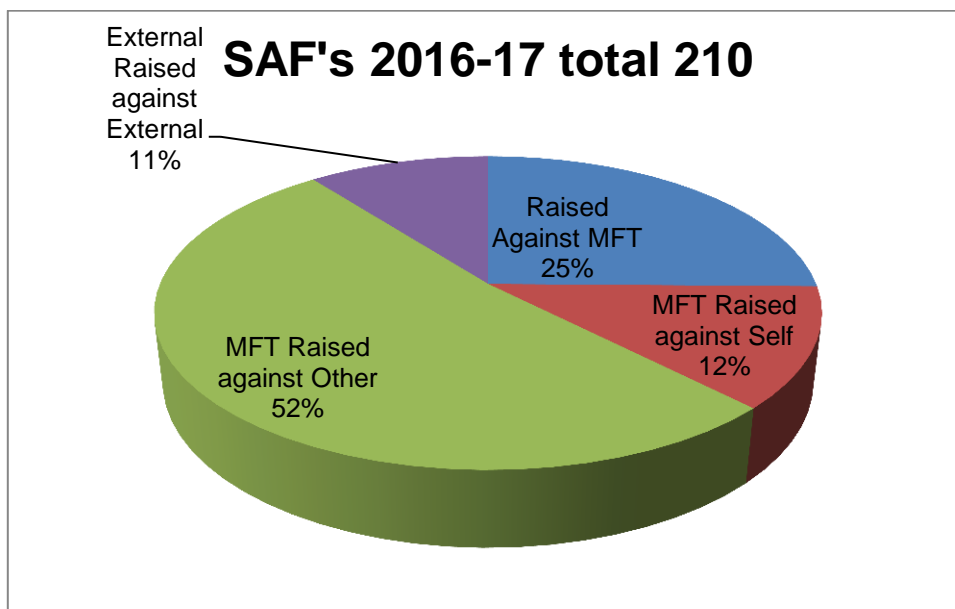
- 5.1 A guiding principal of the Act is to ensure conversations look at the individual overall and not just use a "sticking plaster" approach to problems. Multi agency approaches through conversations and collaborative working must focus on joining up around an individual, making the person the starting point for planning, rather than what

services are provided by what particular agency. Safeguarding duties have a legal effect in relation to organisations other than the local authority on for example the NHS and the Police e.g. Organisational abuse which includes neglect and poor care practice within an institution or specific care setting such as a hospital or care home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

- 5.2 Activity has been steadily growing over the past year as staff awareness and recognition of safeguarding matters has grown. In April 2016, following on from the Contract Performance Notice (CPN) served by the CCG in regards to a lack of response and compliance with safeguarding duties, we were made aware of a significant number of outstanding safeguarding enquiries raised against MFT.
- 5.3 Initially a list of 32 outstanding investigations was provided by Medway Council social workers and this continued to grow over the first 2 quarters as local authorities became aware of the new structure and responsiveness at MFT. 3 of these matters were passed to us by Kent Police.
- 5.4 26 of the cases were safeguarding alert forms (SAF's) that were raised against the Trust during 2015. Of these, retrospective investigations were undertaken by the new safeguarding adults team and reports submitted to the relevant local authorities.
- 5.5 15 of these investigations substantiated that "abuse" caused via neglect by the Trust. of these the highest cause was acquired pressure ulcers and poor nutritional management. Transfer of care and poor discharge was also a factor.
- 5.6 7 cases were closed with no case to answer
- 5.7 4 cases were inconclusive or partially substantiated.
- 5.8 Between January and March 2016 a further 13 SAF's raised against care at the Trust were identified as outstanding investigation. This included an allegation of physical assault from an agency Clinical Support Worker (CSW) that had been assigned to provide one to one care to a vulnerable patient. The allegation was that the inappropriate restraint had been imposed upon the patient by the CSW as she had

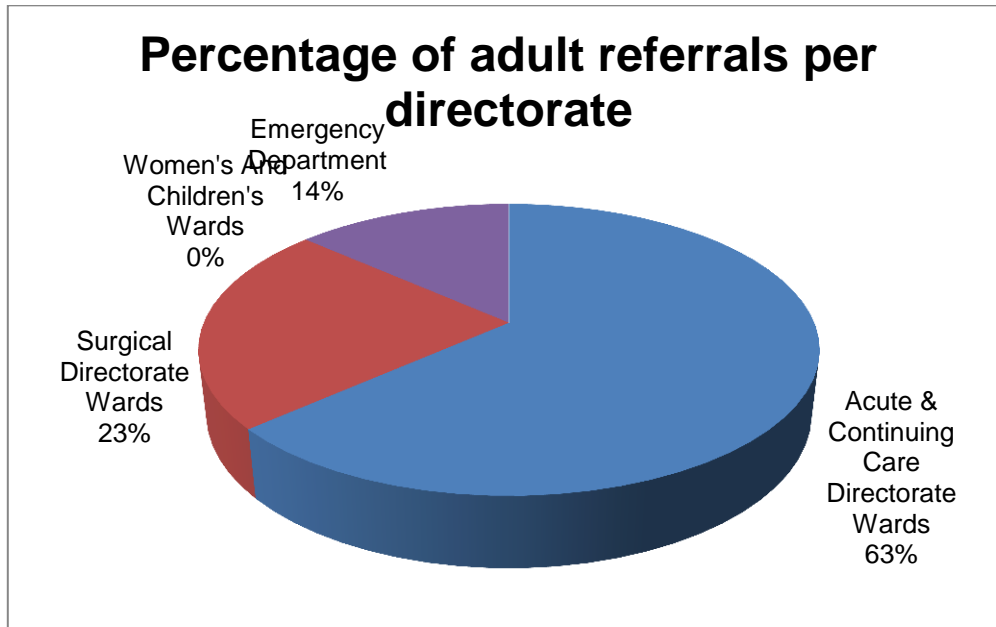
tied the patient to the bed using her nightdress. This matter was investigated by the Combined Safeguarding Team (CST) at Kent police who sought successful prosecution for common assault.

- 5.9 A number of other historic concerns were reviewed and closed as not safeguarding following a number of meetings with the social workers involved. These were due to insufficient detail provided on the SAF, dates not matching inpatient episodes and the SAF form being used inappropriately.
- 5.10 During this reporting year (2016-17) we have seen a total of 210 SAF's investigated by the team. As the year has progressed and the confidence of staff across the organisation has developed we have seen an increase in the number of SAF's raised by staff as soon as neglect has been recognised, abuse has been disclosed or concerns raised about the persons significant vulnerabilities.
- 5.11 In particular we have had 79 Safeguarding investigations relating to care and treatment within the Trust. 26 of which were self recognised and notified.



- 5.12 54 patients that were subject of safeguarding enquiries died whilst in hospital. That is not to say the safeguarding concerns had an impact on each of these deaths nor were all of these patients safeguarding concerns against the Trust.

- 5.13 60 safeguarding enquiries were conducted into pressure ulcer and tissue viability concerns.



- 5.14 Section 42 means that the Local Authority (often referred to as Adult Social Services) must make enquiries, or cause others to do so; This means an enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by who. (Care and Support Guidance 2016).
- 5.15 The Local Authority is the lead agency for making enquiries, however it may require others to undertake them. This is likely to see the role of NHS staff in safeguarding broaden and increase.
- 5.16 A number of the safeguarding enquiries conducted have run concurrently with investigations led by the patient safety team who were managing Serious Incident (SI's) into the acquired grade 4 pressure ulcers.
- 5.17 5 patients were the subject of Section 42 (S42) enquires for acquisition of Grade 4 pressure ulcers. They had all died prior to the S42 being undertaken and their cause of death demonstrated that the acquired pressure ulcers had been directly linked to their deaths. These cases were substantiated against the Trust on the grounds of neglect.

- 5.18 During these investigations there were significant concerns around the nutritional monitoring of the patients, a lack of mental capacity assessment undertaken or review and the lack of staff understanding their role and the importance of analysing the effectiveness of the care they provided to the patient. The directorates have action plans in place to address these matters.
- 5.19 In total 9 patients including the 5 cases mentioned above died as a result of poor care. These cases were substantiated against the Trust on the grounds of Neglect via Acts of Omission following the section 42 enquiries. There are a number of investigations still awaiting the decision from the local authority social workers. In addition to these there are a number of Serious Incident reports awaited linked to safeguarding investigations that are also awaited prior to the decision and closure of the safeguarding cases.
- 5.20 The top 5 causes for safeguarding alerts raised against the Trust in the period 2016/17 are:
1. Pressure Ulcer acquisition or deterioration of.
 2. Poor Discharge / Transfer of Care / Home First concerns
 3. Failure to adequately feed or provide nutrition to a patient during their admission.
 4. Conduct by staff, physical, verbal or psychological
 5. Missing patient whilst subject to a DOLS.
- 5.21 Allegations against staff was a concern raised in the RAP by the CCG. They required that the Trust developed a policy for the “Management of Allegations Against Staff” where allegations of abuse have been raised against them.
- 5.22 This was written in draft as a safeguarding policy document; however this needs to run in parallel with the Trust disciplinary procedures and has taken some time to be approved with HR and Unions. This document has now been ratified as an SOP.

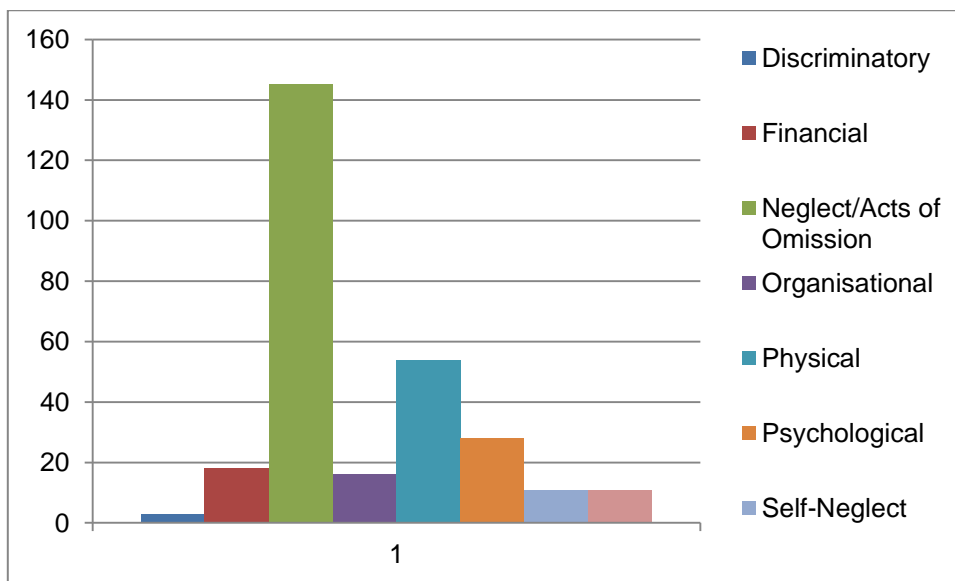
5.23 Safeguarding have been made aware of a number of safeguarding allegations made against staff during the year. Kent police have been asked to review each one of these cases but no prosecutions were sought by them.

- 1 incident of a male nurse from an agency working on a night duty as a 1:1 support for a patient with dementia. This member of staff was not a nurse or an employee of the agency. The person involved disclosed he undertook the shift for a relative. The ward staff, suspicious of his behavior and identity within a short period of time escalated to the Site manager and security escorted him from the premises following investigation. The agency was notified and investigation undertaken by them, The RMN booked has since been referred to the NMC.
- An agency CSW was investigated for inappropriate conduct with an elderly female patient. His agency have been notified and Social Care are meeting with the agency to ensure that he has this notified on his DBS. The police have been requested to review their involvement on the investigation findings by the Trust.
- An agency RMN was investigated for rough handling of a patient that had dementia. She was alleged to have put her hand over the mouth of the patient and this allegation has been substantiated. The police have been advised of this outcome.
- 2 other allegations of rough handling were made against staff that were unsubstantiated.

5.24 The lack of a robust procedure to follow and the lack of pathway to link these to safeguarding has meant that each investigation has not always been managed in line with the Kent and Medway procedures. It has been challenging to bring each investigation to a timely outcome and to ensure a consistent approach to investigation. The Safeguarding team are not always notified of these cases by the directorates and have often found out about these allegations via external means.

5.25 The new SOP will ensure that staff are aware that where an allegation is made against staff a formal process and timeline will be adopted.

- 5.26 A Serious Adult Review (SAR) was commissioned by the KMSAB regarding a patient who was treated at MFT between December 2013 and May 2014. An IMR was undertaken regarding the Trust involvement in this patients care.
- 5.27 The report is awaiting approval and publication by the KMSAB. The IMR demonstrated that the patient had a significant weight loss during her admissions to MFT and the significance of this weight loss was unrecognised by staff.
- 5.28 The introduction of the nutrition nurse role and the relaunch of the Malnutrition Screening Tool will support staff to identify concerns more promptly taking appropriate actions.
- 5.29 A database is now used to collate all information relating to safeguarding adult concerns and allegations including the recording of the outcomes once a Section 42 enquiry has been conducted. This allows us to look at themes and trends, areas of concern related quality and / or clinical practices, environment such as patient areas or care homes and vulnerabilities.
- 5.30 The categories of abuse that have been raised are shown in the chart below. Safeguarding concerns often have more than 1 category of abuse listed and this is demonstrated in our figures.



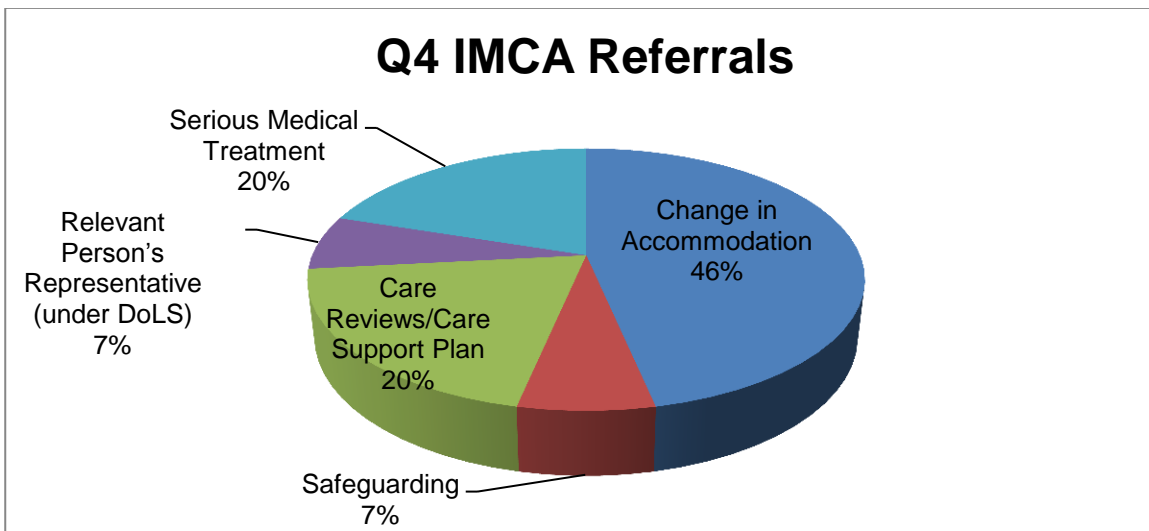
- 5.31 A database is also used to track all Deprivation of Liberty Safeguards (DoLS) urgent authorisations made and subsequent standard authorisations from the local authority. Whilst the process of centralising the DoLS application process has been ongoing we can confidently say that we know the patients in the Trust that are subject to a detainment of this type. We continue to embed the process and quality checking within the team.
- 5.32 Whilst the process of centralising the DoLS application process has been ongoing we can confidently say that we know the patients in the Trust that are subject to a detainment of this type. We continue to embed the process and quality checking within the team.
- 5.33 During 2016 /17 there were 362 urgent authorisation requests made to the local authorities to deprive patients of their liberty, of these only 41 patients received a standard authorisation from their local authority.
- 5.34 Our data collection and monitoring shows that 197 patient breached their 14 day urgent authorisation with the 7 day extension to their urgent requested.
- 5.35 Milton ward made the most applications for a DoLS with 92 referrals. This is not surprising given that their patient caseload is older people with a specialist service for those with dementia.
- 5.36 81 patients died in hospital whilst subject of a DoLS. This is indicative that the patients we are seeing that lack mental capacity and need continual supervision are complex, sick patients, usually with multiple co –morbidityes.
- 5.37 These patients have often got advanced disease with confusional diagnosis made of dementia, delirium or a mixed diagnosis. Frailty and increasing age makes these patient outcomes more challenging.
- 5.38 There had been no data collected previously on DoLS at MFT so this will now allow us to benchmark ourselves and drill down into the quality we want to know. An audit was undertaken in February 2017 of retrospective case notes between September and November 2016 to check compliance and quality. This report is attached as

Appendix 4

- 5.39 Since undertaking this audit there have been 2 changes to the DoLS legislation. From Monday 3 April 2017 the Coroners and Justice Act 2009 was amended so that people subject to authorisations under the Deprivation of Liberty Safeguards are no longer be considered to be 'otherwise in state detention' for the purposes of Section 1 of the Coroners and Justice Act 2009
- 5.40 This means it is no longer a requirement to notify the coroner of patients who die whilst subject of a DoLS unless the cause of death is unknown.
- 5.41 In January 2017 a Supreme Court Ruling meant that patients cared for in Intensive Care settings should not automatically be considered for a DoLS as they are receiving life sustaining treatment, the only indication would be if their treatment would be different to that of another patient with the same condition that did not lack mental capacity.
- “the true cause of their lack of freedom to leave not being a consequence of state action but their underlying illness, a matter for which the state is not responsible. the root cause of any loss of liberty was her physical condition, not any restrictions imposed by the hospital ” Lady Justice Arden.
- 5.42 On 13th March 2017 The Law Commission published their review of the Deprivation on Liberty Safeguards. They have made recommendations that DoLS be repealed and “Liberty Protection Safeguards” be introduced. They suggest wider reforms to the Mental Capacity Act, which will ensure greater safeguards are in place before the person is deprived of their liberty. The new Bill, “Mental Capacity Amendment Bill” is suggested to requesting the age be lowered to 16 in line with MCA. It is likely to be some time until this Bill is reviewed.
- 5.43 The term ‘advocacy’ is used to mean supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need. (DoH Care and Support Statutory Guidance 2017)
- 5.44 Advocacy services have been provided by SEAP in the last year, however this is changing to POHWER for 2017-18. Referrals to the Independent Mental Capacity

Advocacy (IMCA) service have been increasing as staff have been supported by both Safeguarding and Learning Disability nurses.

- 5.45 The use of the IMCA and other advocacy services demonstrates that staff understand how to ensure that the patient has a voice and is represented in treatment, discharge and care decisions.



6. SAFEGUARDING CHILDRENS ACTIVITY

- 6.1 The Trust maintains its commitment to safeguarding children and young people who attend for services. This isn't without challenge and risk and the safeguarding team on a daily basis are working with frontline staff to mitigate and minimise risk where possible.
- 6.2 Safeguarding children arrangements within the Trust is led by a team of named professionals. These arrangements are in line with the requirements outlined in "Working Together to Safeguard Children" (2015). This document highlights the expectations of the Trust which is to provide a named doctor, named nurse and a named midwife where maternity services are provided. There is good compliance within the Trust and this minimum requirement is currently met.
- 6.3 All safeguarding children activities at MFT are governed by the children Acts 1989 and 2004. Under the 2004 Act the following are key:

Section 10 – we must cooperate with partners working with children in the community to improve the well-being of all children and young people in our care.

Section 11 - creates a duty for the key agencies who work with children to put in place arrangements to make sure they take account of the need to safeguard and promote the welfare of children when doing their jobs.

- 6.4 One of the must do actions from the CQC action plan was to ensure there was progress in implementing the flagging of Trust systems. All children subject to a Child Protection Plan are now flagged on the OASIS system, Symphony system in ED and the nursing staff in children's ED now have access to the Medway Children Services system "Framework I". This action plan is shown as **appendix 4**
- 6.5 A&E attendances for children have been high during the past year, 28,031. This number accounts for all attendances aged 0 – 18 year olds.
- 6.7 The task of checking each attendee to see if they are on a CPP or are known to safeguarding has been challenging, however over the past year a project Board has been set up within the Trust working towards developing Child Protection Information Sharing (CPIS). There has been positive collaborative working with NHS Digital, the National team and Medway Council, coordinating systems. The result is that the system is now live and frontline staff would now be better able to quickly identify children who are either on a CP Plan or who are LAC. MFT are one of the first Trusts to have this system implemented across Kent.
- 6.8 We have now got in place a database to capture key information on children and young people attending the Emergency Department. This has given us a clearer picture of the safeguarding issues for those children attending the Emergency Department and how these issues fit into the Safeguarding Board's dataset and priorities for children in the last year.
- 6.9 There have been 39 child deaths in the past year, of these 8 were unexpected and required review. 31 deaths were classified as expected.
- 6.10 There have been 2 Serious Case Reviews (SCR) commissioned by MSCB in the past year involving patients attending MFT. Independent Management Reviews

(IMR's) have been conducted and both cases are awaiting the final SCR reports to be published.

- 6.11 The named midwife has introduced a spreadsheet to monitor midwifery attendance at case conferences. This enables more accurate reporting of, maternity participation in case conferences and participation in the child protection plan. An improvement has already been noted where one of the teams have recorded 100% attendance to review conferences.
- 6.12 In 2017 there has been a maternity case where an existing serious case review was underway in Kent in, the mother being investigated was pregnant with twins. Working with children's Social Care, community teams and internal teams at MFT A successful pre-birth safeguarding plan was adhered to following the management of this situation by the named midwife, social worker and other local hospitals. This ensured that once born the twins were safeguarded and subsequently safely transferred to foster carers as outlined in the pre – birth plan. Due to the high profile nature of this case there were many risks highlighted, both to the parents and the babies. An internal meeting to plan how to manage this situation whilst protecting all involved and ensuring privacy and dignity could be maintained to the individuals proved to be imperative to the success. Led by the named midwife this meeting considered security, communications team to manage any media risks, ward based teams, social services and managers.
- 6.13 In midwifery there has been the introduction of the management of partners who are violent. Managing such cases has been a significant challenge to the named midwife and staff on the wards. Communication between the named midwife, children's social care, Trust security, community midwives and the ward teams is vital.
- 6.14 Domestic Abuse (DA) is becoming a growing concern locally and pregnant women are routinely asked about this when they are booked in with a midwife.
- 6.15 Across Medway DA Incidents are growing (Police Data)
- 5143 incidents of DA 2013/14
 - 5270 incidents of DA 2014/15

- 6117 incidents of DA 2016/17 #

- 6.16 Medway have the largest percentage of DA in Kent with over half of victims not proceeding with prosecution. Many victims attend the hospital services at some time and an increasing number of disclosures and concerns are raised to staff. Supporting patients (and staff) affected by DA must be a consideration.
- 6.17 There is a Domestic Abuse policy for maternity and over the past year we have been working towards a Trust wide policy, we hope this will be ratified over the coming months.
- 6.18 Specified in the RAP was lack of engagement and participation at external meetings such as Multi-Agency Risk Assessment Conferences (MARAC). This is a meeting held by Kent Police and is to discuss high risk domestic abuse victims.
- 6.19 Agencies attend and share information they have on the victims/perpetrators/children and a safety plan is put in place.
- 6.20 There is a weekly half day MARAC in Medway at which we have achieved a fairly regular attendance, on weeks where we have been unable to represent the Trust in person we have reviewed the cases for discussion and shared information relevant to these.
- 6.21 There is a MARAC in Kent which we have as yet been unable to attend.
- 6.22 With such high prevalence locally of DA which is affecting all age groups and genders it is clear that we should be equipped to provide support and advice to those seeking help.
- 6.23 The Female Genital Mutilation (FGM) mandatory reporting duty that requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s was introduced from 31st October 2015. It is recommended that FGM examinations are provided as part of existing clinics seeing children and young people alleging sexual abuse/acute sexual assault or suspected sexual abuse to optimise facilities, skills and competencies.

www.gov.uk/dh/fgm

- 6.24 In April 2016 the government issued Multi-agency statutory guidance on FGM. In the document they state “Cases of failure to comply with the duty will be dealt with in accordance with the existing performance procedures in place for each profession. FGM is child abuse, and employers and the professional regulators are expected to pay due regard to the seriousness of breaches of the duty.
- 6.25 During 2016 /17, 19 cases of FGM have been reported via the named midwife. The identification of such cases should not just come from Midwifery and the CQC identified that key staff required training to ensure they could recognise and report effectively. Training is a key priority for the coming year as our local population and risks associated with continue to evolve.

6.26 Next Steps

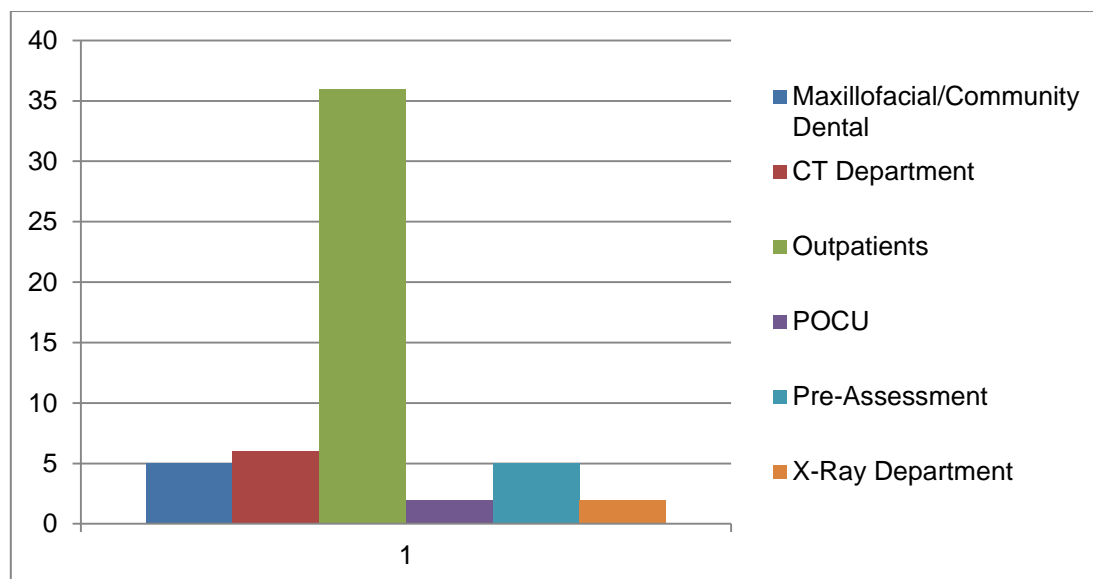
- Review resources to provide support to patients suffering DA – consideration to an Independent Domestic Violence Advisor (IDVA)
- Review of implementation of data collection of those who disclose DA across all departments and specialties.
- Set training profiles for key staff requiring FGM training.

7 LEARNING DISABILITIES

- 7.1 The Learning Disability (LD) nurse took up post in April 2016. There had been over a year without this post being filled at MFT and the need for increased support for those with a learning disability was evident from complaints, safeguarding concerns and carers who felt they were struggling to ensure that reasonable adjustments were considered to meet the needs of their loved ones.
- 7.2 The role of the LD nurse involves supporting adult patients who have learning disabilities, ensuring they receive all the information they need to fully understand their treatment plan and for them to make an informed decision when consenting to

treatment. The LD nurse can support patients that access the emergency department, outpatients & inpatients. In circumstances where a patient has a severe learning disability, they may not be able to give consent for their treatment or procedure, in which case it is the responsibility of the consultant to make that decision in conjunction with the patient, relatives, and carers. The LD nurse works alongside the consultant, to help this process along.

- 7.3 During 2016/17 210 patients have been supported by the LD nurse on the wards. 47 of these patients have had more than 1 attendance or inpatient episode at MFT. A register of these patients is now logging all patients accessing our services that are flagged to the LD nurse. In doing so we are able to ensure that where specific care plans are required they are put in place quickly and vital information is passed to staff via the LD passport 13 patient with a learning disability died whilst in hospital during the past year, 10 of these deaths were expected.
- 7.4 56 LD patient attendances were supported by the LD nurse within other departments in the Trust. This was to support with Mental Capacity Assessments (MCA), Best Interest (BI) decisions, treatment plans and reasonable adjustments.



- 7.5 Since January 2017 there has been monthly training for midwives on the complexities and signs to consider when a patient with learning disabilities becomes

pregnant, e.g. women who have learning disabilities usually become aware of their pregnancy at a later stage and this can increase certain risks for both mother and baby.

- 7.6 In collaboration with the midwifery teams, the LD nurse is working to educate others about the issues associated to Alcohol Fetal Syndrome in the locality (this a syndrome which causes trauma to a baby's brain development when mothers drink too much during pregnancy). These babies then require support for the rest of their lives.
- 7.7 Training the workforce to support patients with an LD has been a significant achievement in the past year. The LD nurse now supplements the Safeguarding adults training with LD awareness training. The development of LD champions across the organisation has also been a great success.
- 7.8 Reasonable adjustments have been a huge achievement for the LD nurse and the Trust. There has been significant progress on collaborative and partnership working between different teams / specialities and departments to improve the experience of the patient. 2 of these examples of success are:
- A patient required 2 procedures, both would be in Day Care. The carers requested support from the LD nurse to see if they could both be done at the same time. Their reason for this request was that the patient was very challenging and would require a number of carers to bring him in each time. In addition he would require sedation prior to arrival plus the general anaesthetic in the procedure. It was felt this may be considered for reasonable adjustment if the teams agreed to work together. The LD nurse liaised between surgery, dental and anaesthetics and eventually it was agreed. The patient then attended for his 1 appointment and had tooth extraction under general anaesthetic and removal of ingrowing toe nails in the same theatre under the same anaesthetic. This prevented the need for a 2nd appointment, anaesthetic and unnecessary stress for the patient.

- A further case of a patient who had 4 different speciality outpatient appointments booked. This lady also required sedation to bring her into hospital for appointments. The carers requested to see if she could have these on the same day. After some considerable negotiation all 4 teams agreed to see the patient on 1 day. This is a significant success to improve the wellbeing of those who find the hospital environment so significantly challenging.

7.9 Reasonable adjustments can vary from having longer appointment times, being first on a clinic list to open visiting hours and easy read documents to name a few.

7.10 The success of the LD role is evident in feedback sent from the parents of a patient that was in hospital for several months which was provided as a testimonial for the National Learning Disability Awards which we nominated our LD nurse Eloise Brett (Nee Smith) for 2016 /17. Unfortunately she was not shortlisted on this occasion.

“ Our son Rick was in the Medway from the middle of March 2016. Understandably they often said Rick could be discharged because he was well enough but we as his parents knew differently. When Eloise arrived and introduced herself as the disability nurse we didn't know what to expect. But from day one she became a vital link between the medical staff and ourselves. Ours and Ricks interests were her priority! Eloise was able to communicate directly with members of staff and various medical teams and clinics where we were unable to. She understood Ricks needs were more than physical, that he needed a new care team on the outside and this takes time. Eloise was able to advise us about different care teams in the local community and saved us a lot of time we would have wasted searching. We eventually found a company we were happy with and Eloise arranged for teams of their carers to come in and get to know Rick. She liaised with the various departments, dietician, pump feed training, out patients etc. When Rick was eventually discharged in November 2016 it was a very smooth transition for him and us, this was in no small part due to Eloise's input.”

Next steps

- Safeguarding / LD representation at Mortality Group and reviews.
- Embed recognition scheme of “Smiley Faces” logo across the Trust.
- Review available resources across the trust to support those with LD.

8 TRAINING

- 8.1 Separate Children’s and Adults Training strategies were brought into effect within the past year. Whilst training at all levels has been a priority and focus within the organisation it has been challenging to maintain compliance figures.
- 8.2 The fluidity of the workforce and numbers of temporary staff have impacted upon this. However with the introduction of the mandatory training days being set up this should address many of the challenges faced.
- 8.3 Adult Safeguarding Training has been completely reviewed at all levels and audience targets reviewed to ensure staff receive the correct levels of training required.
- 8.4 In doing so the statistics dropped significantly, however a remedial plan of increased training and bespoke training was made available to staff. Bespoke training has been made available for all groups of staff and has been utilised on over 90 occasions throughout the year for various topics below.
- 8.5 Data to 31st March 2017 currently shows,

Topic	Staff Count	Staff Compliant	Overall %
Safeguarding Adults Level 1	1658	1136	68.52%
Safeguarding Adults Level 2	3285	1271	38.69%
Prevent Level 1	2024	984	48.62%
Prevent Level 2	3146	1513	48.09%
MCA/DoLS	3817	2407	63.06%

Next steps 2017/18

- Create Medway specific online training for safeguarding level 2. This has been commenced and is the development phase.
- Development of a 3 day induction for staff and mandatory training update day will support staff to achieve the required training levels.

8.6 Safeguarding Children's Training Figures

	Trust Wide			
	Compliant	Percentage	Non Compliant	Percentage
Safeguarding Children Level 1	1335	76.81%	406	23.36%
Safeguarding Children Level 2	1087	62.94%	645	37.35%
Safeguarding Children Level 3	536	68.19%	255	32.44%

- 8.7 The above demonstrates that there is a need to review the audience figures for each level of training.
- 8.8 With over 4000 staff in the organisation there is a need to ensure that all staff have an understanding of their responsibility to ensure that children are safeguarded throughout the Trust.

9 CONCLUSION

- 9.1 Safeguarding Adults and Children is a developing and growing service. The agenda moves in line with each new serious case review / serious adult review and with this comes national recommendations.
- 9.2 We must be responsive and able to adapt our service to meet the demands of the changing environment and people we serve.

- 9.3 Whilst much progress has been made to date there is a long way to go to embed and sustain a culture of prevention in addition to recognising and responding in a timely manner to concerns raised.
- 9.4 The annual report demonstrates the organisations commitment to protecting children, young people and vulnerable adults at risk of harm across all service areas.
- 9.5 The Trust Board is asked to note the report, the improvements made during 2016/17 and those scheduled for implementation during 2017/18.

Remedial Action Plan 2016

Safeguarding Governance Structure	Requirements for success	Date for Achievment & Nominated lead	Actions Required	Exceptions / problems preventing achievment	MFT Achievement date & Evidence source	CCG Assurance Status	Action Update	Closed/ Open RAG RATED	Action for RAP	Expected Final Completion
MFT to demonstrate robust safeguarding governance arrangements enabling the trust to effectively discharge their safeguarding, MCA and Prevent Duties	An organisational safeguarding structure clearly defining individual roles & responsibilities.	31st May 2016 Head of safeguarding Bridget Fordham	To ensure a governance structure is in place demonstrating the reporting lines for both children and adult safeguarding.	Delayed in restructuring Trust safeguarding meetings	Governance structure in place. Approved at QIG			CLOSED	YES	15th OCTOBER 2016
	GSTT Peer review for both adults and childrens safeguarding.	Chief Nurse	To provide overview of report		March 2016 Review report can be provided	Provided 19.12.16		CLOSED		
	Clinical leads for Safeguarding Adults and Children to ensure their roles meet the requirements of the Trust safeguarding policies and procedures	17th June 2016 - Medical Director, Chief Nurse and Head of Safeguarding	Medical lead for Adult Safeguarding /MCA to be appointed. To review the JD and ensure that the leads work collaboratively with the Trust safeguarding teams		No Medical lead for safeguarding yet appointed. Karen Rule liaising with medical director	Trust confirmed Vikram Paraniyothi (Doctor) appointed	Trust confirmed Vikram Paraniyothi (Doctor) appointed	Closed	YES	30th November 2016
		31st May 2016 Head of safeguarding Bridget Fordham	Review the internal safeguarding Committee ensuring it functions effectively - review membership and TOR		The Structure has changed to operational meetings and Quarterly Assurance board meetings . 1st Meeting is scheduled 05.08.16			Closed	YES	

		31st May 2016 Head of safeguarding Bridget Fordham	Table the different meetings /committees responsibilities and escalation structure.		Meetings have been tabled and review of attendees and information sharing via the Steering group.	REQUIREMENT FOR REVIEW OUTCOME REPORT OF FINDINGS OF REVIEW	31.10.16 Agreed to review at next meeting. This has been reviewed and once the substantive appointees commence the sub groups will be divided between team members, reporting back to the operational group monthly.	CLOSED	YES	30th November 2016
	Substantive Recruitment to vacant Safeguarding Adult posts.	31st May 2016 Head of safeguarding Bridget Fordham and karen Rule - Chief Nurse	Job descriptions to be reviewed and substantive recruitment to take place		Interim head of safeguarding appointed 2nd May 2016. Learning Disabilities Liaison Nurse commenced April 2016. Administrator post commences 22nd August. 2 interim adult safeguarding leads in post and Jd's have been approved by HR and banding for substantive band 8A and Band 7. Both posts now advertised on NHS jobs for interview in October 2016.		31.10.16 Interviews for Band 8A this week.28/11/16 One 8A post has been recruited too, there were a lackof suitable candidayes for the other posts. The interim adult lead role may be extended to March 17, which will allow head of safeguarding to re-evaluate needs and develop an alternativebusiness plan proposal. Appointment to B7 role made January 2017	CLOSED	YES	30th March 2017
	An Allegations policy and appointed allegations manager.	Chief Nurse, HR, Head of safeguarding	The trust to have a ratified allegtions against staff policy.	Nadine Adams is the HR Allegations Manager,	HR policy will go for ratification in April 2017. Currently in concultation with unions.	SEE WEEKLY UPDATE	An allegations against staff policy has now been drafted, awaiting some additions from HR and the policy will be ratified at the April 2017 HR meeting.	CLOSED	YES	Apr-17

	Safeguarding strategy, policies and procedures that are fit for purpose and demonstrate compliance with statute and include The Care Act, Human Trafficking and Prevent.	14.10.16 Head of Safeguarding	Overarching trust safeguarding adults policy currently in draft, SOP's will become part of the document . Staff currently utilising the KMSAB multi agency document	Operational, workload and other priority deadlines have impacted on the completion.	All approved documents on intranet page and hyperlinks to guide staff to the Kent & Medway Safeguarding Adults Multi Agency Policy, Protocols and Guidance document revised April 2016	5/10/16 Agreed at the RAP meeting that all SOPs, Safeguarding strategy , training strategy, governance structure, PREVENT policy and allegations against staff policy will be completed and ratified by 15th October.	31.10.16 Only outstanding action is the allegations against staff policy. There is now a draft MFT Safeguarding Adults policy which will be going to the safeguarding assurance group for ratification in May 2017.	Closed	YES	15th OCTOBER 2016
Appropriate resources are required to enable safeguarding team to function well	Undertake a review of the resourcing of the named safeguarding nurse and the named midwife, their functions and their teams to ensure they are properly resourced.	April 2016 Chief Nurse and head of Safeguarding	Review Completed pre april 2016 and further review to take place due to the impact of the Care Act and the supreme court ruling on DoLS increasing the safeguarding adult agenda. • 04.07.2016 No recommendations to increase capacity in safeguarding team. • 10.08.16 – Capacity still an ongoing issue and not resolved • 14.09.2016 -An extra administrator has been agreed and the Job description will be going for banding by early October				31.10.16 Decision is required regarding safeguarding children and adults joining up as one team but will not be required for this RAP	Closed	YES	

MFT to demonstrate robust data collection system to collect all safeguarding activity and alerts. Ensuring that all referrals and investigations are managed and reported in a timely fashion							31.10.16 Agreed that initial data will be ready for the Q2 meeting. To enable the Trust and the CCG to agree metrics for next year. 28/11/16 both children and adult data submitted, still remain some gaps where other departments such as HR and L&D have yet to provide information. Data collection should now improve, should it remain problematic to gain data from other depts, this will be raised at the CCG QFP meeting.	CLOSED	Yes	If metrics agreed at Q2 meeting will close
	MFT to report against all safeguarding metrics quarterly			Number of reports challenging as different metrics required for most in light of CQC assure, IPQR, QIG, QAC, QWAG, CCG metrics.	Improvement in reporting, data collection is not yet robust, however figures are available for the past 12 months and demonstrate a consistent growth as processes become embedded.					
	Staff to send all referrals to safeguarding team for screening. Team will then forward to social care as necessary	31st May 2016 Safeguarding leads and Matrons	Using the Comms team and newsletters and intranet to advise staff of the process on a regular basis		This has improved greatly. Data collection in progress	31.10.16 Assurance received from Karen and Bridget that mechanism for links with social care is in place.		Closed	Yes	
	Social care to notify team of any referrals received relating to the Trust		Regular Scrutiny meetings set with Medway DSO's to discuss case loads and outstanding issues. Strengthening partnership working		Regular meetings take place. Historic concerns addressed. Working towards a 20 day turn around of initial investigations from receipt of SAF	31.10.16 Assurance received from Karen and Bridget that mechanism for links with social care is in place.		Closed	Yes	

MFT must demonstrate it recognises patients that lack mental capacity and assess in accordance to the Mental Capacity Act	MFT must evidence and carry out all necessary processes to ensure that the patient is cared for in the safest, least restrictive way, lawful way incorporating the application of the deprivation of liberty safeguards.	June 16th 2016 Safeguarding leads and Head of safeguarding	Review MCA / DoLS policy Provide regular education and support to staff in their assessment of patients / best interest decisions and DoLS applications where applicable.	SOP's approved	Mental capacity forms changed with Best interest form. Increase in training, visibility from team on ward and template for DoLS on wards with "The Quick Guide Manual."		31.10.16 DOLS SOP at moment in use and audit tools agreed. Audit in progress	CLOSED	Yes	31st December 2016
	MFT must demonstrate a knowledge of the number patients being cared for under a DoLS authorisation and understand the implications of this.		Ensure that Safeguarding Team are aware of all DoLS applications by creating awareness through flow charts, teaching and being a visible team. Develop and maintain data base of all DoLS notifications.	Changing longstanding procedures within MMH has proven challenging.	Attendance at the DoLS Steering Group. Working in partnership with both DoLS offices Data collection process in place. Increased training and buddying with wards	31.10.16 Assured that database exists and daily checks are carried out		Closed	Yes	
	MFT must demonstrate a knowledge of the number patients being cared for under a DoLS authorisation and understand the implications of this.		Team monitor compliance of dates and notify the LA of any changes and CQC notifications are made.		DoLS administrator required - 4 month post out with temporary staffing at present	31.10.16 Assured by Karen and Bridget that the team monitor compliance of dates and notify the LA of any changes and CQC notifications are made		Closed	Yes	
PREVENT strategy is to delivered within MFT.	Safeguarding policy to reflect PREVENT DUTY.	30th June 2016			Prevent Guideline approved		31.10.16 Agreed Policy ratified close action	Closed	YES	15th OCTOBER 2016

	Prevent Level 1 training to be mandatory for all non patient facing staff within MFT.	30th June 2016, Learning and development and Head of Safeguarding	E-learning PREVENT Level 1 training to be added to corporate / mandatory training.	Currently no corporate induction programme only - corporate welcome	Process in place for staff to achieve this training - over 1476 staff have completed the channel elearning module	Process in place for staff to achieve this training - over 1460 staff have completed the channel elearning module		Closed	Yes	
	Prevent Level 2 (WRAP 3) to be delivered to key clinical staff as per safeguarding training strategy		WRAP 3 trainer and train the trainer plan in place		WRAP 3 Trainer in place and training programme in place. Over 400 staff have been WRAP 3 trained.	WRAP 3 Trainer in place and training programme in place. Over 1180 staff have been WRAP 3 trained.	31.10.16 Training is available and prioritised to ED staff. As of 30th January 2017 1400 staff have had WRAP 3 training.	Closed	Yes	
MFT to engage with Multi Agency safeguarding committees and reviews, utilising the learning to influence their strategy and practices	Scope multi agency safeguarding meetings requiring MFT attendance and identify leads and deputies.	31st may 2016 Head of Safeguarding	Regular attendance and input to MARAC. Attend the Safeguarding Boards e.g. MSCB. Complete SAF and peer review	Mapping exercise conducted at May steering group	Meetings attended whenever possible. Process for feeding back through the operational steering group meetings	Meetings attended whenever possible. Process for feeding back through the operational steering group meetings		Closed	Yes	
MFT must ensure that the staff in the safeguarding teams have the necessary training required to enable them to preform their roles effectively		Head of Safeguarding			Multi agency training accessed according to roles and levels appropriate			CLOSED	YES	
			Utilise the multi agency training opportunities that already exist across Medway and Kent councils		Multi agency training has been utilised by key staff and proposal put forward to ensure that staff have the opportunity to attend events appropriate for their roles			CLOSED	YES	

MFT must ensure that the staff at MFT have the necessary training required to enable them to perform their roles effectively	A safeguarding training strategy to include PREVENT, MCA / DoLS, Adult Safeguarding, Childrens Safeguarding, Domestic Violence and FGM	14th October 2016 - Head of safeguarding Bridget Fordham with Safeguarding leads Adult & Children	Ensure paediatric ED practitioners have the opportunities to access multi – agency safeguarding training at level 3, and also in FGM and CSE . Training strategy to be presented to the operationa steering group for comments	Multi agency training has already been offered but due to staffing levels in the ED this can be a challenge. There is conflict between the L&D using the core standards framework from skills for health and Safeguarding working from the Intercollegiate document.	Work has taken place with L&D to ensure correct profiling for job roles. Summer season of safeguarding is ongoing with rolling programmes of education on all aspects of safeguarding. Compliance as of 30.08.16 Mental Capacity Act / DOLS - 83.41%. Prevent L1 (elearning) - 14.96% WRAP 3 - 30.17% Safeguarding Adults L1 - 70.45%. Safeguarding Adults L 2 69.63%. Safeguarding children L1 - 89.29% Safeguarding children L2 - 76.64% Safeguarding children L3 - 85.67%		31.10.16 Only outstanding action is the L & D metrics , A new system was rolled out as below and audiences (role profiling) is being reviewed further.	Closed	YES	31st December 2016
	Assurance required around L & D metrics to enable evidence gathering			There is conflict between the L&D using the core standards framework from skills for health and Safeguarding working from the Intercollegiate document.	Difficulty in establishing upto date figures, working on metrics with L&D January 2017	L & D metrics to be agreed	New system MOLLIE commenced November 2016. January 2017 - The staff profiles for correct levels of training is now updated and training programme is underway.	CLOSED	No	

Status Coding

Red: Safeguarding concerns exist without actions/plans to mitigate risk.

Amber: Concerns exist: Status is supported by submitted evidence and actions/progress to mitigate risk.

Green: Actions to mitigate risk now implemented.

Blue: Implemented evidence now embedded. This is supported by service evaluation and or audit.

Version	Author	Date	Comments
Updated v1.	Jen Sarsby	11.5.2017	Meeting to progress actions 24/5/2017
Updated v2	Jen Sarsby	30.5.2017	Evidence revised and status upgraded
Version 3			

No.	Recommendation –	Organisation	Lead Person (s)	Action to progress recommendation	Evidence	Date Completion due.	Status
1.1	Implement a process in the maternity unit to ensure that information from GPs is captured, recorded and taken account of to inform maternity care planning.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding	Draft GP letter has been written and sent to named GP for Safeguarding for agreement. Letter now includes a space for information sharing between GPs and maternity. 30.7.2017: GPs formally agreed to accept the new communication pathways: 30.5.17 BF to ensure that changes are communicated to all GPs via the Named Doctor for safeguarding.	J.S 11/5/17. Requires audit/ audit tool to ensure practice is now embedded. J.S 30.5.17: evidence accepted. Service evaluation evidence now required.	COMPLETE	

No.	Recommendation –	Organisation	Lead Person (s)	Action to progress recommendation	Evidence	Date Completion due.	Status
1.2	Issue guidance to staff to ensure that an enquiry is routinely made of expectant women about the risks of domestic abuse and that this enquiry is noted in the patient record.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Additions have been made to the Risk Questionnaire to ensure specific questions are asked and answers documented at the appointment when women are seen alone. J.S. 11.5.17 August 2016 Copy of audit of notification of pregnancy to be presented as part of the evidence for change. J.S: 30.5.17 Please provide date implemented and evaluation of implementation and effectiveness so far.	An audit to be completed in 3 months' time (i.e. October) to ensure the revised risk questionnaire is embedded and can evidence routine enquiry is made. J.S evidence accepted: J.S 30.5.17: evidence accepted. Service evaluation evidence now required.	30.7. 2017	<div></div>
1.3	Take steps to ensure young people aged 16 and 17 are assessed and treated in age-appropriate surroundings that are separate from the adult ED.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Review of patient flow and identify possible solutions. J.S 11.5.17/ 30.5.17: BF to provide update on progress actions needed.	Awaiting confirmation from BF to clarify current review process. J.S 30.5.17 B.F to provide confirmation of progress/evaluation of change.	16.6.2017	<div></div>
1.4	Ensure that the newly introduced procedure for making enquiries about children of adults who attend ED are well embedded into practice so that there are more opportunities to identify children at risk.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Introduction of new process will be discussed in all ED forums and incorporated in ED doctors' Induction. Update 04.07.2016 - Meeting with matron for ED and lead consultant for ED and Safeguarding lead. Meeting arranged for 15th July to discuss the next steps. Next update to be provided 18th July 2016. J.S 30.5.17: evaluation of this implementation is needed: Please provide date of implementation.	J.S 30.5.17: Service evaluation required following the implementation in 2016.	30.6.2017	<div></div>
1.5	Ensure that paediatric	Medway	Bridget Fordham	Pilot to be initiated to assess young	J.S draft template to be produced as		<div></div>

No.	Recommendation –	Organisation	Lead Person (s)	Action to progress recommendation	Evidence	Date Completion due.	Status
	admission documentation and templates are routinely used, as opposed to adult paperwork, for all young people up to the age of 17 to ensure that key safeguarding information is identified and acted upon.	Foundation Trust	Head of Safeguarding.	people aged 16 – 17 years attending Adult ED . Update 04.07.2016 - Meeting with matron for ED and lead consultant for ED and Safeguarding lead. Meeting arranged for 15th July to discuss the next steps. Next update to be provided 18 th July 2016. J.S. 30.5.17: Please submits date of implementation and service evaluation report/audit.	justification for amber. J.S 30.5.17 Template provided: Evidence accepted.	30.6.17	
1.6	Ensure that women who attend ED who are pregnant, including those who are young people under the age of 18, or who have access to children, are routinely asked about risks of domestic abuse so that risks to children can be better assessed.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Mandatory field added to Symphony system which ensures that this question is asked for all pregnant women. 04.07.2016 - Update - Awaiting meeting on 15th July 2016 to progress with Staff in ED. J.S. 30.6.2017. Date of implementation and evidence that this is being evaluated. Outcome of evaluation so far.	August 2016 J.S 11.5.17. The evidence embedded is not a DV risk assessment tool. A risk assessment tool is required here. J.S 30.5.17: Risk assessment tool submitted is unacceptable.	15.7.17	
1.7	Introduce formatted or template questions in to an early, fixed point in the ED booking-in or triage process for children so that safeguarding information can be identified at each stage the assessment and treatment process. This should include prompts to make enquiries about siblings of children for whom risk is identified.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Triage Documentation reviewed and this recommendation has now been met. Update – 14/07/16 - Chasing evidence from ED matron – will embed and send update on Monday 18 th July. J.S 11.5.17 please provide evidence of the new template? So that we can action J.S 30.5.17 requires evidence of evaluation and or effectiveness of implementation	J.S 30.5.17 Evidence accepted. Awaiting outcome of evaluation and date of implementation.	30.6.17	

No.	Recommendation –	Organisation	Lead Person (s)	Action to progress recommendation	Evidence	Date Completion due.	Status
1.8	Implement a flagging process on the 'Symphony' patient record database that allows safeguarding information about children to be brought to the attention of ED practitioners by way or an automatic alert throughout each stage of the ED pathway.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Review admin support to increase the capacity which will enable this recommendation to be met. Update - 04.07.2016 - Meeting with Matron and consultant in ED arranged for 15th July to discuss next steps. Oasis to be flagged instead of Symphony J.S 30.5.17: please provide update on number of children flagged.	Waiting for Council to supply list of Children on a plan. SW emailed Sue Duckin 11/07/16 – ongoing. J.S 11.5.17 please provide evidence/update For this action. 30.5.17: Evidence accepted.	COMPLETE	
1.9	Undertake a review of the resourcing of the named safeguarding nurse and the named safeguarding midwife, their functions and their teams to ensure they are properly resourced.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Update 04.07.2016 No recommendations to increase capacity in safeguarding team. J.S new restructuring came into effect June 2017.	J.S 30.5.17 Verbal assurance given by BF	30.9.17	
1.10	Ensure the paediatric liaison role is sufficiently resourced to enable effective oversight and follow-up of admissions of children and young people to ED and the paediatric ward.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding	Full time liaison nurse appointed (awaiting commencement date). August 2016 J.S 11.5.17 Update required	J.S verbal update provided by BF. A paediatric liaison nurse is now in post.	COMPLETE	
1.11	Implement an effective programme of safeguarding supervision for paediatric ED practitioners that supports staff learning from active cases.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Supervision to be incorporated into Team away days when established. Update 04.07.2016 - Meeting with matron for ED and lead consultant for ED and Safeguarding lead. Meeting arranged for 15th July to discuss the next steps. Next update to be provided 18 th July 2016. J.S 11.5.17 data from safeguarding	J.S 30.5.17 evidence accepted	COMPLETE	

No.	Recommendation –	Organisation	Lead Person (s)	Action to progress recommendation	Evidence	Date Completion due.	Status
				supervision provided required here. J.S 30.5.17.compliance date for Maternity outstanding.			
1.12	Ensure paediatric ED practitioners have opportunities to access to multi-agency safeguarding training at level three, and also training in FGM and CSE.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Multi-agency Training offered for level 3. Lead Nurse for Safeguarding has spoken with Senior Sister in ED and is waiting dates to commence training of FGM & CSE. This is currently included in all levels of children's safeguarding training. Update 04.07.2016 - Meeting with matron for ED and lead consultant for ED and Safeguarding lead. Meeting arranged for 15th July to discuss the next steps. Next update to be provided 18 th July 2016. J.S. 30.5. 17 FURTHER CLARITY NEEDED 1. Effective training evaluation data form the last three training session delivered. 2. CSE training slide to reflect the national/legal definition form the Home Office 2017. 3. FGM slides must reflect the explicit legal duties for mandatory reporting.	September 2016 J.S 11.5.17 the evidence provided is inconsistent with the intercollegiate document guidance on level 3 training. Please supply copy of training slides and learning objectives. Dates delivered. J.S 11.5. 2017 Evidence submitted needs minor amendments.	6.6.17	
1.13	Ensure the named nurse for looked after children receives level four safeguarding training.	Medway Foundation Trust	Bridget Fordham Head of Safeguarding.	Level 4 training is booked for September 2016	COMPLETE	September 2016 J.S 11.5.17. Please provide evidence.	

Kent & Medway Safeguarding Adults Board

Self- assessment of organisational arrangements to safeguard and promote the wellbeing of adults at risk

Final version

The self-assessment framework has been developed by the Kent & Medway Safeguarding Adults Board (KMSAB) Quality Assurance Working Group (QAWG). The purpose to provide a consistent framework to assess, monitor and improve safeguarding adults arrangements. The framework has been developed to enable use by a range of organisations, utilising the Solihull Safeguarding Adults Board tool and 'Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services' (March 2013)¹.

Each organisation is to complete and submit a self-declaration by the **31 March 2017** which will inform a report to the KMSAB meeting in **June 2016**. Thereafter the QAWG will monitor improvement and compliance 6 monthly reporting exceptions to the Board.

- Organisations are required to make a judgement as to how well it is achieving each question based on a RAG rating:
 - GREEN** – the organisation meets the requirement consistently across the organisation.
 - AMBER** – the requirement is met in part; there may be pockets of excellence and areas for improvement.
 - RED** - the organisation does not meet this requirement.
- **Areas rated amber or red rating must be supported by an action plan to achieve compliance.**
- Areas deemed not applicable must have the reason explained.
- Any areas for improvement requiring multi agency support will be identified by the QAWG and reported to KMSAB.
- The QAWG will keep the framework under review and change it to reflect legislation, best practice and to ensure the continuous improvement to safeguard adults in Kent & Medway.
- **Where the RAG rating has not changed from GREEN since the 2016 return, there is no requirement to complete the following fields: 'Evidence to support RAG rating' 'Additional Action to Ensure Compliance' and 'progress or date completed'**

Please return completed tool and related Action Plan to: Victoria Widden (victoria.widden@kent.gov.uk)

¹ http://www.local.gov.uk/c/document_library/get_file?uuid=e08e4e9b-4f78-45b2-b07b-3883fe5ee45c&groupId=10180

Organisation	Medway Foundation Trust	
Accountable lead for safeguarding adults	Name: Karen Rule Bridget Fordham	Designation: Director of Nursing Head of Safeguarding
	Tel no: 01634 830000 ext: 3127 01634 830000 ext 5524	Email: B.fordham@nhs.net Karenrule@nhs.net
Name of person completing this audit	Name: Kudzi Mukandi Bridget Fordham	Designation: Interim Safeguarding Adults Lead Head of Safeguarding
	Tel no: 01634 830000 ext 5524	Email: kudzimukandi@nhs.net b.fordham@nhs.net

Areas for action		
No	RAG	Action required
A5		Head of Safeguarding to work with colleagues to progress this matter
A6		Head of Safeguarding to work with colleagues to progress this matter
C5		The Trust needs to develop a process that ensures that views of adults at risk are considered in all relevant service development decisions
C6		The Trust needs to further develop processes that will enable it to engage the public in raising awareness of prevention of abuse and neglect.
D2		The Trust to develop a training programme for staff involved in recruitment
D6		The Trust needs to develop safeguarding Adults Supervision policy or incorporate it in existing supervision policies
D8		Senior Managers to attend Safeguarding training in line with role as indicated in the Training Strategy
D9		The Trust to review Induction programme so that Safeguarding can be reinstated back on the Induction programme.
D10		The Trust will ensure that the work done in the past year is maintained and that the Training Strategy is complied with
D13		Ensure Policy is ratified
D14		Trust to develop training programmes to support staff who are responsible for managing allegations against staff

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Areas identified as not applicable	
No	Rationale

SECTION A: OUTCOMES FOR, AND THE EXPERIENCES OF, PEOPLE WHO USE SERVICES

The boxes within each section can be expanded to facilitate responses.

	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
A1	The organisation can demonstrate it responds to issues of diversity relating to gender, age, disability, faith, sexual orientation, language and ethnicity of service users. (I1) <i>Please specify how.</i>			The Trust has an Equality and Diversity Steering Committee which is chaired by the Director of Human Resources	The Policy is currently under review and will be ratified through the Steering Committee	
A2	The organisation has a code of conduct/policy/contractual requirement for staff concerning acceptable and unacceptable behaviour including discrimination and bullying. (I2)			The Trust has an HR policy that supports this function.		
A3	Issues of diversity are addressed in safeguarding training to staff. (I3) <i>Please explain how.</i>			The Safeguarding Adults training includes issues of diversity. Discriminatory abuse is an identified category of abuse that is discussed at training. Examples of good practice are also included in discussions		

A4	Issues of diversity are addressed in your Safeguarding Adults Policy and Procedures. (I4)			The Safeguarding Adults Policy includes issues of diversity		
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
A5	The organisation has written information available to adults at risk and their families about safeguarding including who to contact if they are concerned about an adult at risk. (J2)			MFT currently have leaflets provided by Kent and Medway Safeguarding Adults Board and Medway council	Head of Safeguarding to work with colleagues to produce MFT information for patients and relatives	
A6	Information provided to adults at risk and their families is provided in relevant formats and languages. (J3) <i>If there are any issues or restraints concerning multi format or language distribution? Please specify.</i>			Not in place	Head of Safeguarding to work with colleagues to progress this matter	
A7	LA only - The organisation has a process for seeking service users' experiences/feedback and actions taken as a result. (K1) <i>Please state how and give examples of when they have</i>					

	<i>changed practice.</i>					
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
A8	LA only - Advocacy services are available and used appropriately, including independent advocates. <i>Please state how.</i>					
A9	LA only - People have access to effective criminal, civil or social justice, to resolution and recovery. <i>Data from CPS re number of charges.</i>					
A10	LA only – The organisation can demonstrate how it works with partners (CSP, Trading Standards, Public Health) in the prevention of abuse and neglect in the community.					

SECTION B: LEADERSHIP, STRATEGY AND WORKING TOGETHER

The boxes within each section can be expanded to facilitate responses.

	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
	LEADERSHIP					
B1	<p>The organisation has a senior person who is accountable for championing safeguarding throughout. (A1)</p> <p><i>Please state what position fulfils this role and % of attendance at SAB meetings. (Where Deputy attends, this would result in an Amber rating)</i></p>			<p>The Director of Nursing is the Executive Lead for Safeguarding Adults. The strategic and operational support is provided by the Head of Safeguarding and her team.</p> <p>A non-exec director also champions safeguarding at board level.</p> <p>The Director of Nursing cascades this responsibility throughout the organisations through the respective Deputy Directors of Nursing, Heads of Nursing, Matrons and Ward Managers.</p> <p>The Director of Nursing or Head of Safeguarding have attended 75% SAB</p>	This is amber rated purely due to the deputising at meetings.	

				meetings in 2016/17		
B2	<p>This senior person maintains competence to undertake the role. (A2)</p> <p><i>How is this achieved?</i></p>			<p>Safeguarding Adults Training is Mandatory for all positions in the Trust.</p> <p>Additionally attendance at Interagency meetings both at County and National Level also enable the maintenance of competence at this level.</p>		
B3	<p>The organisation is committed to safeguarding and promoting wellbeing and this is reflected in strategic documents. (A3)</p> <p><i>Please state the specific documents.</i></p>			<p>Most of the Trusts strategic documents now have a standard Safeguarding commitment included.</p> <p>Work still remains to ensure that this standard is consistently applied to all strategic documents</p> <p>The internal intranet houses a number of safeguarding adult documents for all staff to refer to.</p> <p>The governance has</p>		

				been strengthened and safeguarding is a required element of the quality assurance committee that reports to Trust board.		
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
B4	The organisation is represented at K&M Safeguarding Adults Board and/or its sub-groups. (F1) <i>Please state % of attendance at SAB meetings. (Where Deputy attends, this would result in an Amber rating)</i>			The Director of Nursing and Head of Safeguarding represent the Trust at the SAB. The Head of Safeguarding or a nominated deputy attend the majority of the sub group meetings.	Attendance at these external meetings has improved greatly, however remains inconsistent due to the prioritisation of workload and staffing issues. Engagement is considered a vital part of our development and support.	
	STRATEGY					
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
B5	The organisation's policy and procedures outline its responsibility to safeguard and promote the wellbeing of adults at risk, including domestic abuse, self-neglect,			The policies and procedures have all been reviewed over the past 12 months and a number of SOP's and		

	MCA/DOLS/PREVENT. (B1) <i>Please state how.</i>			guidelines produced. The Trust has a maternity domestic abuse policy however we are currently working on a Trust wide policy documents and awaiting ratification of the new safeguarding adult policy.		
B6	Commissioned, subcontracted, agency or locum services are aware of the organisation's Safeguarding policy and procedures. (B3) <i>Please state how.</i>			This is included in contracts		
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
	WORKING TOGETHER					
B7	Staff have access to the K&M Safeguarding Adults Multi Agency procedures? (F2) <i>How are these accessed by staff?</i>			Yes On the staff intranet		

B8	How does the organisation demonstrate its commitment to inter-agency working? (F4)			<p>The Safeguarding Adults Policy and supporting documents are all in line with multi-agency requirements.</p> <p>The Trust is represented at the Board and some of its sub-groups</p> <p>The Trust participates in SAR panels and IMR's and works closely with the local authority and other partner agencies to ensure that robust safeguarding investigations are carried out and learning occurs.</p>		
B9	<p>The organisation enables appropriate sharing of information with other organisations. (G1)</p> <p><i>Please state how?</i></p>			<p>The Trust has made huge progress in how information is shared with other organisations.</p> <p>The Safeguarding team has developed a Safeguarding Database for Safeguarding Alerts and DoLS activity. This enables the Trust to a) contribute meaningfully to the interagency work</p>		

				<p>but b) track safeguarding activity and support staff in ensuring compliance with safeguarding obligations.</p> <p>The regular participation in professionals meetings, strategy meetings and case conferences allows for meaningful and safe data sharing in line with protocols.</p>		
B10	The guidance is in accordance with the K&M Information Sharing Agreement (June 2013). (G2)			Yes		
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
B11	<p>The organisation has record keeping or recording and records management policies in place. (G4)</p> <p><i>Where can staff access the document/s?</i></p>			The Trust has a policy and staff can access this on the staff Intranet		

SECTION C: COMMISSIONING, SERVICE DELIVERY AND EFFECTIVE PRACTICE

The boxes within each section can be expanded to facilitate responses.

	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
	COMMISSIONING			We do not commission services		
C1	Commissioners only – Commissioned, subcontracted, agency or locum services commission safe services. <i>Contract monitoring, quality assurance.</i>					
C2	Commissioners only - The Councils and the NHS have developed mechanisms for people who are organising their own support and services to manage risks and benefits.					
C3	The views of adults at risk are specifically taken into account when commissioning services.					

	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
	SERVICE DELIVERY AND EFFECTIVE PRACTICE					
C4	There is an emphasis on outcomes throughout all strategies and plans.			<p>The Trust's Safeguarding Strategy has a strong emphasis on outcomes. This was developed in line with the Care Act and Kent & Medway Adult Safeguarding Procedures.</p> <p>The safeguarding team work closely with patient safety teams and governance leads to ensure that outcomes are communicated and learned from across the organisation.</p>		
C5	The views of adults at risk are specifically taken into account concerning both individual decisions and the establishment of services. (A5) <i>Please state how.</i>			<p>There are procedures in place to act in best interests of patients that lack capacity to be involved in certain decisions.</p> <p>Staff are encouraged</p>	The Trust needs to develop a process that ensures that views of adults at risk are considered in all relevant service development decisions	

				during training and when raising a concern to make safeguarding personal and engage patients and/or their representative about what they want to happen.		
C6	There is evidence that the organisation has a multi-agency approach to raising public awareness of prevention of abuse and neglect.			<p>The Trust has reviewed its Safeguarding Policies and Procedures. These are now in line with the Kent & Medway Adult safeguarding Procedures.</p> <p>The Trust takes an active part in raising public awareness of prevention of abuse and neglect in partnership with the KMSAB and other partner agencies</p>	The Trust needs to further develop processes that will enable it to engage the public in raising awareness of prevention of abuse and neglect.	
C7	LA only - Domestic abuse, hate crime, anti-social behaviour and community cohesion work includes adults needing care and support.					

SECTION D: PERFORMANCE AND RESOURCE MANAGEMENT

The boxes within each section can be expanded to facilitate responses.

	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
	RECRUITMENT AND SUPERVISION					
D1	<p>The organisation has <i>Safer Recruitment</i> processes that include:</p> <ul style="list-style-type: none"> • Job description • Full employment history via an application form, • Interviewing prospective employee / volunteer • Two written references • Disclosure and Barring Service check • Verification of identify and qualifications. (E1) <p><i>How is this evidenced?</i> <i>Please advise if any staff are excluded from any of the above aspects of the recruitment procedures.</i></p>			<p>The Trust has Safer Recruitment processes in place with standardised Safeguarding Commitment in all job advertisements as well as job descriptions.</p> <p>Additionally the Trust has a Recruitment and Selection Policy which expires March 2018.– Trust is compliant with required NHS employment processes and checks</p>		
D2	Staff involved in recruitment have received training in <i>Safer Recruitment</i> . (E2)			The Trust is still developing training for Safer Recruitment	The Trust to develop a training programme for	

					staff involved in recruitment	
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
D3	All staff attend an Induction and are subject to a probationary period. (E3) <i>Please state any reason why anyone would not attend induction or be subject to a probationary period.</i>			The Trust has a rolling Induction programme and all staff attend this. All contracts include a probationary period		
D4	A line of accountabilities, from an individual employee up to the most senior person with overall responsibility is explicit in the policy and procedures. (C1) <i>If not how is this assured?</i>			Clear lines of accountability are also stipulated both at individual level through the Job Descriptions as well as organisationally through the Organisational Structures.		
D5	Each individual has responsibility to safeguard and promote wellbeing stated within their job description. (C2) <i>If not how is this assured?</i>			The Trust has a standard Safeguarding commitment included in all Job Descriptions		

D6	The organisation has a policy that sets out the frequency that employees in contact with adults at risk receive supervision and an appraisal. (C3)			The Trust is yet to develop a Supervision Policy for staff looking after adults	The Trust needs to develop safeguarding Adults Supervision policy or incorporate it in existing supervision policies	
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
D7	The individual, to whom safeguarding concerns are reported, has a job description with specific commitments to safeguard and promote the wellbeing of those at risk. (C4) <i>Please specify the post holder.</i>			The Trust has a standard Safeguarding commitment included in all Job Descriptions The Director of Nursing is the Executive Lead for Safeguarding. The Trust has a governance structure that identifies lead roles to whom safeguarding concerns are reported to.		

				The Safeguarding Team coordinates all safeguarding referrals.		
	TRAINING					
D8	<p>Senior members/managers of the organisation have been trained in safeguarding adults. (A6)</p> <p><i>Please state how.</i></p>			<p>Safeguarding Training is Mandatory for all staff and the Trust is making good progress in ensuring that Senior Managers are trained to the required level.</p> <p>Although previously compliant, the recent job profiling has meant that some senior managers although compliant with level 1 training have become non-compliant at their appropriate level</p>	Senior Managers to attend Safeguarding training in line with role as indicated in the Training Strategy	
D9	Induction for all staff includes basic awareness of safeguarding adults and PREVENT. (B4)			Safeguarding training is not currently included at Induction. The Trust is however in the process of embedding Safeguarding training including	The Trust to review Induction programme so that Safeguarding can be reinstated back on the Induction programme.	

				PREVENT																												
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed																										
D10	Staff are trained to levels appropriate to their roles and responsibilities, including MCA/DOLS/DA/PREVENT and links to safeguarding children. (D1) <i>Please specify % of eligible staff trained to each level.</i>			<p>The Trust has in the past year reviewed Safeguarding Adults Training. There is now a Safeguarding Adults Training Strategy in line with the intercollegiate document and Skills for Health document. Additionally there has been a review of all roles to ensure compliance with the Training Strategy.</p> <p>The Trust has made significant progress with regards to compliance and although the overall percentage may appear low, this has to be understood within the context of</p>		<table><tr><th>Topic</th><th>Staff Count</th><th>Staff Compliant</th><th>Overall</th></tr><tr><td>SGA Level 1</td><td>1658</td><td>1136</td><td>68.52%</td></tr><tr><td>SGA Level 2</td><td>3285</td><td>1271</td><td>38.69%</td></tr><tr><td>Prevent L 1</td><td>2024</td><td>984</td><td>48.62%</td></tr><tr><td>Prevent L 2</td><td>3146</td><td>1513</td><td>48.09%</td></tr><tr><td>MCA/DoLS</td><td>3817</td><td>2407</td><td>63.06%</td></tr></table>	Topic	Staff Count	Staff Compliant	Overall	SGA Level 1	1658	1136	68.52%	SGA Level 2	3285	1271	38.69%	Prevent L 1	2024	984	48.62%	Prevent L 2	3146	1513	48.09%	MCA/DoLS	3817	2407	63.06%		
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				the Trust's review of role profiling which in the short term would account for the seeming reduction in compliance.		
D11	<p>A process is in place to support learning from SAR/DHR/MHR, integrating the learning into training.</p> <p><i>Please specify.</i></p>			<p>Safeguarding is now included in the Trusts weekly Harm Free meetings-a forum to discuss and consider incidents.</p> <p>The Safeguarding team take part in and support investigations including recommendations.</p> <p>Each Directorate has an allocated Safeguarding Adults Lead who support in day to day operational issues and feedback is given as part of service improvement.</p>		

D12	Staff attend training on information sharing. (G3) <i>Please specify % of eligible staff trained.</i>			Information Sharing is included on all Safeguarding Adults Training, PREVENT training and Information Governance training is mandatory for all staff which also covers this.		
	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
	ALLEGATIONS AGAINST STAFF					
D13	The organisation has a policy for managing allegations against staff. (H1) <i>How are these accessed by staff?</i>			The Trust has a new Allegations Against Staff Policy. This is awaiting ratification pending a meeting scheduled for April 2017 with Staff Side Representatives. The children's safeguarding policy has guidance for reporting to the LADO. This is on the Trust's	Ensure Policy is ratified	

				Staff Intranet		
D14	Staff responsible for managing allegations against staff are trained in the process. (H2)			The Trusts Safeguarding Adults Training Strategy specifies a need for investigating managers to have completed Level 3 training. The Trust is currently developing this training	Trust to develop training programmes to support staff who are responsible for managing allegations against staff	
D15	The organisation has a whistle-blowing policy and a culture that enables issues about safeguarding and promoting the wellbeing of adults at risk to be addressed. (H3) <i>How are staff encouraged?</i>			<p>The Trust has a Raising Concerns and Whistleblowing Policy.</p> <p>There are regular staff briefings sent out via email, news bulletins as well as face to face.</p> <p>Candour and transparency is a running theme of these meetings with staff being encouraged to speak up when they have concerns</p>		

	Requirement	RAG Rating 2016	RAG Rating 2017	Evidence to support RAG rating	Additional action to ensure compliance and by whom	Progress or date completed
	PERFORMANCE MANAGEMENT					
D16	Services are held accountable through performance measures, including quality measures, towards the outcomes for people (file and practice audits, customer feedback, training activity, performance reports etc).			Directorate Performance Reviews take place monthly – Executive Team holds Directorates to account for their quality, operational and financial performance. Performance measures set out in Directorate Dashboards		
D17	Safeguarding Adult Reviews are used as the basis of improvement for the future.			Safeguarding is now included in the Trusts weekly Harm Free meetings-a forum to discuss and consider incidents. The Safeguarding team take part in and		

				<p>support investigations including recommendations.</p> <p>Each Directorate has an allocated Safeguarding Adults Lead who support in day to day operational issues and feedback is given as part of service improvement.</p>		
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SAFEGUARDING ADULTS: DEPRIVATION OF LIBERTY SAFEGUARDS AUDIT

April 2017

Audit Team:

*Eve McGrath, Interim Safeguarding Adult Lead
Kudzi Mukandi, Interim Safeguarding Adult Lead
Sally Lloyd, Clinical Audit Facilitator*

1.0 BACKGROUND

The Deprivation of Liberty Safeguards (DoLS) were added to the Mental Capacity Act 2005 by the Mental Health Act 2007. The Safeguards came into effect in April 2009 with the aim of preventing breaches of Article 5 of the European Convention on Human Rights, as had been found in HL v UK1 (known as the Bournemouth case).

Article 5 of the Human Rights Act 1998¹ states that *'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'*. The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

The Cheshire West Supreme Court Judgment in March 2014 made reference to the 'acid test' to see whether a person is being deprived of their liberty, which consisted of two questions:

- Is the person subject to continuous supervision and control? *and*
- Is the person free to leave? – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

See the Department of Health Guidance: Response to the Supreme Court Judgment / Deprivation of Liberty Safeguards issued October 2015² for further information on the implications and guidance arising from this judgment and SCIE website: Deprivation of Liberty Safeguards (DoLS) at a glance³

If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty. But even with the 'acid test' it can be difficult to be clear when the use of restrictions and restraint in someone's support crosses the line to depriving a person of their liberty. Each case must be considered on its own merits, but in addition to the two 'acid test' questions, if the following features are present, it would make sense to consider a deprivation of liberty application:

- Frequent use of sedation/medication to control behaviour
- Regular use of physical restraint to control behaviour
- The person concerned objects verbally or physically to the restriction and/or restraint
- Objections from family and/or friends to the restriction or restraint
- The person is confined to a particular part of the establishment in which they are being cared for
- Possible challenge to the restriction and restraint being proposed to the Court of Protection or the Ombudsman, or a letter of complaint or a solicitor's letter
- The person is already subject to a deprivation of liberty authorisation which is about to expire.

The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the care giver is seeking to prevent, and can include:

- Using locks or key pads which stop a person going out or into different areas of a building
- The use of some medication, for example, to calm a person
- Close supervision in the home, or the use of isolation
- Requiring a person to be supervised when out
- Restricting contact with friends, family and acquaintances, including if they could cause the person harm

¹ <http://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/I/chapter/4>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/485122/DH_Consolidated_Guidance.pdf

³ <http://www.scie.org.uk/publications/atagance/atagance43.asp>

- Physically stopping a person from doing something which could cause them harm
- Removing items from a person which could cause them harm
- Holding a person so that they can be given care, support or treatment
- Bedrails, wheelchair straps, restraints in a vehicle, and splints
- The person having to stay somewhere against their wishes or the wishes of a family member
- Repeatedly saying to a person they will be restrained if they persist in a certain behaviour.

Such restrictions or restraint can take away a person's freedom and so deprive them of their liberty. They should be borne in mind when considering whether the support offered to a person is the least restrictive way of providing that support. If patients at Medway NHS Foundation Trust are being deprived of the liberty and are deemed to lack capacity, a DoLS application must be submitted to the Local Authority in which they are normally resident.

If the Trust makes an application to a local authority for a deprivation of liberty authorisation, it must inform the Care Quality Commission, once the outcome of the application is approved. CQC provides a form for this purpose, using the same form available via link: <https://www.cqc.org.uk/content/notifications>.

If a person subject to a deprivation of liberty authorisation should die while subject to the authorisation the local Coroner's Office should be informed by the care provider. Managing authorities are required to complete a notification of death form for anyone in their care who was subject to a DOLS process using the attached form: [Notification of Death whilst subject to DOLS](#).

Failure to comply with the Safeguards may result in civil litigation against Trusts/Hospitals, as well as claims of breach of the European Convention on Human Rights. Trust/Hospital Boards therefore require assurance that appropriate steps have been taken to implement and monitor application of the Safeguards to ensure compliance.

2.0 INTRODUCTION

The Trust is required by law to submit applications for Deprivation of Liberty Safeguards for patient who lack capacity and are subject to continuous supervision and control and are not free to leave (form available on the intranet via link:

<http://www.medway.nhs.uk/EasysiteWeb/getresource.axd?AssetID=479425&type=Full&servicetype=Attachment>

The Clinical Commissioning Group Operational Standards for Safeguarding quality requirements require the Trust to audit:

- Urgent and standard applications and number of episodes of restraint applied across trust
- Deprivation of Liberty Safeguard applications made to the Local Authority
- Number of Deprivation of Liberty applications authorized and reported to the CQC
- number of patients who are still being deprived of their liberty and the organisation has breached the 14 day requirement for Urgent authorisations (i.e. Standard authorisation has not been authorised by the Supervisory Body).

3.0 STANDARDS / GUIDELINES / EVIDENCE BASE

The Trust have a statutory duty to request a DoLS authorisation from the supervisory body (the relevant Local Authority) in any situation where it appears to the managing authority (Trust/Hospital) that the relevant person is or is likely to be detained in a hospital for the purpose of being given care or treatment in circumstances which amount to a deprivation of liberty and is likely to meet all of the qualifying criteria:

- Age requirement: aged 18 or over
- Mental health requirement: suffering from a mental disorder (any disorder or disability of the mind)

- Mental capacity requirement: lacks capacity in relation to the question whether or not he should be accommodated in the relevant hospital for the purpose of being given the relevant care or treatment
- Best Interests requirement: is detained in circumstances amounting to a deprivation of liberty, the deprivation of liberty is in best interests, deprivation is necessary to prevent harm and the deprivation is a proportionate response to the likelihood and seriousness of the potential harm
- Eligibility requirement: not excluded from the Safeguards by being subject to detention under the Mental Health Act 1983 or meeting the criteria for detention under the Mental Health Act 1983 and objecting to some or all of the proposed care or treatment for mental disorder; and
- No refusals requirement: no valid refusal of the proposed care or treatment has been made by an Advance Decision to Refuse Treatment, a Lasting Power of Attorney or a Court-Appointed Deputy.

Staff are required to complete an application form for a deprivation of liberty safeguards using a 'Deprivation of liberty safeguards form 1 - request for standard authorisation and urgent authorisation' form.

When it is believed someone is already being deprived of their liberty in their best interests in order to provide them with the care and treatment they need, the Trust is able to grant itself an Urgent Authorisation for up to 7 days (this can be extended to cover a total of 14 days in exceptional circumstances where there are delays in assessments being progressed provided an extension is applied for using the relevant section at the end of the DoLS application form).

The supervisory body will then arrange for assessments to be completed by appropriately qualified individuals to ensure the individual for whom the application is being made does meet all of the qualifying requirements:

All Deprivation of Liberty Safeguards applications submitted by staff need to be:

- Fully completed and provide suffice information for the supervisory body to proceed with their assessments and to proceed with the standard authorisation
- Submitted within required timescales.

The conditions that need to be met to allow the person to be deprived of their liberty under the safeguards include:

- The person is 18 or over (different safeguards apply for children).
- The person is suffering from a mental disorder.
- The person lacks capacity to decide for themselves about the restrictions which are proposed so they can receive the necessary care and treatment.
- The restrictions would deprive the person of their liberty.
- The proposed restrictions would be in the person's best interests.
- Whether the person should instead be considered for detention under the Mental Health Act.
- There is no valid advance decision to refuse treatment or support that would be overridden by any DoLS process.

4.0 AIM

This audit's aim is to evidence compliance with the relevant national requirements for Deprivation of Liberty Safeguard procedures and to meet data reporting requirements to our commissioners.

5.0 OBJECTIVES

The objectives of the audit are to provide evidence based assurance that:

- The Trust is monitoring compliance with documentation of Mental Capacity assessments
- The Trust is monitoring compliance with the DoLS application processes
- Staff are completing Deprivation of Liberty Safeguard applications correctly
- Referrals for DoLS authorisations are being progressed for appropriate patients
- DoLS applications are not exceeding statutory timescale requirements
- The Trust is monitoring notification of death to Coroner for persons in their care who die whilst subject to a DOLS authorisation.
- To identify areas of trends or areas of concern relating to DoLS applications and to develop an action plan to address areas of concern.

6.0 METHODOLOGY

This was a retrospective patient case note audit. Data collected from patient records was gathered, analysed and presented in a report format.

7.0 AUDIT TOOL

The audit tool used for this audit was developed using an audit tool produced by Guys and St Thomas's Hospital.

8.0 AUDIT SAMPLE

A randomised sample of medical records were selected from wards where Deprivation of Liberty Safeguards had been submitted during a 3 month period where:

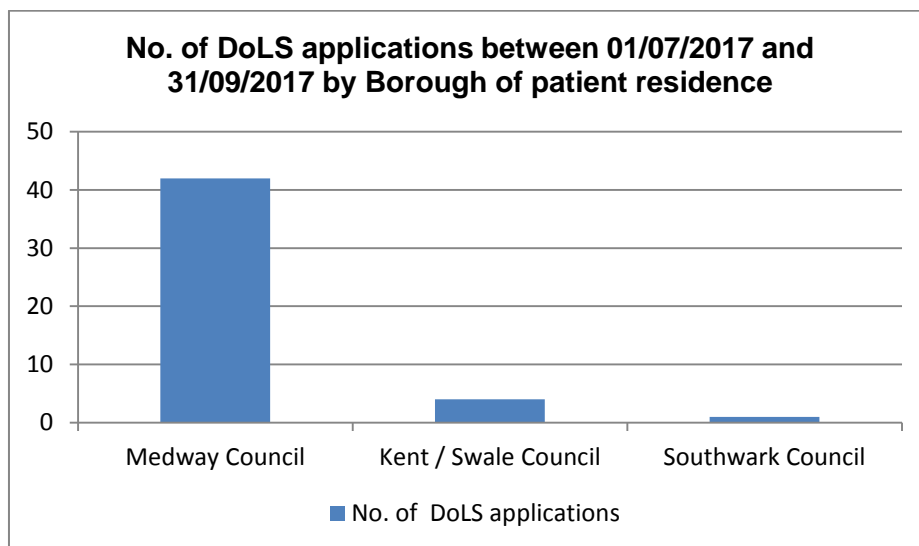
- DoLS applications had been submitted between 1st September – 31st November 2016
- Patients had been inpatients for over 7 days
- The audit aimed to look at 5 sets of notes from each area, however due to the availability of notes this was not always possible.

9.0 AUDIT FINDINGS

Sample size n=47

9.1 Local Authority

89% (n=42) of the sample audited where residents of Medway Council. 9% (n=4) were residents from Kent Council and 2% (n=1) was from Southwark Council.

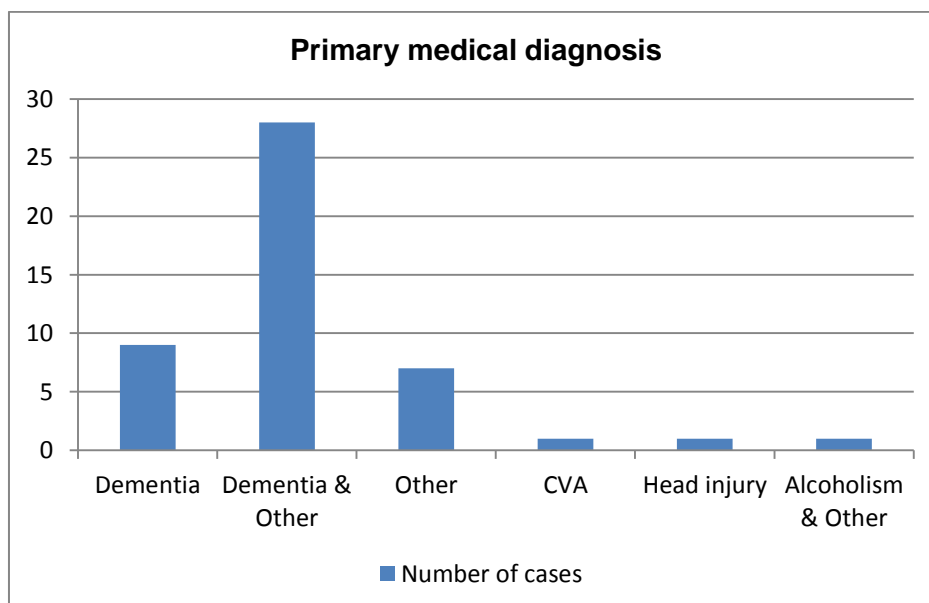


9.2 Admission route

98% (n=46) of the sample audit were admitted to hospital as emergency admissions via the Emergency Department. Only 2% (n=1) was an elective admission and they were admitted direct to the surgical ward area.

9.3 Medical diagnosis – reason for admission

Patient's medical diagnosis was recorded to identify reason for admission to hospital. Dementia diagnosis was a common theme for this group of patients.

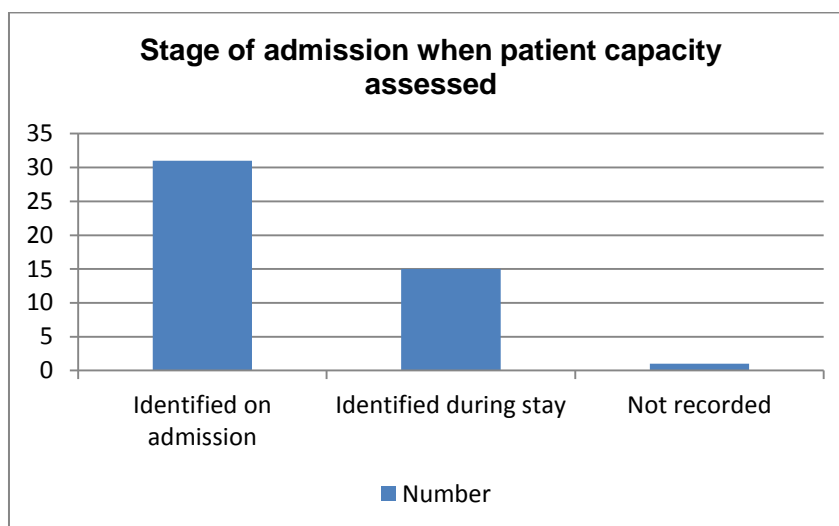


9.4 Mental Capacity Assessment

100% (n=47) of the sample audited were deemed to lack capacity.

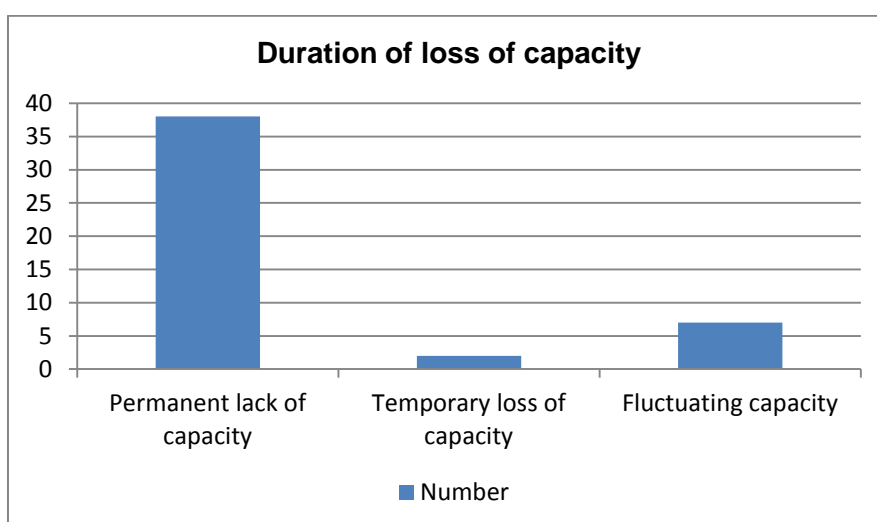
9.5 At what stage of the patient stay was the mental capacity assessment recorded?

66% (n=31) of sample audited were assessed as lacking capacity on admission to hospital whilst in 32% (n=15) the lack of capacity was identified during the patient's stay in hospital.



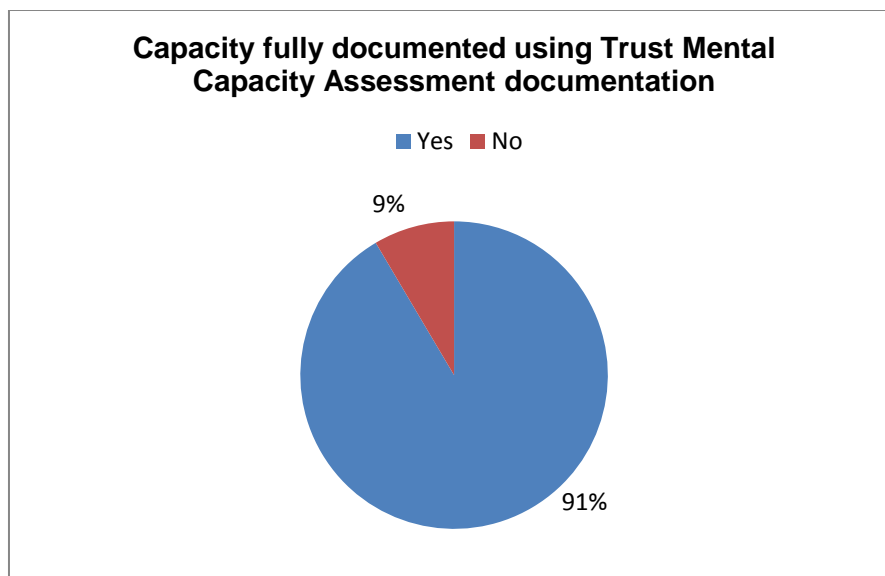
9.6 Duration of loss of capacity

- 81% (n=38) of sample audited were deemed to have permanent loss of capacity.
- 4% (n=2) lacked capacity temporarily but for duration of stay
- 15% (n=7) had fluctuating capacity during their stay in hospital.



9.7 Mental capacity assessment fully documented using MCA assessment tool?

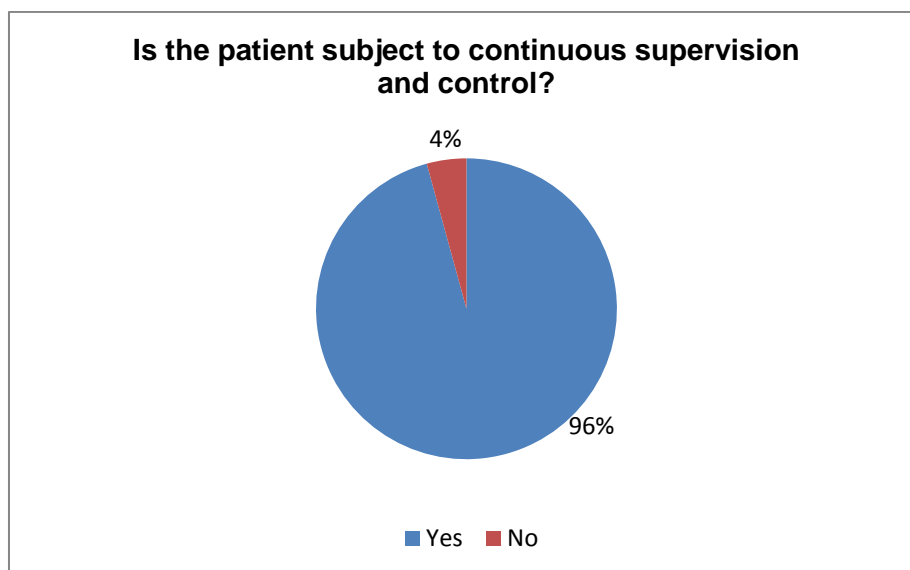
In 91% (n=43) of the sample audited, there was evidence of a formal mental capacity assessment found in the patient record. In 9% (n=4) the auditors could not find evidence of a Mental Capacity assessment being documented in the patient records using the Trust assessment documentation tool.



9.8 Restraint

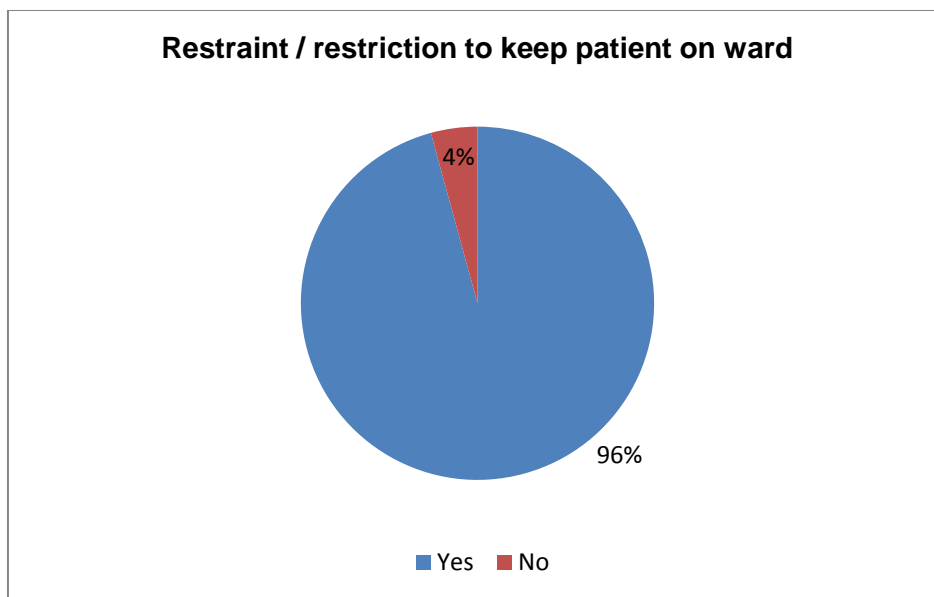
9.8.1 Continuous supervision and control?

None of the sample audited were deemed to be free to leave. 96% (n=45) were subject to continuous supervision and control. In some cases a member of staff was assigned to stay with the patient continuously (1:1) because they needed to manage confusion, aggression or falls risks.



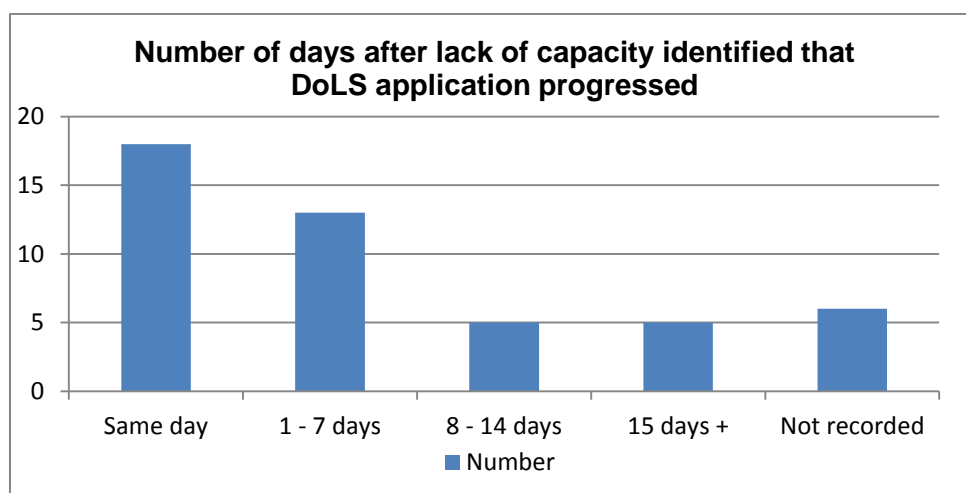
9.8.2 Restraint / restriction used to keep patient on ward

96% (n=45) of the sample audited were subject to some form of restraint or restriction e.g: medication, sedation, bedrails or soft mittens used to protect invasive line and oxygen administration.

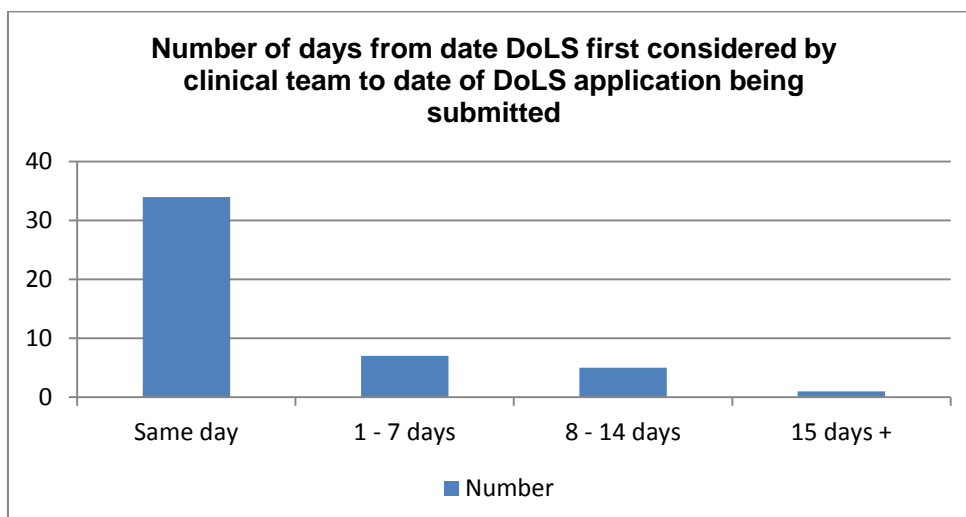


9.9 DoLS application to Safeguarding Teams

9.9.1 Number of days from lack of capacity identified to DoLS first considered

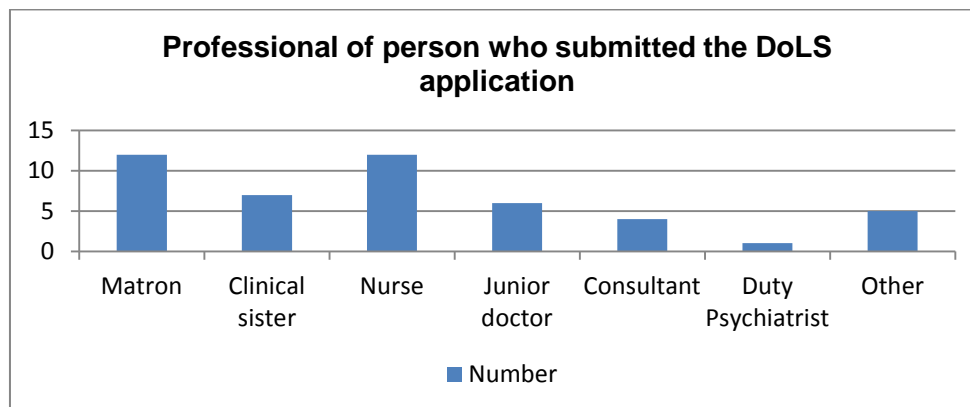


9.9.2 Number of days from date of DoLS being considered to DoLS application being submitted.



72% (n=34) of application requests were submitted on the date that they were requested by the clinical team.

9.10 Professional Group of person who applied for the DoLS



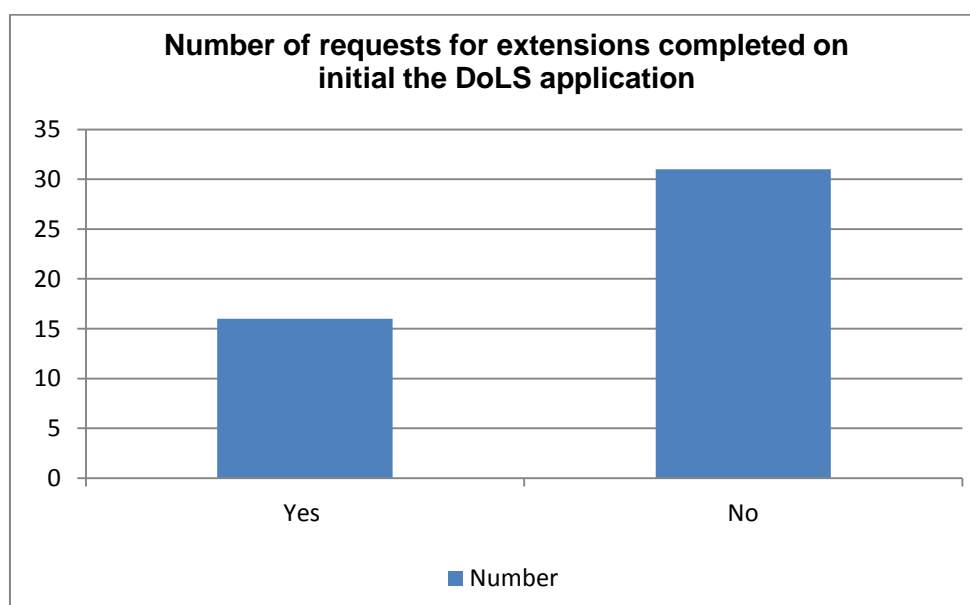
9.11 Type of DoLS application form used

In 98% (n=46) of cases the correct application form (Form 1 – urgent and standard authorisation form) was used to submit the DoLS application. Both urgent and standard DoLS applications were requested on the updated national DoLS form 1.

9.12 Was an extension for urgent authorisation completed?

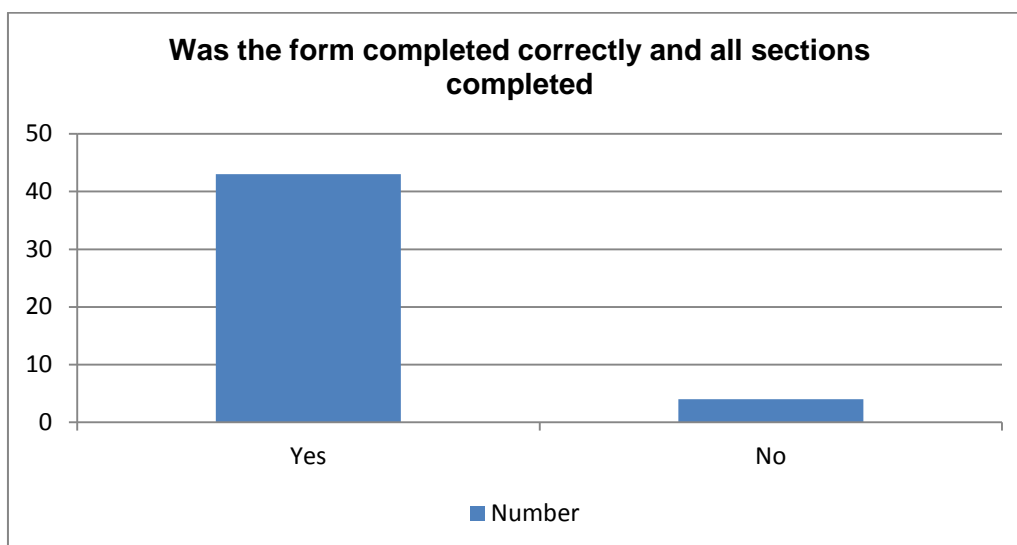
Note: Medway Council DoLS Team have specifically asked that an extension for an urgent authorisation is completed at the same time as the initial authorisation is submitted. This is a local requirement as opposed to a national requirement.

- 34% (n=16) of DoLS application had requested an extension for the urgent application at the time of submission of the request.
- 66% (n=31) failed to request extension for the urgent authorisation at the time of submission to the Local Authority DoLS Team.



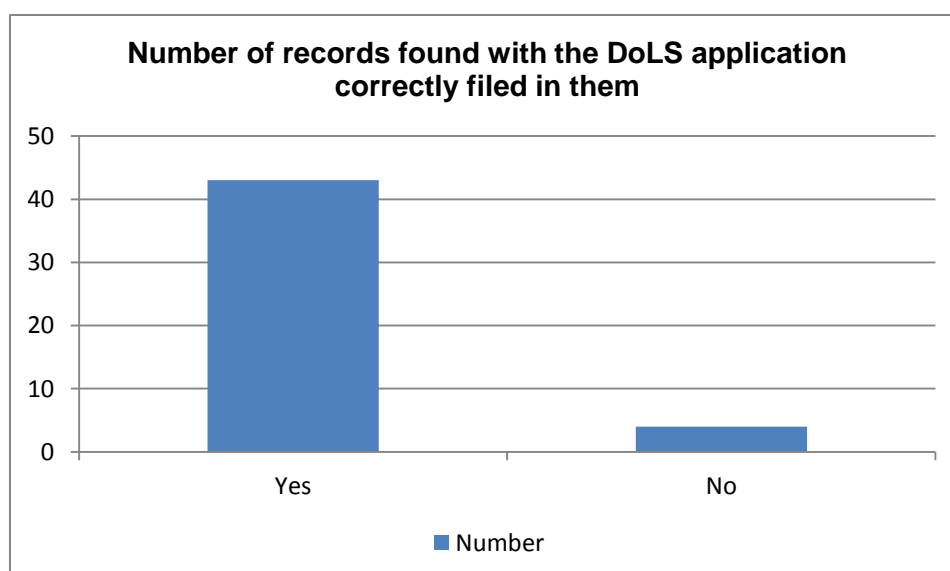
9.13 Deprivation of Liberty Safeguards procedures applied

9.13.1 Completion of DoLS applications



91% (n=43) of the sample audited DoLS forms were correctly completed. 9% (n=4) were not completed correctly. Comments for those not correctly completed:

- Could have provided more detail on the type of restrictions to be authorised for use under the standard authorisation
- Referred to incorrect local authority on the DoLS application form
- Dates for standard application incorrectly calculated.
- Patient home postcode incorrect on application form
- DoLS application form recorded incorrect local authority and progressed to incorrect DoLS team



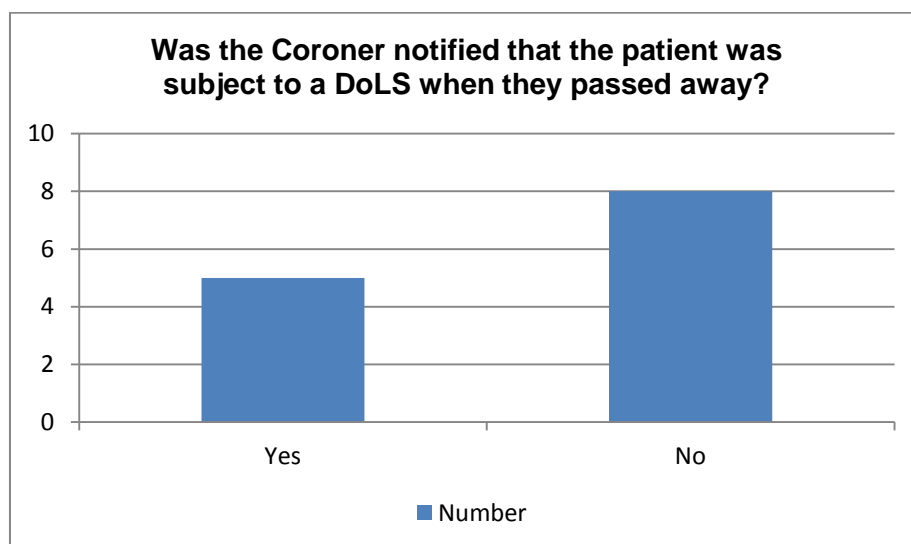
89% (n=42) of the patient records audited had copies of the DoLS application forms correctly filed in them.

9.13.2 Did the patient pass away whilst under a DoLS?

13 of the sample audited passed away whilst under a DoLS authorisation process.

9.13.3 Of the 13 patients who passed away in hospital whilst under a DoLS authorisation, was the Coroner notified that the patient was subject to a DoLS?

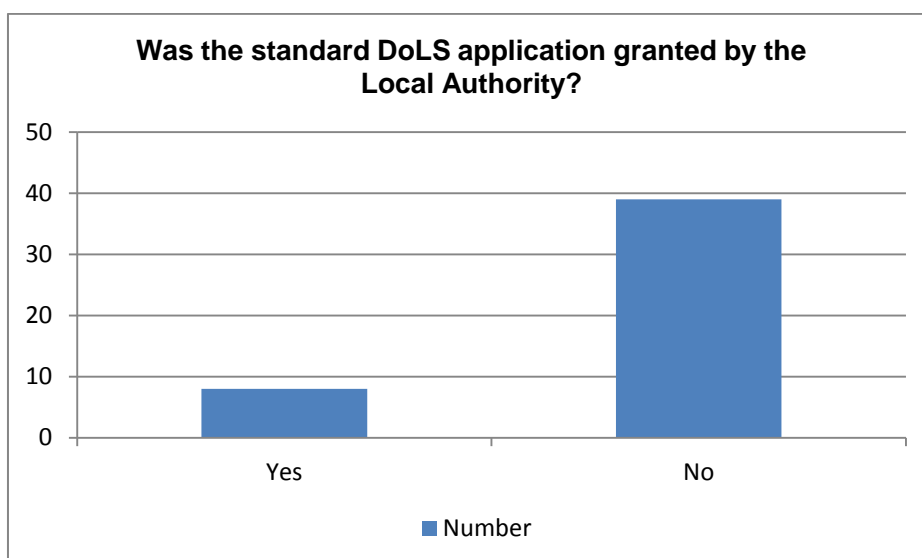
Trusts are required to complete a notification of death form to the Coroner for anyone who dies whilst subject to a DoLS authorisation.



9.14 Submission Outcome

9.14.1 Was the DoLS application authorised / granted?

17% (n=8) of the DoLS applications sample audited were granted by the Local Authority. However, 83% (n=39) were not granted.



9.14.2 Reasons found for DoLS applications not being granted included:

- Requests submitted to Local Authority for Standard Authorisation not progressed by date requested and patient discharged from hospital before this was progressed
- Patient died in hospital before the Standard Authorisation was authorised
- Patient discharged during the period covered by the extension of urgent authorisation and before the standard authorisation was granted
- Patient died the same day the Standard Authorisation was granted

9.14.3 Reasons for delays in DoLS applications being progressed:

- DoLS paperwork does not appear to have been completed until after discharge planning commenced
- Patient was initially deemed to have capacity by the Best Interest Assessor
- Incorrect Supervisory Body identified on DoLS application
- Patients home address incorrectly recorded on application form
- Local authority not able to progress standard assessment until all sections of the application form completed ... therefore standard authorisation was delayed

10.0 CONCLUSION

Overall compliance with requirements for completion of DoLS applications was good across the Trust, although some of the applications had incorrect dates entered for 'expiry dates of urgent authorisations' and 'date for commencements of standard authorisations'.

The sample audited showed that a range of professional disciplines were progressing DoLS applications and that they were using the correct application forms form 1 standard and urgent authorisations.

Only 34% of the audit sample, staff did not apply for an extension to the urgent authorisation at the same time that the initial request is submitted. Although this is local requirement by the Medway DoLS Team (not a statutory requirement) this need to be emphasised in staff training.

In 62% (n=8) of the 13 patients who died during their hospital admission, there was no indication of whether the Coroner had been formally notified that a DoLS application was in process at the time that the patient died. Prior to 3rd April 2017, any patient who died whilst subject to a DOLS authorisation had to be notified to the Coroner. However, as from 3rd April 2017, there is no longer a mandatory requirement to refer to the Coroner simply because a person has died whilst subject to a DoLS authorisation⁴.

11.0 RECOMMENDATIONS

- Ensure DoLS application forms are completed with correct dates for urgent / standard authorisations
- Staff need to be reminded to store a copy of the patient's Mental Capacity assessments and the DoLS paperwork in the patient records
- Staff need to reminded to complete Mental Capacity assessments and DoLS applications earlier during the inpatient stay (Day 0 – 7 of inpatient stay)
- Clarity is required for procedures to be followed for escalation when there are delays in standard authorisations being granted.

⁴ <https://www.wessexlmcs.com/deprivationoflibertysafeguardingdols>

APPENDIX I

Safeguarding Adults: Deprivation of Liberty Audit Template

Section 1. Primary Data									
1.1 Hospital Number:					1.2 Local Authority:				
Section 2. Admission									
2.1 Date of admission:					2.2 Age on admission:				
2.3 Admission type:		Elective				Emergency			
2.5 Admitted via:		A&E				Direct to ward			
2.4 Admitting Consultant:									
2.6 Admitting Ward/Area (or Transfer):									
2.7 Medical diagnosis:		Dementia				Alcoholism			
Head Injury				Cerebral Vascular Accident (CVA)					
Other				Please specify:					
Section 3. Mental Capacity Assessment									
					Yes	No	Details/Comments		
3.1 Does patient lack capacity for care and treatment decision?									
3.1a <i>If yes, when was the lack of capacity identified:</i>									
On Admission:		<input type="text"/>		During Stay:		<input type="text"/>		Date Identified: _____	

3.1b	Is the lack of capacity:	Permanent <input style="width: 40px;" type="checkbox"/>	Temporary but for duration of stay <input style="width: 40px;" type="checkbox"/>	Temporary, status altered during stay <input style="width: 40px;" type="checkbox"/>						
					If temporary and status altered enter dates(s)/time(s) patient lacked capacity: _____					
3.2	Mental capacity assessment fully documented?	Yes	No	Details/Comments (full assessment or one sentence and where documented)						
		<input style="width: 30px;" type="checkbox"/>	<input style="width: 30px;" type="checkbox"/>							
3.3	Grade(s) of Professional making assessment:	Consultant		<input style="width: 30px;" type="checkbox"/>	Junior Doctor	<input style="width: 30px;" type="checkbox"/>	Qualified nurse	<input style="width: 30px;" type="checkbox"/>	Other	<input style="width: 30px;" type="checkbox"/>
Section 4. Restraint										
Details about the patient:		Yes	No	Details/Comments (what and how often)						
4.1	Is the patient subject to continuous supervision and control ?	<input style="width: 30px;" type="checkbox"/>	<input style="width: 30px;" type="checkbox"/>							
4.2	Is the patient free to leave ?	<input style="width: 30px;" type="checkbox"/>	<input style="width: 30px;" type="checkbox"/>							
4.3	Restraint/restriction used to keep patient in the ward	<input style="width: 30px;" type="checkbox"/>	<input style="width: 30px;" type="checkbox"/>							
4.3a	If yes, type of restraint applied (please tick all that apply):									
	One-to-one nursing/surveillance	<input style="width: 30px;" type="checkbox"/>	Side room	<input style="width: 30px;" type="checkbox"/>	With Door Closed	<input style="width: 30px;" type="checkbox"/>	With Door Open	<input style="width: 30px;" type="checkbox"/>		
	Sedation	<input style="width: 30px;" type="checkbox"/>	On open ward but prevented from leaving alone	<input style="width: 30px;" type="checkbox"/>						
	Returned to ward if absented	<input style="width: 30px;" type="checkbox"/>	Other form of barrier (specify):	_____						
	Other (please specify):	_____								

Section 5. DOLS Application Request to Safeguarding			
5.1	Ward/Area:	5.2	Consultant:
5.3	Date DOLS first considered:	5.4	Professional who considered DOLS first:
5.5	Date of request:	5.6	Grade of requester (if applicable)
5.7	Reason for request:		
<p><i>If request of assessment delayed, reason/comments: (Explain why?)</i></p>			
Section 6. DOLS Application to Supervisory Body			
6.1	Date applied for DoLs:	6.2	Who applied:
6.3	Type of form used:	Yes	No
6.3a	Urgent authorisation completed:		
6.3b	Standard authorisation completed:		
6.3c	Extension for urgent authorisation completed:		

Section 7. Deprivation of Liberty Safeguard procedures applied

	Yes	No	Comment
7.1 Was the form completed correctly and all sections completed			
7.2 Was a copy of the DoLs application stored in the patient records?			
7.3 Did the patient pass away whilst under DoLs?			
7.4 Was the Coroner notified that the patient passed away whilst under a DoLs?			

Section 8. Submission Outcome

	Yes	No	If yes, period authorised
8.1 Was the application authorised?			
8.2 Review			
8.2a Reapplication of exceeded date?			

Additional Comments

Appendix 2

Deprivation of Liberty Safeguards Audit Action Plan

Accountable Lead: Bridget Fordham

Action Plan Completion Date: 03/05/2017

Objectives List of actions	Tasks What you need to do to achieve the action	Success Criteria How will you identify success	Target Date	Resources What or who can help you complete the action	Owner	Current position	Actual Date	Evidence Source
Staff to be reminded to store a copy of the patient's Mental Capacity assessments and the DoLS paperwork in the patient records.	MCA & DoLS Training to include reminder for staff to print and store copies of the DoLS application and paperwork in patient records.	Target for 100% compliance in subsequent DoLS audits	End May 2017	Adult Safeguarding Lead	Head of Safeguarding	This has now been included in staff training for MCA / DoLS		
Ensure DoLS form are completed with correct dates for urgent / standard authorisations	Ensure feedback is given to staff when they submit DoLS application forms with incorrect dates on them Communication cascade to all staff with a link to the DoLS date calculator	100% DoLS applications forms will be submitted with correct dates on applications forms	End May 2017	DoLS administrator Communications Team	Head of Safeguarding Head of Safeguarding	Feedback is given to staff when current DoLS forms are submitted There is already a DoLS date calculator on the Trust intranet		

Objectives List of actions	Tasks What you need to do to achieve the action	Success Criteria How will you identify success	Target Date	Resources What or who can help you complete the action	Owner	Current position	Actual Date	Evidence Source
Mental Capacity assessments and DoLS applications to be completed as earlier as possible during the inpatient stay to allow time for DoLS to be authorised.	MCA & DoLS training to include reminder for staff to complete Mental Capacity assessments and DoLS applications as early as possible during the patient stay in hospital inpatient stay	100% MCA assessments completed for patients who lack capacity during day 1 – 7 of their inpatient stay 100% DoLS applications submitted during day 1 – 7 of inpatient stay.	End May 2017	Adult Safeguarding Lead	Head of Safeguarding	Training slides for MCA / DoLS have been updated		
Staff complete the section for an extension to the urgent authorisation for the DoLS at the same time that the initial request is submitted to the Local Authority.	Emphasis need to apply for 7 day extension to staff in MCA / DoLS training sessions.	100% compliance with completion of application for 7 day extension on DoLS authorisation request forms.	End May 2017	Adult Safeguarding Lead	Head of Safeguarding	This has now been included in staff training for MCA / DoLS		

Overdue

On target

Near completion

Complete

Report to the Trust Board

Board Date: August 2017

Agenda Item:

11a

Title of Report	Finance Report Month 3 June 2017
Presented 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	<p>The purpose of this report is to summarise the M3 year to date and forecast financial performance of the Trust against the agreed plan.</p> <p>Key points are :</p> <ol style="list-style-type: none"> 1. In month performance has been reported in line with the planned deficit, however, the current levels of clinical income being identified via the Trust systems are lower than would be expected based on the 2017-18 planning. The analysis currently undertaken suggests a potential shortfall on income in the year. Work is currently being undertaken to validate and agree the items on the contract work plan to ensure all income can be correctly recovered. 2. Year End Forecast – The forecast outturn is currently aligned to plan but it is recognised that there are a number of risks and opportunities that will arise during the year. As noted at 1. above, the largest risk in the forecast is income. 3. Income – Income is below plan by £1.2m after accounting for potential contract work plan additions. 4. Expenditure – Month 3 expenditure is below plan by £1.13m, £5k favourable on pay and £1.08m favourable on non-pay. However there are significant overspends on pay in the Coordinated Surgical and Families and Children's Services directorates. All 3 of the clinical directorates are overspent on non-pay. These variances need to be addressed quickly to ensure the ability to achieve the financial control total. 5. Agency spend improved in month, however this has been offset by an increase in bank costs to a similar value. The CIP plan includes a significant reduction in overall spend

	<p>(combined bank and agency cost) which is not reflected in the current runrate. This is being investigated to determine whether the agency premium saving is offsetting an increase in filled shifts.</p> <p>6. CIP – the year end forecast for CIP is delivery to plan. At month 3 CIP delivery is behind plan by £1.13m, with £2.01m achieved. This largely relates to the current unidentified CIP target, and the phasing of the plan.</p> <p>7. Cash – Cash has been drawn down from DH in the form of loans in line with the revenue plan. Additional cash has been provided to support the ED build. With the current shortfall on income year to date, there is an additional pressure on the cash balance, which is impacting creditor terms.</p> <p>8. Capital – The 2 year operational plan submitted in March 2017 included £32m capital spend. The current forecast is for c. £21m based on ED works and programmes funded by internally generated funds. Any additional capital projects would be reliant on DH funding approval.</p>
Resource Implications	As outlined
Risk and Assurance	<ul style="list-style-type: none"> Contract Work plan – this is a large risk to the organisation as the full value of provider intentions is included in our plan, contributing to a system gap. The Board is asked to note that work is on-going to refine the work plan and confirm the values within this. CIP Delivery is a risk with a significant level of unidentified CIP and a further £3.4m stretch target. The Board is asked to note that actions are already being taken to improve the delivery process. <ul style="list-style-type: none"> 2020 are currently supporting the Improvement workstream for Financial Recovery with a 4 week “sprint”. Focus on specialty contribution to highlight target areas for savings. Reviewing coding. Focus on unwarranted variation (Carter) Governance process for CIP now deployed Inefficient use of Trust resources remains a risk due to assurance gaps in the financial controls environment. The Board is asked to note that work has already commenced to enhance the financial controls environment as part of the Trust Financial Recovery Plan and will further roll out through the Summer of 2017 as part of the Trust FRP. Grip and Control measures are being reviewed and updated.

	<ul style="list-style-type: none"> 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 improvements have already commenced on both minor and major works, including ED. However, as there is unlikely to be additional capital funding made available to the Trust over and above ED funding, the capital programme has had to be scaled back to those schemes approved for funding within the internally generated funds. This primarily includes backlog maintenance, fire safety, IT and medical equipment.
Legal Implications/Regulatory Requirements	<p>Lack of achievement of the agreed control total would lead to Further Regulatory actions, including Financial Special Measures.</p> <p>The aged estate requires significant investment relating to fire, health and safety over coming years to ensure that the Trust is compliant with regulation.</p>
Recovery 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	The Board is asked to note the report
Purpose & Actions required by the Board :	<div> <div>Approval</div> <div><input type="checkbox"/></div> </div> <div> <div>Assurance</div> <div><input type="checkbox"/></div> </div> <div> <div>Discussion</div> <div><input type="checkbox"/></div> </div> <div> <div>Noting</div> <div><input checked="" type="checkbox"/></div> </div>

Finance Report

Month 3

2017/18

Finance Report for June 2017

1. Liquidity
 - a. Cash Flow
 - b. Loan Conditions
2. Financial Performance
 - a. Consolidated I&E
 - b. Run Rate Analysis - Financial
 - c. Workforce
 - d. Run rate analysis Pay
3. Balance Sheet
 - a. Balance Sheet
 - b. Debtors
 - c. Creditors
4. Capital
 - a. Capital Summary

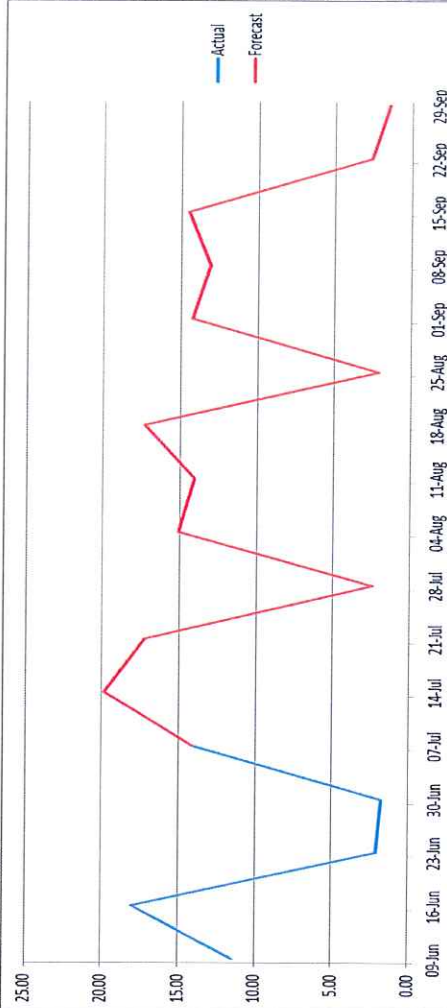
1. Liquidity

1a. Cash Flow

13 Week Forecast

Em	Actual				Forecast													
	09/06/17	16/06/17	23/06/17	30/06/17	07/07/17	14/07/17	21/07/17	28/07/17	04/08/17	11/08/17	18/08/17	25/08/17	01/09/17	08/09/17	15/09/17	22/09/17	29/09/17	
BANK BALANCE B/FWD	14.36	11.47	18.03	2.05	1.78	13.63	17.69	12.47	1.41	13.90	15.12	17.25	2.02	14.36	12.51	12.20	2.85	
Receipts																		
NHS Contract Income	0.12	3.43	0.21	1.41	14.21	5.41	0.00	0.00	14.48	0.00	3.72	0.00	14.27	0.00	3.37	0.00	0.00	
Other	0.32	0.70	0.20	0.30	0.48	2.68	0.28	0.28	0.40	0.61	0.40	0.28	0.28	0.53	0.48	0.28	0.28	
STF Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.45	0.00	0.00	0.00	0.00	(2.10)	0.00	
Total receipts	0.44	4.12	0.40	1.71	14.69	8.09	0.28	0.28	14.88	0.61	7.57	0.28	14.55	0.53	3.85	(1.83)	0.28	
Payments																		
Pay Expenditure (excl. Agency)	0.00	0.00	(14.96)	(0.01)	0.00	0.00	(6.90)	(8.40)	(0.01)	0.00	(2.43)	(12.63)	(0.01)	0.00	0.00	(14.99)	(0.01)	
Non Pay Expenditure	(3.32)	(3.43)	(1.39)	(0.11)	(2.84)	(4.03)	(5.01)	(0.20)	(2.38)	(2.38)	(3.83)	(0.93)	(2.20)	(2.38)	(3.16)	(3.25)	(0.33)	
Capital Expenditure	0.00	0.00	0.00	(2.50)	0.00	0.00	0.00	(2.73)	0.00	0.00	0.00	(1.95)	0.00	0.00	0.00	0.00	(1.37)	
Total payments	(3.32)	(3.43)	(16.35)	(2.62)	(2.84)	(4.03)	(11.90)	(11.33)	(2.39)	(2.38)	(6.26)	(15.51)	(2.21)	(2.38)	(3.16)	(18.24)	(1.71)	
Net Receipts/ (Payments)	(2.89)	0.70	(15.94)	(0.91)	11.85	4.06	(11.63)	(11.06)	12.49	(1.78)	1.31	(15.23)	12.34	(1.86)	0.69	(20.06)	(1.44)	
Funding Flows																		
STFF/DOH - Revenue	0.00	5.86	0.00	0.00	0.00	0.00	3.10	0.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00	11.00	0.00	
STFF/DOH - Capital	0.00	0.00	0.00	0.00	0.00	0.00	3.30	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.40	0.00	
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	(1.00)	0.00	0.00	
PDC Capital	0.00	0.00	0.00	0.63	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	(0.04)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.18)	0.00	0.00	0.00	0.00	(0.69)	0.00	
Dividend payable	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	
	0.00	5.86	(0.04)	0.63	0.00	0.00	9.70	0.00	0.00	0.00	2.82	0.00	0.00	0.00	(1.00)	10.72	0.00	
BANK BALANCE C/FWD	11.47	18.03	2.05	1.78	13.63	17.69	15.77	1.41	13.90	12.12	16.25	2.02	14.36	12.51	12.20	2.85	1.41	

Fig1. Cashflow Forecast



Commentary

The opening cash balance for June 2017 was £2.1m, with a closing balance of £1.8m. This is above the minimum liquidity level (£1.4m) required by DH by £0.4m.

The graph shows the actual cashflow for June and the projected weekly cashflow up to and including w/e 29 September 2017.

Receipts in the month were £21.3m, plus £6.5m loans & funding, therefore the total cash inflow for June was £27.8m. Payments, including capital in the month were £28.1m.

The Trust has received £5.9m of deficit loan funding YTD, drawn during June, in the form of an uncommitted revenue loan. In addition, PDC of £0.6m was drawn during the month in relation to the Emergency Department capital project.

Monthly payments for 17/18 have so far averaged at £27.1m, with 58% relating to payroll costs. This includes £9.2m per month for direct salary payments and £6.5m in relation to employer costs. Monthly receipts (excluding loans & STF) for 17/18 have averaged at £24.9m, however it should be noted that this includes an additional monthly contract payment received from Medway CCG during April.

Contracts with the Trust's commissioners for 2017/18 were agreed and in place for the start of the financial year. Agreement in relation to the 2016/17 NHS England Specialist Commissioning contract has now been reached with a final settlement (£1.5m) expected mid July. Discussions however remain ongoing with commissioners in relation to settlement of additional clinical performance for 2016/17. The Trust has experienced significant cash pressures during Q1 which are likely to continue into Q2 with non-pay expenditure requiring careful monitoring.

2. Financial Performance

2a. Consolidated Income & Expenditure

Consolidated I&E (June 2017)

	Current Month			Year to Date (YTD)			Annual		
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Forecast £'000	Plan £'000	Variance £'000
Revenue									
Clinical Income	19,709	20,926	-1,217	57,837	58,948	-1,111	237,659	237,659	237,659
High Cost Drugs	1,889	1,733	156	5,460	5,202	257	20,924	20,924	20,924
STF Income	451	451	0	1,351	1,351	0	9,006	9,006	9,006
Other Operating Income	2,129	2,035	94	5,690	6,104	-414	24,562	24,562	24,562
Total Revenue	24,178	25,145	-967	70,338	71,606	-1,268	292,151	292,151	292,151
Expenditure									
Substantive	-14,327	-15,763	1,436	-42,639	-47,172	4,533	-189,419	-189,419	-189,419
Bank	-2,047	0	-2,047	-4,956	-15	-4,942	-1,811	-1,811	-1,811
Agency	-860	-1,565	705	-4,378	-4,803	425	-16,930	-16,930	-16,930
Total Pay	-17,234	-17,328	94	-51,973	-51,990	17	-208,160	-208,160	-208,160
Clinical supplies	-2,850	-3,178	328	-9,281	-9,480	199	-37,133	-37,133	-37,133
Drugs	-2,662	-2,497	-165	-7,877	-7,432	-445	-30,219	-30,219	-30,219
Consultancy	-182	-90	-92	-494	-270	-224	-959	-959	-959
Other non pay	-2,566	-3,309	743	-8,568	-10,046	1,478	-40,566	-40,566	-40,566
Total Non Pay	-8,260	-9,074	814	-26,220	-27,228	1,008	-108,877	-108,877	-108,877
Total Expenditure	-25,494	-26,402	908	-78,193	-79,218	1,025	-317,037	-317,037	-317,037
EBITDA	-1,316	-1,257	-59	-7,855	-7,612	-243	-24,886	-24,886	-24,886
Post EBITDA									
Depreciation	-814	-808	-7	-2,443	-2,423	-20	-9,693	-9,693	-9,693
Interest	-194	-265	71	-528	-795	267	-3,186	-3,186	-3,186
Dividend	-7	-7	0	-21	-21	0	-81	-81	-81
Profit/(loss) on sale of asset	0	0	0	0	0	0	0	0	0
	-1,016	-1,080	64	-2,991	-3,239	248	-12,960	-12,960	-12,960
Net (Surplus) / Deficit	-2,332	-2,337	5	-10,846	-10,851	5	-37,846	-37,846	-37,846

NHSI Control Total

Variance Against Control Total (Favourable/-Adverse)

37,846

0

Commentary

Net (Surplus) / Deficit

The Trust reported a £2.3m deficit in June, which was marginally favourable to plan. The YTD position is a deficit of £10.8m (£5.5m favourable to plan). The YTD position includes the £1.4m YTD STF income.

Clinical Income

Clinical Income is adverse to plan by £853k at month 3. This is split £1.148m adverse on clinical income, £295k favourable on high cost drugs. The actual income for month 3 assumes that the Trust is successful in achieving income linked to several areas of the current contract work plan. This is a risk for the Trust as resolution is still to be agreed with the CCGs.

Other Operating Income

It shows a £0.1m favourable in month variance and an adverse YTD variance against plan of £0.4m, reflecting the reduction in education and training revenue from Health Education England (HEE), CIP under-delivery and a change in categorisation of actual income from Other Operating Income to Clinical Income.

Pay

Pay expenditure is favourable to plan in month £0.1m and shows a marginal favourable variance YTD. However the position in the individual Directorates shows significant overspends in CSD, FCSS and Estates and Facilities of £0.5m, £0.8m and £0.3m respectively. Agency monthly run rate shows a £1.5m / 60% reduction when compared to the last quarter of the previous financial year; Bank monthly run rate shows a £0.9m / 113% increase when compared to the last quarter of the previous financial year which reflects the output of management intervention. The impact of skill mix reviews on the medical wards for dealing with high dependency patients continue to result in reduced agency nursing costs.

Non Pay

Non pay shows a favourable variance against plan in month and YTD of £0.8m and £1.0m. However the position in individual directorate shows significant overspends in ACC, CSD and FCSS of £0.5m, £0.4m and £0.2m respectively. Clinical supplies shows an in month and YTD favourable variance to plan of £0.3m and £0.2m respectively reflecting activity under-performance against plan; drugs shows in month and YTD adverse variance to plan of £0.2m and £0.4m respectively which is partially offset by the High Cost Drugs income over performance; consultancy shows an adverse variance in month and YTD of £0.1m and £0.2m respectively reflecting a shift from agency pay; other non pay shows an in month and YTD favourable variance to plan of £0.7m and £1.5m mainly reflecting an underspend associated with planned service developments which are now being recognised as CIP savings considering the level of risk present.

CIP

As of Month 3 £2m of CIP has been delivered which is on track with the planned identified CIP target, however an overall adverse variance from the NHSI plan of £1.1m YTD. Schemes to the value of £10.1m (PVE) have been identified for the year. This represents 80% delivery against the £12.6m target, which is an increase from Month 2 of £0.5m. In addition, pipeline schemes of £2.4m have been identified and are in the process of being scoped and validated.

Whilst the identified CIP total has increased by £0.5m, the risk assessed value has increased significantly by £1.4m, due to the improved assurance of delivery gained during the validation and reconciliation process in month. The risk assessed value is now £7.5m (PVE) represents 60% delivery to target. Work continues as priority with the Directorates to identify the CIP gap of £2.5m, with pipeline schemes being scoped in order to close the gap to the stretch CIP target of £16m.

Risks and Mitigations

A high level of CIP remains unidentified for 2017/18 and remains one of the main priorities for the Trust.

Clinical Income plans are ambitious and opportunities to enable the plan are being explored.

Sustainability & Transformation funding will be contingent upon achievement of the agreed performance trajectories and delivery of the financial control total.

2b. Run Rate Analysis - Financial

Analysis of 15 monthly performance - Financials

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Revenue	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Clinical income	16.9	16.9	22.1	19.2	17.9	19.3	19.9	19.5	18.4	19.7	18.6	22.6	18.5	19.1	19.7
High Cost Drugs	1.8	1.6	1.8	1.7	1.6	2.0	1.8	1.7	1.5	1.8	1.6	1.6	1.7	1.9	1.9
STF Income	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.0	2.4	0.5	0.5	0.5
Other Operating Income	1.9	2.1	2.3	2.1	1.9	2.2	2.0	1.7	2.0	2.3	2.1	3.0	2.0	1.6	2.1
Total Revenue	21.3	21.3	26.9	23.7	22.2	24.2	24.4	23.6	22.6	24.6	23.4	29.5	22.6	23.2	24.2
Expenditure															
Substantive	-13.5	-13.5	-13.7	-13.6	-13.7	-13.7	-13.6	-14.0	-13.6	-13.9	-14.0	-13.6	-14.0	-14.3	-14.3
Bank	-0.6	-0.5	-0.6	-0.8	-0.7	-0.6	-0.6	-0.9	-0.8	-0.7	-0.8	-0.9	-1.1	-1.2	-2.0
Agency	-2.6	-2.8	-3.6	-2.8	-3.1	-3.6	-3.5	-3.8	-3.5	-3.7	-3.6	-3.9	-2.2	-1.9	-0.9
Total Pay	-16.8	-16.8	-17.9	-17.2	-17.5	-17.8	-17.6	-18.6	-17.9	-18.3	-18.3	-18.4	-17.3	-17.4	-17.2
Clinical supplies	-3.2	-3.4	-3.4	-3.4	-3.3	-3.2	-2.8	-2.7	-2.8	-2.9	-3.1	-3.0	-2.7	-3.4	-2.9
Drugs	-2.7	-2.9	-2.7	-2.5	-2.7	-2.8	-2.5	-2.1	-1.7	-2.4	-2.4	-2.4	-2.5	-2.7	-2.7
Consultancy	0.0	-0.1	0.0	-0.1	0.0	-0.1	0.0	0.1	0.0	-0.1	0.0	0.0	-0.2	-0.1	-0.2
Other non pay	-2.9	-2.4	-2.9	-2.6	-2.6	-2.4	-2.9	-3.0	-3.0	-3.0	-2.9	-7.0	-3.5	-2.5	-2.6
Total Non Pay	-8.8	-8.8	-9.0	-8.6	-8.6	-8.5	-8.2	-7.8	-7.4	-8.5	-8.4	-12.4	-8.9	-8.7	-8.3
Total Expenditure	-25.6	-25.6	-26.9	-25.8	-26.1	-26.3	-25.8	-26.4	-25.3	-26.8	-26.7	-30.8	-26.2	-26.1	-25.5
EBITDA	-4.3	-4.3	0.0	-2.1	-3.9	-2.1	-1.4	-2.8	-2.7	-2.2	-3.3	-1.3	-3.6	-2.9	-1.3
Post EBITDA															
Depreciation	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.9	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8
Interest	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.1	-0.2
Dividend	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	0.0	0.0	0.0	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	0.0
Profit on sale of asset	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0
	-1.0	-1.0	-1.0	-1.0	-1.1	-1.1	-1.0	-1.2	-1.1	-1.1	-0.9	-1.0	-1.1	-0.9	-1.0
Net Surplus / (Deficit)	-5.3	-5.3	-1.0	-3.1	-5.0	-3.2	-2.4	-3.9	-3.8	-3.3	-4.2	-2.2	-4.7	-3.8	-2.3

2c. Workforce

	Current Month					Prior Year In Month	Year to Date			Prior Year YTD	Commentary:				
	Actual		Variance		Plan	Actual	Variance		Actual						
	WTE	WTE	WTE	WTE			£m	£m		£m					
Substantive	Consultants	187	211	-24	2.55	2.43	0.12	2.33	7.45	7.20	0.25	7.00	Pay expenditure is overspent compared to plan in month by £0.1m mainly related to CIP under delivery, premium agency costs due to the level of vacancies and demand pressures. There has been a 45% reduction in the monthly agency run rate when compared to the final quarter of 2016/17, and a 88% increase in the monthly bank run rate (overall the run rate for temporary staff reduced by 30% when compared to the final quarter of 2016/17 reflecting the outcome of management intervention)		
	Junior Medical	320	374	-54	2.00	2.01	-0.01	1.91	5.79	6.02	-0.23	5.60			
	Nurses & Midwives	1148	1548	-401	4.12	5.09	-0.98	4.00	12.32	15.26	-2.94	11.91			
	Scientific, Therapeutic & Technical	426	520	-94	1.34	1.53	-0.19	1.41	4.14	4.58	-0.44	4.28			
	Healthcare Assts, etc.	491	607	-116	1.25	1.25	-0.21	0.97	3.09	3.75	-0.66	2.90			
	Admin & Clerical	825	941	-116	2.14	2.34	-0.20	1.98	6.40	7.01	-0.61	5.88			
	Chair & NEDs	7	7	0	0.02	0.01	0.01	0.01	0.04	0.04	0.00	0.04			
	Executives	8	9	-1	0.12	0.15	-0.03	0.17	0.40	0.46	-0.06	0.34			
	Other Non Clinical	446	500	-55	0.93	1.00	-0.07	0.90	2.79	3.00	-0.21	2.66			
	Pay Reserves	0	0	0	0.07	-0.06	0.13	0.00	0.20	-0.18	0.38	0.00			
Substantive Total	3,857	4,717	-860	14.32	15.75	-1.43	13.69	42.61	47.14	-4.53	40.60				
Agency	Consultants	14	0	14	0.03	0.27	-0.24	0.31	0.58	0.90	-0.3	0.82	Substantive establishments have increased by 1% when compared to March have been set based on a run rate basis including vacancies and agreed opening budgets with Directorates.		
	Junior Medical	33	0	33	0.18	0.36	-0.18	0.50	0.82	1.07	-0.3	1.70			
	Nurses & Midwives	141	2	139	0.37	0.49	-0.12	1.73	1.81	1.48	0.3	3.36			
	Scientific, Therapeutic & Technical	38	0	38	0.16	0.04	0.04	0.31	0.63	0.36	0.3	0.88			
	Healthcare Assts, etc.	0	0	0	0.00	0.04	-0.04	0.12	0.15	0.12	0.0	0.24			
	Admin & Clerical	8	19	-11	0.06	0.27	-0.21	0.59	0.21	0.82	-0.6	1.54			
	Other Non Clinical	26	0	26	0.07	0.03	0.04	0.12	0.21	0.09	0.1	0.39			
	Agency Total	261	21	240	0.87	1.58	-0.72	3.69	4.40	4.82	-0.42	8.93			
	Bank	Consultants	7	0	7	0.21	0.00	0.21	0.00	0.25	0.00	0.3		0.00	Wte for agency and bank staff for the majority of areas are included in the substantive wte as they are covering established posts whereas the financial premium cost is included in the agency/bank budget. The planned agency wte relates to the PMO as these are non recurrent posts.
		Nurses & Midwives	97	0	97	1.16	-0.07	1.23	0.21	1.38	-0.20	1.6		0.64	
Junior Medical		21	0	21	0.50	0.00	0.50	0.00	0.78	0.00	0.8	0.00			
Scientific, Therapeutic & Technical		10	0	10	0.04	0.00	0.04	0.10	0.05	0.01	0.0	0.11			
Healthcare Assts, etc.		161	0	161	0.81	0.03	0.78	0.29	1.49	0.10	1.4	0.73			
Admin & Clerical		84	4	80	-0.89	0.02	-0.91	-0.05	0.65	0.07	0.6	0.14			
Other Non Clinical		44	4	40	0.23	0.01	0.22	0.00	0.36	0.03	0.3	0.04			
Bank Total		423	8	415	2.05	-0.01	2.06	0.56	4.96	0.01	4.95	1.66			
Workforce Total		4,540	4,746	-206	17.23	17.32	-0.09	17.94	51.97	51.97	0.00	51.18			
Staff Group:		Consultants	208	211	-3	2.78	2.70	0.08	2.65	8.27	8.10	0.18	7.82		
	Junior Medical	374	374	-0	2.68	2.37	0	2.42	7.38	7.09	0.30	7.30			
	Nurses & Midwives	1,385	1,550	-165	5.64	5.51	0.13	5.94	15.51	16.54	-1.03	15.90			
	Scientific, Therapeutic & Technical	474	520	-46	1.54	1.65	-0.11	1.82	4.82	4.95	-0.13	5.27			
	Healthcare Assts, etc.	652	607	45	1.85	1.32	0.53	1.38	4.73	3.97	0.76	3.87			
	Executives	825	941	-116	2.14	2.34	-0.20	1.98	6.40	7.01	-0.61	5.88			
	Chair & NEDs	7	7	0	0.02	0.01	0.01	0.01	0.04	0.04	0.00	0.04			
	Admin & Clerical	100	32	68	-0.71	0.44	-1.15	0.71	1.26	1.35	-0.09	2.02			
	Other Non Clinical	516	504	12	1.22	1.04	0.18	1.02	3.36	3.12	0.24	3.09			
	Pay Reserves	0	0	0	0.07	-0.06	0.13	0.00	0.20	-0.18	0.38	0.00			
Workforce Total	4,540	4,746	-206	17.23	17.32	-0.09	17.94	51.97	51.97	0.00	51.18				

2d. Run rate analysis pay

2d. Run rate analysis pay																
Agency	Substantive	Apr-16														
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Agency	Consultants	178	181	179	177	179	179	180	181	178	179	178	179	180	184	187
	Junior Medical	321	311	322	307	334	328	329	327	321	321	321	320	320	320	320
	Nurses & Midwives	1,110	1,107	1,105	1,089	1,084	1,097	1,105	1,106	1,118	1,134	1,120	1,087	1,096	1,148	1,148
	Scientific, Therapeutic & Technical	464	466	460	452	451	456	442	446	450	448	446	437	437	426	426
	Healthcare Assts, etc	471	465	457	461	450	457	458	459	463	455	472	479	470	478	491
	Admin & Clerical	794	800	801	802	801	809	808	809	812	821	837	894	889	895	895
	Chair & NECs	7	7	7	7	7	7	6	6	6	6	5	3	11	7	7
	Executives	7	7	7	7	7	7	8	10	6	5	7	7	7	8	8
	Other Non Clinical	443	435	451	467	464	458	464	458	434	433	438	441	440	445	446
	Substantive Total	3,795	3,779	3,789	3,768	3,778	3,805	3,801	3,804	3,772	3,777	3,823	3,824	3,833	3,888	3,857
Agency	Consultants	10	13	14	16	19	25	20	18	18	19	20	28	20	15	14
	Junior Medical	50	52	51	54	59	65	68	61	70	62	53	56	47	40	33
	Nurses & Midwives	168	224	330	201	254	340	324	364	366	339	411	168	125	144	135
	Scientific, Therapeutic & Technical	44	52	61	55	61	28	35	54	63	50	37	35	46	32	38
	Healthcare Assts, etc	9	31	46	26	44	63	49	57	45	82	63	53	1	1	-
	Admin & Clerical	40	41	61	58	30	22	22	57	57	51	47	24	12	8	8
	Other Non Clinical	57	45	36	35	35	35	44	45	45	45	51	47	31	22	26
	Agency Total	840	458	598	444	502	578	562	656	588	675	611	654	925	243	261
	Consultants	-	-	-	-	-	-	-	-	-	-	-	-	-	-	7
	Nurses & Midwives	58	58	46	51	47	44	53	57	57	39	64	107	71	78	97
Bank	Junior Medical	-	-	-	-	-	-	-	-	-	-	1	3	5	22	21
	Scientific, Therapeutic & Technical	4	4	28	27	18	17	18	20	21	6	3	11	1	1	10
	Healthcare Assts, etc	91	91	153	120	117	108	114	124	127	121	134	209	130	142	161
	Admin & Clerical	36	36	1	62	105	51	59	78	59	67	64	52	263	105	84
	Other Non Clinical	3	3	1	4	9	3	13	45	40	41	44	40	37	41	44
	Bank Total	132	132	247	264	297	223	257	324	304	274	310	422	507	390	423
	Workforce Total	4,347	4,429	4,634	4,476	4,577	4,606	4,619	4,784	4,664	4,726	4,743	4,900	4,665	4,502	4,340

Analysis of 15 monthly performance - £

			Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	
			Em	Em	Em	Em	Em	Em	Em	Em	Em	Em	Em	Em	Em	Em	Em	Em
Substantive	Consultants		2.31	2.37	2.33	2.38	2.33	2.30	2.48	2.48	2.34	2.40	2.46	2.19	2.55	2.36	2.55	
	Junior Medical		1.86	1.83	1.91	1.88	1.99	1.95	1.96	2.10	1.95	2.01	1.86	2.08	1.84	1.95	2.00	
	Nurses & Midwives		3.97	3.95	4.00	3.89	3.91	3.92	3.92	3.91	3.89	3.91	4.14	3.96	3.94	4.03	4.12	
	Scientific, Therapeutic & Technical		1.45	1.43	1.42	1.38	1.38	1.42	1.18	1.39	1.40	1.40	1.42	1.36	1.33	1.36	1.34	
	Healthcare Assts, etc		0.99	0.95	0.97	0.96	0.94	0.97	0.94	0.96	0.94	1.02	0.97	0.93	1.00	1.05	1.04	
	Admin & Clerical		1.98	2.01	2.00	2.01	2.01	2.02	2.03	2.04	2.08	2.06	2.07	2.08	2.26	2.07	2.14	
	Chair & NECs		0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.02	0.00	0.01	0.01	0.01	0.04	0.01	0.02	
	Executives		0.11	0.11	0.13	0.15	0.12	0.13	0.10	0.12	0.10	0.12	0.09	0.10	0.14	0.17	0.16	
	Other Non Clinical		0.91	0.87	0.91	0.93	0.96	0.94	0.93	0.96	0.85	0.89	0.92	0.91	0.90	0.94	0.93	
	Substantive Total		13.59	13.52	13.76	13.65	13.65	13.66	13.63	14.03	13.57	13.78	13.96	13.76	13.99	14.37	14.32	
Agency	Consultants		0.24	0.26	0.31	0.37	0.37	0.44	0.31	0.29	0.37	0.41	0.37	0.42	0.37	0.18	0.03	
	Junior Medical		0.66	0.54	0.50	0.56	0.60	0.64	0.57	0.62	0.72	0.61	0.64	0.52	0.39	0.24	0.18	
	Nurses & Midwives		0.72	0.96	1.68	1.01	1.18	1.58	1.56	1.81	1.43	1.82	1.69	2.03	0.19	1.25	0.37	
	Scientific, Therapeutic & Technical		0.28	0.28	0.31	0.27	0.26	0.14	0.24	0.29	0.25	0.21	0.10	0.18	0.29	0.19	0.16	
	Healthcare Assts, etc		0.04	0.08	0.12	0.06	0.11	0.16	0.12	0.15	0.13	0.31	0.19	0.14	0.01	0.00	-	
	Admin & Clerical		0.53	0.50	0.50	0.40	0.52	0.42	0.56	0.52	0.50	0.49	0.41	0.21	0.13	0.01	0.06	
	Other Non Clinical		0.15	0.14	0.13	0.14	0.09	0.17	0.10	0.08	0.09	0.08	0.16	0.11	0.21	0.07	0.07	
	Agency Total		2.63	2.76	3.55	2.81	3.13	3.55	3.47	3.76	3.49	3.94	3.55	3.61	1.58	1.94	0.87	
	Bank	Consultants		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	0.21
		Nurses & Midwives		0.20	0.24	0.22	0.30	0.17	0.16	0.10	0.27	0.31	0.20	0.24	0.29	0.25	-	
Junior Medical			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.05	0.09	0.23	1.16	
Scientific, Therapeutic & Technical			0.00	0.01	0.10	0.08	0.06	0.06	0.06	0.06	0.07	0.02	0.01	0.04	0.00	0.01	0.04	
Healthcare Assts, etc			0.22	0.22	0.29	0.28	0.26	0.24	0.26	0.28	0.27	0.30	0.31	0.58	0.33	0.35	0.81	
Admin & Clerical			0.14	0.07	-0.05	0.13	0.21	0.09	0.05	0.14	0.11	0.12	0.15	0.15	0.97	0.58	-0.69	
Other Non Clinical			0.03	0.01	0.00	0.00	0.02	0.01	0.09	0.10	0.09	0.07	0.08	0.09	0.07	0.08	0.23	
Bank Total			0.59	0.54	0.56	0.79	0.72	0.57	0.55	0.85	0.85	0.71	0.80	1.20	1.70	1.21	2.05	
Workforce Total			16.81	16.82	17.87	17.25	17.50	17.78	17.65	18.65	17.91	18.43	18.30	18.57	17.77	17.52	17.32	

3. Balance Sheet

3a. Statement of Financial Position

	Note	Last Month Actual £m	Current Month Actual £m	Plan £m	Variance £m
Non current Assets					
Property, Plant and Equipment	4a	180.0	181.7	180.9	0.9
Trade and Other Receivables: Other		0.3	0.5	0.5	0.0
Total Non current Assets		180.2	182.2	181.4	0.8
Current Assets					
Inventories		6.8	6.9	6.4	0.5
Trade and Other Receivables: Trade	3b	30.9	36.5	14.3	22.2
Trade and Other Receivables: Accruals		10.1	3.7	4.0	-0.3
Trade and Other Receivables: Prepayments		5.6	4.1	2.0	2.1
Trade and Other Receivables: Other		1.9	2.0	2.0	0.0
Cash and Cash Equivalents	1a	4.0	1.7	2.8	-1.1
Total Current Assets		59.3	55.0	31.5	23.5
Current Liabilities					
Borrowings		-58.1	-58.1	-1.4	-56.7
Trade and Other Payables: Trade	3c	-30.7	-29.0	-23.4	-5.6
Trade and other payables: Accruals		-17.7	-17.7	-16.8	-0.9
Trade and other payables: Other		-4.9	-5.2	-5.2	0.0
Other liabilities: Deferred Income		-11.5	-6.5	-2.3	-4.2
Provisions		-4.8	-4.9	0.0	-4.9
Total Current Liabilities		-127.7	-121.3	-49.1	-72.2
Total Assets Less Current Liabilities		111.7	115.8	163.7	-47.9
Non Current Liabilities					
Borrowings		-78.5	-84.4	-135.6	51.2
Provisions		-0.8	-0.8	-0.9	0.1
Total Non Current Liabilities		-79.3	-85.2	-136.4	51.3
Net Assets Employed		32.4	30.7	27.3	3.4
Taxpayers Equity					
Public Dividend Capital		136.1	136.7	138.8	-2.1
Retained Earnings		-140.8	-143.1	-143.8	0.7
Revaluation Reserve		37.1	37.1	32.3	4.8
Total taxpayers' equity		32.4	30.7	27.3	3.4

Commentary

Non Current Assets

Trade and Other Receivables balances relate to Road Traffic Incidents (RTI) outstanding receivables as advised by NHS England.

These debts are managed externally by NHBSA who advises The Trust on balances outstanding and the Current/Non Current Classification.

Current Assets

Trade and Other Receivables have been reported over four separate headings to provide further detail:

Trade, these are balances owed to the Trust for trading activities for which sales invoices have been raised and are yet to be paid. The balance at month 3 is currently higher than the plan due to high levels of unresolved balances with commissioners in relation to previous financial years. Please see note 3b, which further analyses over debtor categories and age.

Accruals, these relate to balances owed to The Trust which are yet to be invoiced for. Contract invoicing is up to date, the current balance mainly relates to Partially Completed Spells (PCS) which always remains as an accrual.

Prepayments, payments made in advance for purchases such as equipment, software, maintenance. Payments for some of these services are paid annually in advance which is the reason for the current variance on plan. This balance should reduce each month.

Other, included in other are further RTA debts, VAT Contracted Out Services refunds.

Cash and Cash Equivalents, a condition of the deficit loans is for The Trust to hold a balance of £1.4m to ensure there is always an adequate balance from which to deal with any emergency payments. The balance as at 30th June 2017 was £1.7m, which is lower than the plan but within the conditions of the loans.

Current Liabilities

Borrowings, the variance on plan mainly relates to a re-classification between current and non current borrowing as advised by the Department of Health in March. A further update on this is expected, for the debt to be classified as current repayments would be expected in the financial year however this is not the case on this balance. The balance mainly relates to prior year deficit funding which as yet is not repayable. Regardless of classification Borrowing is expected to increase in excess of the plan due to the increase required to cover this years deficit.

Trade and Other Payables

Trade, please see note 3c for further information. The main reasons for the variance to plan relate to 1. A process change in Finance, it is estimated the previous manual Accounts Payable system understated the value of payables significantly as invoices were not immediately being registered. 2. Reduced cash to pay creditors due to the shortfall on actual clinical income v. plan.

Other, mainly relates to payovers such as Pensions and HMRC costs. Payment to these bodies is required a month in arrears.

Deferred Income, this balance mainly relates to a prepayment made by Medway Clinical Commissioning Group (CCG). In April the CCG paid 2 months of the agreed contract value to assist with Trust cash flow, this will unwind in March 2018. The remaining deferred income relate to the agreed accounting treatment for Maternity income billed at the start of the Clinical Pathway.

Non Current Liabilities - see narrative for the same categories in Current Liabilities

Taxpayers Equity

Variances relate to the phasing of the PDC drawdown (-£2.1m) and the year end upwards revaluation of the hospital site and associated residences and dwellings (£4.8m).

Please see additional notes as specified in the table for further analysis and commentary for Capital, Cash and Trade Payables/Receivables.

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	29.24	4.24	(0.13)	0.42	18.89	5.82
NHS FTs	1.68	0.36	0.06	0.02	0.34	0.91
NHS Trusts	1.28	0.44	0.07	0.04	0.23	0.51
Health Education England	2.23	2.23	0.00	0.00	0.00	(0.01)
Special Health Authorities	0.05	0.00	0.00	0.00	0.05	0.00
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	34.48	7.27	0.01	0.47	19.50	7.23
Non NHS						
Bodies external to Government	2.26	0.58	0.01	0.11	0.59	0.97
other WGA bodies	0.02	0.00	(0.00)	0.00	0.00	0.01
Local Authorities	0.22	0.06	0.05	0.05	0.01	0.05
Total Non NHS	2.50	0.64	0.06	0.16	0.61	1.03
Bad Debt Provision	(0.53)	0.00	0.00	0.00	0.00	(0.53)
Total Receivables	36.45	7.92	0.06	0.63	20.11	7.73

Fig 1 Aged Receivables Analysis

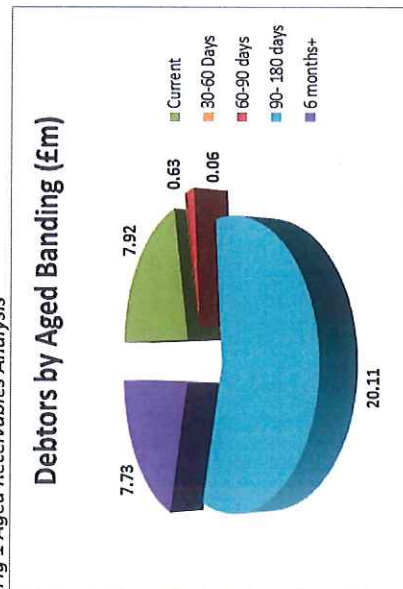


Fig 2 - Debtor Trends

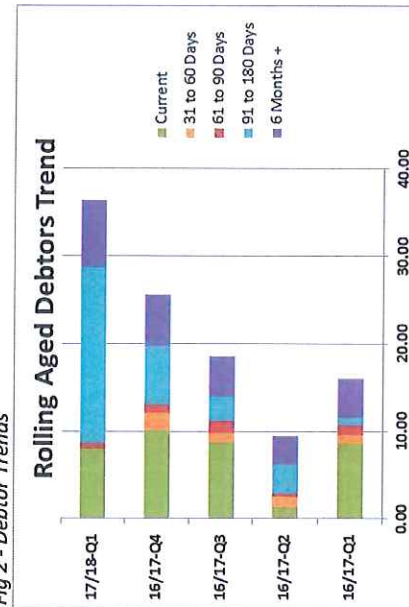
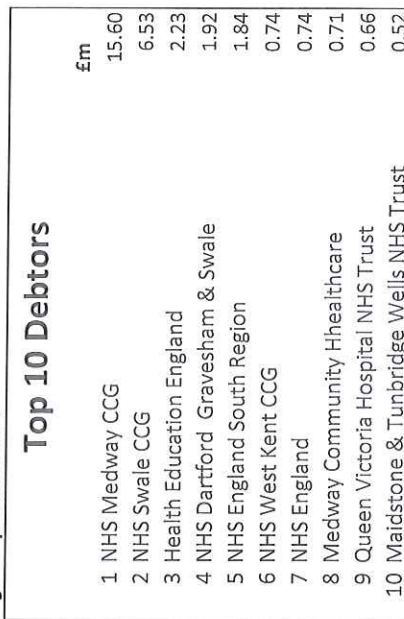


Fig.3 Top Ten Debtors



Commentary

Total outstanding Trade Receivables as at the 30 June 2017 are £36.5m. This includes a £0.52m bad debt provision.

NHS Debt excluding PCS is £34.48m (94.6%), the majority of which is with Clinical Commissioning Groups and relates to unpaid invoices for overperformance, non contract activity and drugs.

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.

3c. Creditors

Aged Creditors

	Total £m	Current £m	31 to 60 Days £m	61 to 90 Days £m	91 - 180 Days £m	6 months + £m
NHS						
NHS FTs	2.32	0.23	0.25	0.28	0.30	1.25
NHS Trusts	4.10	0.65	0.26	0.66	0.47	2.06
DH	0.00	0.00	0.00	0.00	0.00	0.00
Public Health England	0.02	0.00	0.00	0.00	0.00	0.01
Health Education England	0.01	0.00	0.00	0.00	0.00	0.01
CCGs and NHS England	0.00	0.00	0.00	0.00	0.00	0.00
Special Health Authorities	(0.16)	0.13	0.14	0.11	0.11	(0.66)
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.51	0.00	0.04	0.00	0.03	0.44
Total NHS	6.80	1.01	0.69	1.06	0.91	3.12
Non NHS						
other WGA bodies	0.01	(0.00)	0.01	0.00	0.00	0.00
Local Authorities	1.39	1.22	0.14	0.00	0.00	0.02
Bodies external to Government	20.70	5.56	7.63	3.95	1.34	2.20
Total Non NHS	22.09	6.79	7.78	3.96	1.34	2.23
Total Creditors	28.89	7.80	8.47	5.01	2.26	5.35

Commentary

Total outstanding creditors as at 30th June are £28.89m of which 71% (£21.1m) are overdue based on 30 day payment terms. Overall this is an adverse movement of £0.62m on month 2 and overdue creditors have increased by £0.99m.

The Trust endeavours to maintain payments for all approved invoices between 45 and 60 days from the invoice date. However there are significant issues with purchase orders that haven't been goods received on the purchase orders system and invoices not sent to the Finance Department. An action plan has been implemented to address this.

Average payment days for 16/17 were 61.31 days.

The Trust has £5.35m 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

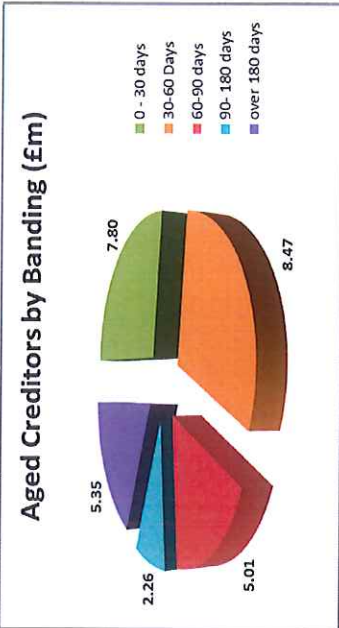


Fig.2 - Creditor Trends

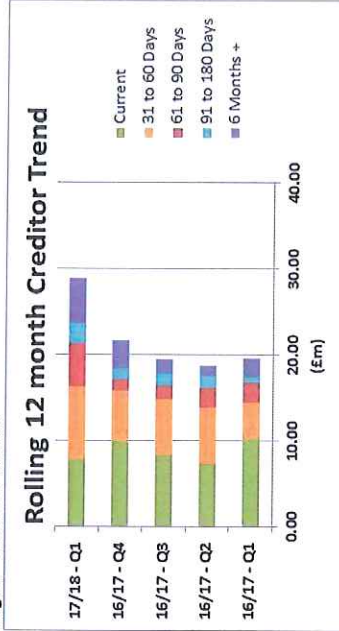


Fig.3 - Top 10 Creditors

	£m
1 Maidstone & Tunbridge Wells NHS	1.98
2 Dartford & Gravesham NHS	1.98
3 Medway Council	1.37
4 Healthcare at Home Ltd	1.24
5 NHS Supply Chain	2.05
6 Kent Community Health NHS	0.73
7 Kings College Hospital NHS	0.60
8 TFS Healthcare	0.59
9 Medway Community Healthcare CIC	0.58
10 East Kent Hospitals NHS	0.56

4. Capital

4a. Capital

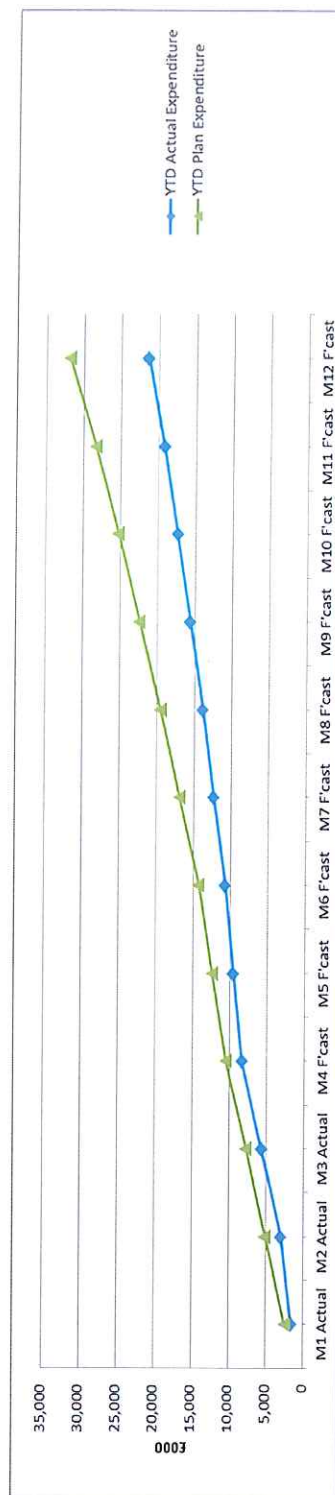
Capital Programme Summary

	Current Month			Year to Date		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
Expenditure						
Recurrent Estates & Site Infrastructure	0.34	0.33	0.01	0.64	0.93	-0.29
ITM&T	0.04	0.22	-0.18	0.43	0.62	-0.19
Medical & Surgical Equipment	0.04	0.09	-0.05	0.18	0.26	-0.08
Specific Business Cases	0.73	0.65	0.08	0.83	1.85	-1.02
Transform Projects (ED/A&U)	1.46	1.28	0.18	3.57	4.07	-0.50
Total	2.61	2.57	0.04	5.65	7.73	-2.08

Forecast year end position		Forecast	Forecast
Original	Plan	Out-turn	Variance
£m	£m	£m	£m
5.93	5.93	5.93	0.00
3.65	3.65	3.65	0.00
1.50	1.50	1.42	0.08
10.41	10.41	0.10	10.31
10.32	10.32	10.32	0.00
31.82	31.82	21.42	10.40

Commentary

Cumulative capital spend as at Month 3 amounts to £5.65m and represents a variance from the original plan of £2m for the period to date. It should be noted that £1m of this variance relates to those schemes that were included based on additional external funding being available. The remainder of the variance reflects the recent and ongoing re-prioritisation process of backlog maintenance and essential Health and Safety Fire and Security issues, immediate clinical and operational risks and any other projects for which there is an existing contractual commitment. Actual spend to date continues to be dominated by the ED refurbishment project and the acquisition and installation of the second CT scanner during June.



Report to the Board of Directors

Board Date: 3 August 2017

Agenda Item:

11b

Title of Report	Communications report
Presented by	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications
Committees or Groups who have considered this report	NA
Executive Summary	<p>The purpose of this report is to provide an update on internal and external communications and engagement activity.</p> <p>Key points are :</p> <ul style="list-style-type: none"> • Communications and engagement to support our improvement plan, Better, Best Brilliant, is now in full swing, with a number of methods being employed to inform and involve staff. External communications channels are also being used to spread the message further afield. • As part of moving to a more strategic and planned approach to communications, we have been more proactive in identifying examples of improvement and good practice by working more closely with directorates, to inform our media and social media activity. • A community engagement plan is in place to deliver the pledges set out in the Community Engagement strategy.
Resource Implications	Not applicable
Risk and Assurance	None
Legal Implications/Regulatory Requirements	Not applicable
Recovery Plan Implication	The Communications Team's work is aligned with the improvement plan
Quality Impact Assessment	Not applicable
Recommendation	For noting by the Board

Purpose & Actions required by the Board :	Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Noting <input checked="" type="checkbox"/>
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Communications report – August 2017

1. EXECUTIVE SUMMARY

- 1.1. Communications and engagement to support our improvement plan, Better, Best Brilliant, is now in full swing, with a number of methods being employed to inform and involve staff. External communications channels are also being used to spread the message further afield.
- 1.2. As part of moving to a more strategic and planned approach to communications, we have been more proactive in identifying examples of improvement and good practice by working more closely with directorates, to inform our media and social media activity.
- 1.3. A community engagement plan is in place to deliver the pledges set out in the Community Engagement strategy, namely to:
 - Inform, engage or consult the public before we make any significant changes that affect services
 - Forge links with all sections of the diverse community we serve.
 - Target hard to reach groups of people who are likely to need our services regularly.
 - Be proactive in our engagement rather than reactive, and two-way – not just informing, but listening to suggestions on how to improve what we do, and acting upon what we hear, and involving those with suggestions in our work.
 - Ensure that our engagement in Medway is matched by similar engagement in Swale.

2. ENGAGING COLLEAGUES

- 2.1. Internal communications and staff engagement are largely focused on our improvement plan, Better, Best, Brilliant.
- 2.2. We began by raising awareness of work taking place to improve flow and reach the target of at least 95 per cent of Emergency Department patients being seen,

treated and admitted or discharged within four hours. This included daily messaging about progress and actions required, along with screensavers to ensure as many staff as possible were made aware.

- 2.3. This was followed up with the first staff engagement workshop. Feedback from the workshop was excellent, with staff saying they found it interesting and informative and that they liked the interactive nature of the event. After this we conducted a survey to understand what would encourage more staff to attend. This will be used in future planning.
- 2.4. As the improvement plan has expanded to other areas, including workforce, digital and finance, we have used the chief executive's weekly message to describe progress, produced an animation giving a visual representation of the plan, created pocket-size information cards and displayed posters so that all staff have an opportunity to engage with at least some element of Better, Best, Brilliant.
- 2.5. We are also beginning to provide staff with more information about the Sustainability and Transformation Plan, including sharing newsletters and bulletins that give the wider Kent and Medway context.
- 2.6. More localised information will be provided at a staff engagement workshop planned for 5 September 2017.
- 2.7. We have also advertised public engagement meetings being held by our local CCG in August and September, which might be of interest to our staff and their families.
- 2.8. In addition to staff communications about our improvement plan, we provide responsive and proactive communications to ensure staff are aware of any current or impending issues that could affect their work.

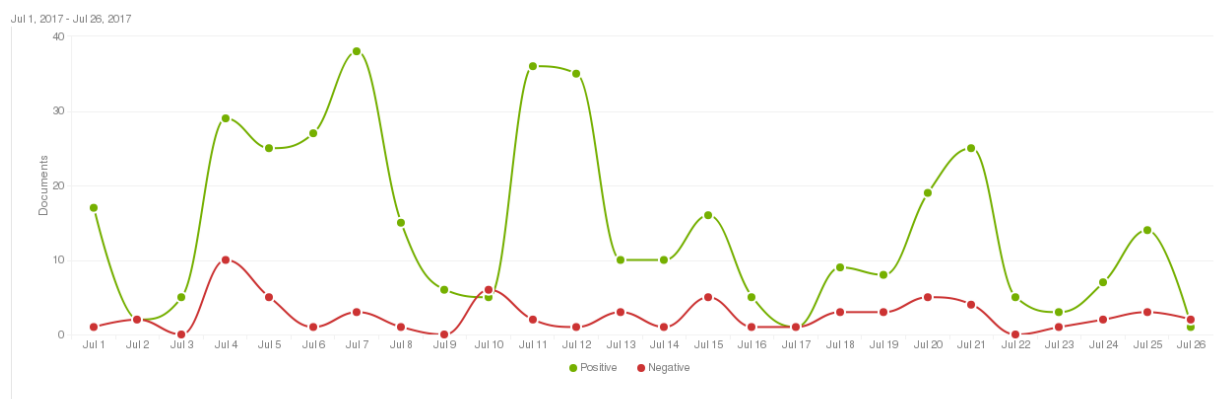
3. MEDIA

- 3.1 Improvements in our Emergency Department have received widespread coverage following visits by the editor and reporter from our local paper, and an interview with Consultant Nurse Cliff Evans.
- 3.2 Print and broadcast media have covered the concerns of a patient who has had knee surgery cancelled on several occasions. The Trust issued a statement apologising for the delays.
- 3.3 Other articles relating to patient experience include a patient who broke his arm 19 years ago and still suffers pain from it, and a report of a soiled gown which had been left under a trolley.
- 3.4 On a more positive note, our success in filling midwifery vacancies was highlighted in the local press.

- 3.5 We have also used the media to help promote our excellent clinical research programme and Hello My Name Is... day.

4. SOCIAL MEDIA

- 4.1 Over the past 28 days we have engaged almost 50,000 people on Twitter and nearly 120,000 people on Facebook.
- 4.2 We have gained 57 new followers on Twitter and 103 on our Facebook account, taking our total number of followers to 2,923 and 4,671 respectively. Key topics over the last month were avoiding unnecessary attendance at our Emergency Department (during the heatwave), our recruitment stand at the Kent County Show, and our post about midwifery vacancies being one of the lowest in the country.
- 4.3 The Communications and Engagement Team is now using video on social media where appropriate, as we know this attracts more interest.
- 4.4 We continue to engage with health organisations and stakeholders with our posts retweeted/shared by a number of followers, including Medway Council, Medway Community Healthcare, Healthwatch Medway and the CCGs.
- 4.5 Our Director of Nursing has become the latest senior staff member to join Twitter, helping to engage with potential recruits, as well as demonstrating thought leadership which in turn raises the profile of the Trust.
- 4.6 We encourage staff to post on Twitter, mentioning our username @Medway_NHS_FT to highlight success stories, best practice and initiatives that we can all be proud of.
- 4.7 The graph below shows the sentiment of Tweets about the Trust during the month of July. The top line represents positive messages, and the lower line the negative messages.



5. ENGAGEMENT

- 5.1 Our Community Engagement Officer has compiled an extensive, and growing, database of local groups and organisations who wish to engage more regularly and more fully with the Trust.
- 5.2 Through her connections, she is able to listen to the views and concerns of local people and link with Trust leads, providing feedback on any points raised.
- 5.3 We are also seeking more opportunities to engage with the people of Medway and Swale at local events. The County Show at the beginning of July created an opportunity to talk to many people who live in, work in or visit Medway and Swale.
- 5.4 At our most recent members' event the audience was treated to two excellent presentations and question and answer sessions, one about our clinical research and one on our Medi Lead programme. The common theme in both presentations was that what patients say and feel is important, and that should never be forgotten.
- 5.5 Governor coffee mornings have been planned to take place in Hoo on 16 September, and Luton on 16 November.
- 5.6 Membership recruitment stands are held in the main entrance regularly.
- 5.7 We are working with Medway CCG to promote public engagement events in August and September, two of which will concentrate on the future of urgent care, and a third that will focus on the Medway Model for local care, with a discussion about the Sustainability and Transformation Partnership.

Report to the Board of Directors

Board Date: 3 August 2017

Agenda Item:

Title of Report	Communications strategy
Presented by	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications
Committees or Groups who have considered this report	NA
Executive Summary	<p>The purpose of this paper is to seek approval of the Trust's new Communications Strategy.</p> <p>Over the past months work has been taking place to ensure our communications and engagement are more strategically planned, more effective and more evidenced, as well as enhancing the quality of our outputs.</p> <p>An overarching communications strategy has been produced, the first for the Trust, with communications plans for specific areas providing more details of proposed activity and tactics.</p> <p>The team is also working to an engagement delivery plan which underpins the engagement strategy approved by Board last year.</p> <p>The communications and engagement plans will be living documents, evolving throughout the year.</p> <p>A house style guide has been produced to bring a consistent, high standard to all the materials we create, both in print and online. This is being promoted to staff in a number of ways to raise awareness.</p> <p>Having an overarching strategy in place, along with these other documents, will be a milestone in terms of taking a professional, outcomes-based approach to our communications and engagement for staff, patients and public.</p>
Resource Implications	Within existing resources
Risk and Assurance	Without a communications strategy in place the Trust's communications activity is likely to be less effective.
Legal Implications/Regulatory Requirements	Not applicable

Recovery Plan Implication	The Communications Team's work is aligned with the improvement plan
Quality Impact Assessment	Not applicable
Recommendation	For approval.
Purpose & Actions required by the Board :	<div> Approval Assurance Discussion Noting </div> <div> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> </div>

Communications Strategy

2017-2018

Communications Strategy – 2017-2018

1. INTRODUCTION

- 1.1 Medway NHS Foundation Trust acknowledges that high quality communications are essential to deliver its vision of the ‘best of care’ through the ‘best of people’. Only through good, clear communications, will staff be able to engage with the Trust’s values and objectives, and patients, public and stakeholders understand and become involved with improving services.
- 1.2 Medway Maritime Hospital is at the heart of the community, and connecting with the people of Medway and Swale is considered vital to ensure the services provided by the Trust in future are aligned to the demands and desires of local people.
- 1.3 The Trust has developed a strong communications service in the past two years, but to date has operated on a reactive basis, or with short-term plans.
- 1.4 A communications strategy is now required to ensure the service:
 - Is aligned to strategic objectives
 - Reflects our vision and values
 - Supports the Trust’s improvement plan, Better, Best, Brilliant
 - Supports the Kent and Medway Sustainability and Transformation Partnership
 - Serves the Trust’s engagement strategy and activity plan.

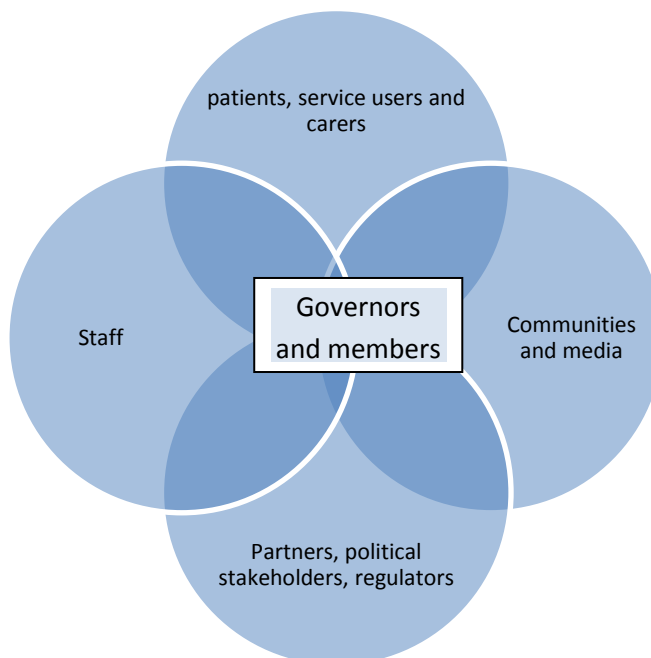
2. PRINCIPLES AND APPROACH

- 2.1 Following best practice guidelines, the Trust’s Communications will be:
 - Open, honest and accurate
 - Responsive and proactive
 - Timely
 - Relevant
 - Evidence-based
 - Accessible, using plain English and avoiding jargon
 - Inclusive and meaningful
 - Respectful
 - Targeted and tailored
 - Creative
 - Two-way
 - Measurable
 - Impactful.

- 2.2 We will use the most appropriate channels of communications to reach our various audiences including: staff, patients, public, politicians, health and social care partners.
- 2.3 We will ensure our communications are produced in the most appropriate format for our audiences.
- 2.4 We will strive to communicate with, and create a dialogue with, audiences who traditionally have been less listened to.
- 2.5 We will provide communications that are good value for money.
- 2.6 We will ensure our communications are outcome-driven and demonstrate impact on audiences
- 2.7 Where appropriate, we will test our communications with audiences before delivery, to ensure they meet the standards required – and expected – by patients and public.

3. AUDIENCE SEGMENTATION

- 3.1 The Trust has a range of audiences shown by the simplified diagram below.



Detailed communications plans identify specific audiences and the most appropriate channels and methods in each case.

As the diagram indicates, audiences overlap. The relationships and influences across the different groups are complex. A good understanding of these enables communications to be tailored, targeted and effective.

4. OBJECTIVES

- 4.1 Medway NHS Foundation Trust has ambitious goals based around improving the quality of care for patients. Our communications will match this ambition, supporting engagement so that patients and public can have a say in the future of services, with feedback channels so the patient voice can be heard and acted upon.
- 4.2 Communications plans will help bring the Trust's vision and values to life, working with staff and patients to raise awareness of improvements in a creative way, using patient-centred examples wherever possible.
- 4.3 We will work to protect and promote the reputation of the Trust by sharing best practice and responding appropriately where improvements to care and services are needed.
- 4.4 Clear objectives, milestones and deadlines need to be communicated so that staff and partners understand their role and are engaged in the Trust's strategic aims.

5. INSIGHTS

- 5.1 We will use insight gained from sources such as the annual staff survey, patient surveys, and the Friends and Family Test, to understand where communications needs to be focused.
- 5.2 Further insight will be sought through engagement around specific projects and proposals to inform communications activity. This might include surveys, focus groups, patient feedback, and community and voluntary sector networks.

6. PRIORITIES

- 6.1 Internal communications and staff engagement
 - Develop new communications channels to ensure staff have the opportunity to speak to members of the Executive Team.

- Support delivery of phase three of the Trust Improvement Plan, ensuring staff awareness, understanding and support for the plans and are involved in their delivery.
- Review Trust intranet and ensure information is accurate and presented in an easily accessible format.
- Launch style guidelines for the organisation.
- Launch new templates for Trust communications.
- Increase the use of video and technology in Trust communications.

6.2 External/ stakeholder communications

- Planned, regular, face-to-face briefings for key stakeholders including MPs and councilors, with the Chief Executive and Chair.
- Briefings for health and social care partners and regulator, for example NHS Improvement and NHS England, as required.
- Regular engagement with the Medway Health and Wellbeing Board, Medway HASC and Kent HOSC.
- Good relationships and face-to-face meeting with Healthwatch (Medway and Kent).
- Communications to ensure our Governors are well-informed and supported in their roles, including briefings and attendance at engagement events, such as 'Meet the Governor' coffee mornings.
- Regular, engaging and two-way communications with Trust Members, supporting them in their role to have a good understanding of the work of the Trust and creating opportunities for their input, and to be ambassadors for the Trust.
- Campaigns to encourage membership of the Trust, including recruitment stands and promotion through media and social media channels.
- Development of content on the Trust website to ensure it is patient-focused, and that the site is an engagement platform as well as information source.
- Relaunch News@Medway to increase level of engagement with staff and public.

6.3 Media relations

- Build and maintain good relationships with local journalists, national and regional health correspondents, and trade press.
- Seek opportunities to share good news stories that are patient-focused.
- Provide timely, honest and accurate responses to press enquiries.
- Monitor coverage and provide reporting based on tone, position, and impact.
- Work closely with health and social care partners to obtain maximum coverage for positive stories where there is collaboration or integration
- Deliver internal and external communications in the event of major emergency
- Provide 24/7 on call media support for emergency incidents.

6.4 Workforce recruitment and retention

- Support Workforce recruitment and retention plans with branded print and online materials.
- Provide digital support, including design for online recruitment, video, photography and social media.
- Provide regular briefings for internal and external stakeholders about recruitment and retention strategies.

6.5.1 Reputation building

- Develop the Trust's strategic narrative for internal and external stakeholders in a useable concise format.
- Support recruitment programmes.
- Review and update core sections of the Trust website.
- Develop a library of high quality photography and videos for use in corporate campaigns.
- Support award entries, so that Trust staff and initiatives gain the recognition they deserve.
- Develop a social media strategy that support and promotes Trust initiatives.

6.6 Branding

- Enhance and strengthen the brand identity of the Trust through high quality, professional materials that reflect our vision and values with excellent graphics and adherence to our house style.
- Promotion of our house style, and understanding that The Trust's brand is not our name or our logo. It's what people say about us when we're not in the room.
- Promotion of new branded templates that create a professional, standardised approach to Trust materials.
- Engender a more creative approach to communications and engagement, using best practice from elsewhere, but also introducing innovation to the way we engage our internal and external audiences through digital channels broadening our way of non-digital communications.

7. CHANNELS

7.1 Internally we have a number of well-established channels, which have been shown to be effective and well received by staff. These include:

- Chief Executive weekly message
- Monday weekly message
- Executive visits to wards

- Theme of the week
- Intranet
- Screensavers
- Metacompliance – short, quick flash-up messages
- News@Medway
- Staff briefings
- Social media
- Newsletters
- Messages with payslips
- Printed collateral
- Clinical Council
- Nursing and Midwifery Forum
- MediLead junior doctors' programme.

7.2 In addition, we intend to extend our range of communications to introduce fresh methods of raising awareness and creating opportunities for dialogue, as set out below:

Method	Description
Executive drop-in sessions for staff	These will focus on a key theme and provide staff with an opportunity to have an informal discussion with members of the Executive Team
Staff app	Staff will be asked to download an app to their smartphone enabling the Trust to push messages directly to them
Ask the Execs	Forum via the intranet (or email) where staff can ask questions directly to the executives
Staff Blog	Publish a regular blog written by different staff from around the organisation, giving insight into their working lives
Executive Team shadowing	Members of the senior team to shadow or fulfil various roles in the organisation
Communications Guide	Produce a communications guide for staff and managers, outlining their responsibilities, existing processes, and available tools
Yammer or Workplace by Facebook	Create a work-specific social network where staff can connect, share ideas, and keep up-to-date
Live Streaming	Utilise Periscope or equivalent to stream live briefings around the organisation that people can access from their mobile phones
Twitter takeover	Staff member to take over the Trust's Twitter account on a monthly basis and

	tweet about their work
#IAmMedway	Campaign profiling staff throughout the organisation
Head to head	A regular feature where members of staff interview one another (eg HCA interviews Medical Director)
News@Medway guest column	Regular column in News@Medway written by a member of staff

7.3 Externally

Channel	Summary	Audience and frequency
Face to face		
Board meetings	Attendees heard first hand from Board members and have the chance to raise questions. Board papers, presentations, speakers.	Governors, members, public, press. Monthly
AGM	Opportunity to share improvements, initiatives and innovations. Presentations, updates, opportunity for dialogue with attendees	Staff, governors, members, patients and public. Annually
Member events	Members are able to influence the theme of the events. Presentations, workshops, dialogue, engagement opportunity	Members of the Trust, Governors. However, member events are also open to the public. Monthly. For consideration – hold events less frequently but seek to encourage higher attendance, and give members more opportunity to share their views.
Member recruitment stands	Stands within the hospital to encourage more people to become members.	Bi-monthly. Also needs to take place in Swale. Doesn't need to be within hospital.
Meet the Governor coffee mornings	Governors encourage discussion with patients, carers and members of the public.	Patients, carers and members of the public. Ad hoc. To be reviewed – frequency, format, location and timing.
Community engagement	Wide range of	Members of community

events	meetings/events where the Trust's vision, values, priorities, success stories can be communicated. Engagement plan begins to formulate structure and approach to ensure these are effective.	and voluntary organisations/ patients and public. Ongoing.
MP meetings	Briefings with the Chief Executive/ Chair / other Executive Directors. Opportunities for in-depth briefings about the Trust's progress, challenges and successes.	Five MPs within our area. Held quarterly.
Overview and Scrutiny meetings – Medway and Kent	Updates on Trust progress presented to Committees as requested.	As requested by Committees.
Medway Health and Wellbeing Board	Attendance to provide Trust updates.	Bi-monthly
Written		
News@Medway	Newsletter distribution through the Trust, council, libraries and Gateways.	Staff, patients, public, stakeholders. Bi-monthly. Format, frequency and distribution to be reviewed in 2017/8
Press releases	Used to promote Trust initiatives, projects, successes.	As required.
Featured articles in press/journals	Used to promote Trust initiatives, projects, successes. Also useful to promote thought leadership, and to demonstrate the Trust's expertise in specialisms	As opportunities arise.
Stakeholder briefings	These briefings are provided to keep MPs, councillors, health and social care partners and regulators up-to-date about the Trust.	As required
Member bulletin	Bulletin about Trust progress and key priorities and initiatives, emailed to Members on behalf of the Chair	Members of the Trust. Monthly. To be reviewed – bulletin could be more visually eye-catching. Also need to ensure we are reaching as many

		Members as possible.
Annual report	Formal corporate publication. While there are strict guidelines about how this must be produced, it is important to ensure it is accessible to the reader. A summary version is produced which is intended to be more widely read and is therefore more visual, with graphics and plain English through.	Regulators/ health and social care partners/ public
Quality account	Formal corporate publication	Regulators/ health and social care partners/ public
Marketing materials – leaflets, posters, pop-up banners etc	High quality materials produced to raise patient awareness on important issues, and to convey significant messages.	Patients and public. Produced as required.
Online and digital		
Website	Relaunched in March 2017. Needs to be updated and refreshed regularly.	Patients, public, potential employees
Social media	Well-used. Currently used ad hoc – needs a more strategic approach for corporate and marketing use. Also useful for patient engagement dialogue.	Staff, patients, public, stakeholders, media. Ongoing.
Video	Used to present information about projects, successes and new ways of working in visually exciting and engaging way.	Staff, patients, public, stakeholders, media. As required.

- 7.4 It is important to note that the most important communication channel we have with patients and carers is the daily face-to-face, telephone and written interactions people have with our frontline services. There are a number of Trust quality indicators which measure how patients feel about the way we interact with them. These are collated and fed into the quality strategy through patient experience channels, and are therefore not included in this strategy.

8. ROLES AND RESPONSIBILITIES

- 8.1 Communication by all staff within the Trust has an effect on the Trust's reputation and the perception of the quality of care we provide.
- 8.2 It is therefore essential that all verbal or written communications are conveyed to the same high standard, accessible to patients and public, free of jargon and in plain English.
- 8.3 Where needed, communications materials should be provided in different formats such as Easy Read or in audio format, to ensure information is reaching all audiences.
- 8.4 It is the responsibility of all staff to ensure communications materials are up-to-date and accurate, and in line with Trust style and branding guidelines. They must also be made available to all audiences.
- 8.5 All staff should seek the expert support of the Communications Team when producing communications or marketing materials.
- 8.6 All staff are expected to participate in engagement events, and to keep themselves up-to-date by reading internal communications message.
- 8.7 All staff have a responsibility to alert the central communications team to reputational risks that need to be promote/managed with internal and external stakeholders.

9. EVALUATION

- 9.1 Measuring impact is important to demonstrate that communications are effective and meeting objectives, whether that is raising awareness, contributing to a decision-making process, or changing behaviours.
- 9.2 Clear objectives must be built into any communications plan, and the question posed: "How will we know if we have been successful?" Evaluation criteria should be identified within communications plans, along with agreed measurement methods.
- 9.3 A number of methodologies will be employed to measure achievement, including surveys (established set pieces such as the annual staff survey, and ad hoc questionnaires); focus groups, and feedback mechanisms.
- 9.4 Sometimes there will be harder evidence of success with communications activity, such as take up of services or changes in behaviours.

10. CONCLUSION

- 10.1 Good communications is an essential element in providing the best possible care to our staff, our patients and their relatives. It is therefore everyone's business. Research shows that organisations that communicate well are also the most effective and highly rated by the people they serve.
- 10.2 This overarching communications strategy is underpinned by:
- comprehensive communications plans
 - a refreshed internal communications plan
 - engagement plan, and
 - communications plan to support improvement.
- 10.3 The communications strategy will ensure our staff, patients, stakeholders and public are well informed and able to have input into future improvements.
- 10.4 Communications and engagement activity will be designed to be outcomes-based, with regular evaluation to demonstrate impact.

Report to the Trust Board

Date: 03 August 2017

Agenda item:

12a

Title of Report	Board Assurance Framework
Presented by	Katy White, Acting Director of Corporate Governance
Lead Director	Katy White, Acting Director of Corporate Governance
Committees or Groups who have considered this report	N/A
Executive Summary	<p>The Board have requested that the Board Assurance Framework (BAF) is a standing agenda item for every board meeting. This report presents the current Board Assurance Framework, including any recent updates and amendments.</p> <p>There have been no adjustments in the scoring of the strategic risks since the Board last reviewed the BAF in July 2017. There have however been some positive updates on assurance and actions to address gaps in control.</p> <p>The Board is requested to note the reference to the Trust Fire plan as an action to address the gaps in control related to the reprioritisation of identified capital priorities leading to mitigation of critical risks, especially following the Grenfell Tower incident.</p>
Resource Implications	N/A
Risk and Assurance	Set out in report.
Legal Implications/Regulatory Requirements	<p>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 include financial, corporate and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation.</p> <p>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.</p>
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	<p>The Board are requested to review the strategic risks considering:-</p> <ol style="list-style-type: none"> Assessment of the current risk rating and whether it adequately reflects the controls in place, in particular Strategic Objective 2 (strategic risk 3) The stated risk mitigation assurance and its appropriateness The gaps in control and appropriateness of the

	actions identified to address them d) The adequacy of the systems of internal control.			
Purpose & Actions required by the Executive Group :	Approval <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>	Discussion <input checked="" type="checkbox"/>	Noting <input type="checkbox"/>

Board Assurance Framework – August 2017

1. EXECUTIVE SUMMARY

- 1.1. The Board have requested that the Board Assurance Framework (BAF) is a standing agenda item for every board meeting. This report presents the current Board Assurance Framework, including any recent updates and amendments.

2. THE BOARD ASSURANCE FRAMEWORK

- 2.1. The Board Assurance Framework (BAF) pulls together the organization's strategic risks (with the aligned corporate risks drawn from the Trust risk registers), to create a combined risk and assurance framework document.
- 2.2. The BAF sets out the assurances and controls, and details of any gaps in control or actions required. The Board's role is to consider the adequacy of the assurance and mitigating actions and consider whether they are sufficient in reducing risks to a level within the Board's tolerance (risk appetite). This level is set out in the target risk column.
- 2.3. There have been no formal adjustments in the scoring of the strategic risks since the Board last reviewed the BAF in July 2017, however with regard to Strategic Objective 2 (strategic risk 3) the Board is invited to discuss whether the current risk score of 16 should be downgraded to a score of 12 (3x4). There have also been some positive updates on assurance and actions to address gaps in control.
- 2.4. The Board is requested to note the reference to the Trust Fire plan as an action to address the gaps in control related to reprioritisation of identified capital priorities leading to mitigation of critical risks, especially following the Grenfell Tower incident.

3. RECOMMENDATION

- 3.1. It is the responsibility of the Board to monitor the mitigation of the strategic risks that may impact on its ability to achieve its stated strategic objectives.
- 3.2. To this end it is recommended that the Board reviews the strategic risks considering:-
 - a) Assessment of the current risk rating and whether it adequately reflects the controls in place, in particular Strategic Objective 2 (strategic risk 3)
 - b) The stated risk mitigation assurance and its appropriateness
 - c) The gaps in control and appropriateness of the actions identified to address them
 - d) The adequacy of the systems of internal control.

4. APPENDICES

Appendix 1 - Medway NHS Foundation Trust Board Assurance Framework (MFT BAF)

Strategic Objective One**Our People: We will enable our people to give their best and achieve their best****Strategic Blueprint**

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.

Lead Directors

Director of Human Resources and Organisational Development (HR & OD), Medical Director, Director of Nursing.

Risk Register Reference

Corporate Risk Register: CRR-2016-001, CRR-2016-002, CRR-2016-003, CRR-2016-004, CRR-2016-011, CRR-2016-012, CRR-2016-013

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
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.	Vacancy rates. Temporary staff usage rates. Patient safety incidents	Nursing staff shortages may lead to sub optimal care, impacting on patient safety processes and clinical outcomes. Inability to recruit sufficient numbers of suitably qualified medical staff may lead to sub optimal care, impacting on patient safety processes and clinical outcomes. Reduced capacity and capability across the organisation impacts on delivery of operational objectives and may compromise patient care.	15 (5x3)	12 (4x3)	4 (2x2)	Increased referral demand in Dermatology and Gastroenterology Diagnostic delays (MRI and CT), particularly affecting T&O. Difficulty filling all medical shifts. Successful Nurse recruitment programmes with some new starters, others to follow.
Workforce diversity is not achieved due to a lack of strategic focus and oversight on	Workforce Race Equality Standards (WRES) Equality Delivery System	The Trust may not be compliant with key statutory and mandatory requirements. This may lead to patient harm, regulator interventions and reputational damage.	9 (3x3)	6 (3x2)	4 (2x2)	EDS2 process has commenced and is a priority for the newly appointed Head of Equality & Diversity. Lack of Board understanding/focus on the

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Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
statutory and contractual equality and diversity obligations.	(EDS2) outputs					requirements due to absence of board development or induction in this area.
Trust may not have stable and effective leadership and well trained, competent staff at all levels.	Appraisal rates, Induction rates, Mandatory training rates, Leadership development programme, Management development programme.	<p>Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients.</p> <p>Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately disseminated and further patient harm may result from repeat incidents.</p> <p>Tools and skills in recognising and escalating deterioration in patients is not embedded successfully in the Trust leading to poor outcomes for patients</p>	9 (3x3)	6 (3x2)	4 (2x2)	<p>Formal development plans for middle and frontline staff.</p> <p>Training needs analysis has not been formalised in a way that gives organisational oversight and enables a planned approach to addressing training needs or areas of risk</p> <p>Mandatory training and appraisal rates are insufficient in some areas</p> <p>Organisational development planning being developed to map out a culture change programme; diagnostic around prevailing culture has not been undertaken</p> <p>Structured succession planning and talent management approach is not in place</p>
Staff are unable to participate in learning and development opportunities due to staffing shortages.	Mandatory training rates, Learning and development programme and take-up, Appraisal rates, Induction rates.	<p>Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients.</p> <p>Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately disseminated and further patient harm may result from repeat incidents.</p>	9 (3x3)	9 (3x3)	4 (2x2)	<p>Migrating data from Oracle Learning System (OLM) to Medway on Line Learning & Interactive Education System (MOLLIE).</p> <p>Incomplete data and difficulty in assessing areas of poor training and appraisal rates.</p>

Assurance Providers

First Line (Business Management)	Second Line (Corporate Oversight)	Third Line (Independent)
<p>The Director of Nursing monthly report to the Board, detailing the previous month's Unify data, areas of risk, mitigations in place and plans going forward.</p> <p>The Director of HR & OD monthly Board paper introduces other staff groups.</p> <p>The international recruitment plan for nursing continues with a total of 176 nurses being processed for posts at Medway NHS Foundation Trust. A further 15 nurses commence in July from successful EU recruitment.</p> <p>The Trust is taking part in a collaborative regional procurement approach for international recruitment as part of the STP, following selection of two partner agencies.</p> <p>Dedicated nurse recruitment campaign commenced January 2017 and includes the review of incentives; and analysis of exit data to ascertain why individuals leave the Trust, showing improved position with reducing number of leavers.</p> <p>Medical Staffing have engaged with permanent recruitment agencies to recruit to hard to fill medical posts. 1 Medical Training Initiative scheme doctor (MTI) commenced in Medicine in June with a further 3 MTI doctors</p>	<p>The Head of Resourcing and Deputy Finance Director hold weekly reviews of non-clinical temporary staffing usage.</p> <p>PID developed Performance Review meetings with Directorates / ToR and framework.</p> <p>Monitoring of quality and safety indicators via clinical governance framework:</p> <ul style="list-style-type: none"> • Quality Assurance Committee; • Quality Improvement Group; with upward reporting from the following <ul style="list-style-type: none"> ○ Patient Safety Group (with upward reporting from Resuscitation and Acute Deterioration Group, Hospital Transfusion and Thrombosis Group, and Nutrition group) ○ Patient Experience Group (with upward reporting from End of Life Care Group and Food Quality Focus Group); ○ Clinical Effectiveness and Research Group (with upward reporting from Clinical Audit & NICE Guidance Compliance Group, Mortality & Morbidity and Clinical Outcomes Group, Research & Development and Innovation Governance Group and Research Operational Group); ○ Medicines Management Group (with upward reporting from Drugs & Therapeutics Group, Safe Sedation Group and Medical Gases Group); ○ Safeguarding Assurance Group (with upward reporting from Children and Adult Safeguarding Group); ○ Infection & Anti-Microbial Stewardship Group (with upward reporting from Water Safety Group and Decontamination Group) 	<p>The CQC report March 2017 noted that there had been an effective nurse recruitment Programme, and there had been a marked reduction in the use of agency nurses.</p> <p>Monthly Quality Oversight Committee with NHSI, CQC, CCGs</p> <p>Weekly reporting on KPIs via email submission by Head of Staff Resourcing and Deputy Director of Finance, to the CCG, NHSI and the CQC</p> <p>Published monthly Unify data.</p> <p>Board/Executive visits to ward areas</p> <p>Trust Wide (CQC) and Service Specific regulatory bodies, review service outputs as an assessment of staffing levels, these include evidence of staff meetings, mandatory training percentages, appraisal rates, responsiveness to incident reporting and follow up investigations and actions complete, audit performance and non-conformance management, training and competency records, equipment maintenance logs, staff feedback mechanisms and the results of these.</p>

Assurance Providers

First Line (Business Management)	Second Line (Corporate Oversight)	Third Line (Independent)
<p>due to commence in July. TMP Worldwide (TMPW) completed some focused diagnostic work on junior doctor and consultant vacancies and the Trust is utilising TMPW feedback to advertise directly in European Medical Journals, in Greece, Netherlands and Germany.</p> <p>A Strategic Workforce Group has been established as a sub-group of the Executive Group.</p>		
<p>The Equality and Diversity Group Terms of Reference with onward reporting to the Executive Group. Head of Equality & Inclusion in post from April 2017.</p>	<p>Board Equality and Diversity champion now identified</p> <p>Equality and Diversity Annual Report to Board</p>	<p>Reporting to Commissioners on WRES outputs</p>
<p>Monthly reporting to Directors of Clinical Operations and Executives provides data on recruitment, appraisal, induction, mandatory training rates</p> <p>Directorate Management Board and Programme Board structure and upward reporting to Quality Improvement Group and Performance Review meetings.</p>	<p>Workforce Report to the Board by Director of HR & OD for July 2017 shows 71% of staff had completed mandatory training and 83% completed achievement review. Appointed an Associate Director of Workforce Development and OD, who is now leading this agenda.</p> <p>Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan.</p> <p>Directorate Management Board and Programme Board structure and upward reporting to Quality Improvement Group and Performance Review meetings</p>	<p>Local Supervising Authority Audit Report (Supervision of Midwives)</p>

Actions to address gaps in control / assurance

Work being undertaken on reviewing areas of continued reliance on temporary staffing, with dedicated support from HR Business Partners, reviewed at monthly Performance Review Meetings (PRMs).

June / July 2017 – Better, Best Brilliant (BBB) improvement programme focus on workforce with Rapid Improvement workforce month running from 12.06.2017, focused on reducing use of agency staff and ensuring that key operational roles are fully staffed.

Strategic Objective Two

Innovation: We will embrace innovation and digital technology to support the best of care

Strategic Blueprint:

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.

Lead Directors

Director of Finance

Risk Register Reference

Corporate Risk Register: CRR-2017-001

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
The Trust remains behind peers in the implementation of technology and is reliant on outmoded systems. The Trust does not have the ability to generate requisite financial resources to introduce all technical innovations that are needed. Although the Trust has made progress in implementing technology it is still reliant on multiple outmoded systems and multiple interfaces. Whilst capital funding may be allocated, financial resources	Business Case submissions to Executive Group for approval.	Due to financial constraints, conflicting priorities and the current capacity for innovative change, there is a risk that the Trust may not be in a position to embrace innovation and digital technology to support the best level of care for patients and facilitate improved working practices for staff.	16 (4x4)	12 (4x3)	9 (3x3)	<p>Undertaking review of all clinical systems to determine opportunities to streamline.</p> <p>Identifying digital projects that can provide savings opportunities for reinvestment.</p> <p>NHS Digital providing workshop in Sept 17 to help with development of local digital strategy.</p> <p>Clinical champions identified for</p>

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
required to accelerate implementation may not be available unless clear and defined benefits are identified and ultimately delivered.						some initial projects.
Developing and aligning a digital strategy to meet Sustainability and Transformation Plan (STP) aspirations, could mean that local improvements, that have been developed or already approved, do not then get implemented as the STP changes the direction of travel from the original concept. This may cause delays in implementing local improvements and cause developments designed to improve patient care to stagnate, if STP partners are not aligned around the digital strategy.	Digital Strategy in place Health Informatics Project Management plans implementation reporting (% outstanding)	The STP digital strategy is currently focused on a Kent patient record which has high capital costs. There is a risk that if the Trust is required to contribute to the STP project there may be insufficient remaining capital funds to deliver local projects	16 (4x4)	12 (4x3)	9 (3x3)	STP governance is not developed. Resources are not aligned to STP requirements; staff are internally focussed dealing with Trust issues
A culture and environment for innovation where staff are encouraged to innovate or feel confident with modern technology requires development and time commitment and creating the conditions for innovation is difficult when staff are focussing on dealing with fundamental issues such as staff shortages. This may impede progress and support for innovation, impacting detrimentally on sustainability improvements designed to improve patient care.	Research income Successful project implementation outcomes High take up of new systems by end users leading to improved processes		16 (4x4)	16 (4x4)	9 (3x3)	Limited capacity and capability in Business Intelligence function: seeking sharing opportunities with other Kent acute trusts. Recruitment campaign underway to replace temporary workforce. Focus on developing standardised web based reports to reduce reliance on ad hoc.

Assurance Providers

First Line (Business Management)	Second Line (Corporate Oversight)	Third Line (Independent)
<p>Health Informatics Risk Register maintenance and review process</p> <p>Health Informatics Programme Management Office.</p> <p>Project Change Advisory Board and upward reporting to Corporate Informatics Group.</p> <p>Corporate Informatics Group (CIG) re-instated and onward reporting to the Executive Group via Key Issues Reporting.</p>	<p>Data Quality Group Terms of Reference and onward reporting to CIG</p> <p>Implementation of improved site management processes to improve flow management (based on the Luton and Dunstable model) supported by improved utilisation of acute bed management software.</p>	<p>Internal Audit report on IT change management showed significant assurance with minor improvement opportunities.</p> <p>CQC report March 2017 - reported ED Information technology systems had been put in place to support safety, flow and data collection.</p>
<p>Chief Executive's and Medical Director's integration into STP process.</p>	<p>Chief Executive's reporting to Board on wider STP developments</p>	<p>External review of STPs and monitoring of health economy progress in development and implementation.</p>
<p>Speciality/Programme Board and upward reporting in the Directorate governance structure.</p> <p>ExtraMed, Patient Bed Management information system go-live 28.06.2017.</p> <p>A new electronic discharge notification template has been launched, which has helped to streamline the discharge process.</p>	<p>Research Group reporting upwards to Clinical Effectiveness and Research Group</p> <p>Medical Devices & Equipment Group and upwards reporting to Patient Safety Group.</p>	<p>CQC report March 2017 Critical Care: - Services had successfully recruited to research studies that aimed to improve outcomes for critical care patients, including studies of psychological impact of intensive care.</p> <p>2020 - External consultancy support to facilitate change in vision.</p>

Actions to address gaps in control / assurance

Development of Digital Strategy within Trust and across STP footprint by 30.09.17. Identification of investment money to implement change by 30.09.17. June / July 2017 – Better, Best Brilliant programme, Digital Improvement Team (work stream) has progressed digital improvement to support flow.

Strategic Objective Three

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

Strategic Blueprint

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.

Lead Directors

Chief Executive, Director of Finance, Medical Director, Director of Clinical Operations Acute and Continuing Care.

Risk Register Reference

Corporate Risk Register: CRR-2016-005, CRR-2016-008, CRR-2016-009, CRR-2016-010.

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
<p>Partners do not work strategically for the greater good and are not willing to sacrifice local interests.</p> <p>Delivery of transformation remains an aspiration rather than a reality; Other providers interests' may not be aligned and there may be resistance to change from within the organisation or the local authority</p>	<p>Representation & contribution to key strategic groups/meetings</p> <p>Clinical engagement with wider health economy via Clinical Council and CRGs.</p> <p>Key access targets:</p> <ul style="list-style-type: none"> ED 4hr RTT CWT DM01 	<p>Failure to meet national performance standards may result in delayed diagnosis and harm to patients, financial penalties and reputation damage.</p> <p>Physical restrictions in the layout of ED may lead to overcrowding within the department which may impact on patient care. Resus and Trolleys area of the ED are not suitable for the service provided, or big enough to accommodate the potential number of people using the service at any one time.</p> <p>Significant high cost equipment that is out of date and past its replacement date may not be reliable or fit for purpose impacting on</p>	16 (4x3)	12 (4x3)	6 (2x3)	<p>Continued focus on patient flow and daily actions to consistently achieve the 95% target.</p> <p>Capital constraints impacting adversely on equipment replacement programmes.</p>

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
		<p>service delivery and income</p> <p>Poor patient flow throughout the hospital impacts on performance, results in sub-optimal care for patients and discharge delays</p> <p>Failure to protect vulnerable children and adults may cause harm and potential reputation damage due to inadequacies in meeting statutory responsibilities.</p>				

Assurance Providers		
First Line (Business Management)	Second Line (Corporate Oversight)	Third Line (Independent)
<p>Medway & Swale A/E Delivery Board & Planned Care Board.</p> <p>Directorate Performance Review Meetings.</p> <p>Trust re-organisation of accountability and re- distribution of programme management to better meet the demands on the service.</p> <p>May to July 2017, sustained focus to improve patient flow has resulted in a great improvement in ED performance against the national four-hour target.</p>	<p>Integrated Quality & Performance Report (IQPR). Chief Executive's monthly report to Board.</p> <p>CQUINS and monitoring of compliance.</p> <p>Board approved STP; governance arrangements for STP are that accountability / decision making rests with each component organisation</p> <p>EPRR Group and Local Health Resilience Partnership representation - onward reporting to the Board</p>	<p>Medway Council Overview and Scrutiny Committee</p> <p>Medway Health and Wellbeing Board</p> <p>Monthly Quality Oversight Committee with NHSI, CQC, CCGs Monthly Progress Review meeting with NHSI Quarterly Quality and Performance Committee with CCG. NHS England Assurance Process (EPRR)</p> <p>The Chief Executive of the Kent & Medway STP has been appointed; the Board has been established with representation from MFT Chief Executive. Governance Processes are being implemented, MFT are represented at all levels.</p> <p>External regulatory standards require accredited and regulated services to assess the quality of services they commission by the review of service level agreements and quality outputs of the service, e.g. result turnaround times, participation in external quality assurance schemes etc. E.g. a Clinical Pathology Accreditation (CPA) accreditation requirement.</p>

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Joint plans under development with commissioners to increase GP referrals to local alternative dermatology service providers, which include the establishment of MFT-consultant supported GP clinics and tele-dermatology services.

The Trust will be creating opportunities from June for patients and the public from a range of different user groups to hear about and have input into the STP. The Trust is taking part in a collaborative regional procurement approach for international recruitment as part of the Sustainability and Transformation Partnership.

June / July 2017 Better, Best Brilliant programme to engage and communicate with staff, and external partners (NHSI, STP, CCG, other health economy providers) to help them understand the origins of the Better, Best, Brilliant programme and then develop a collaborative improvement culture to drive 2017-18 (and further) trust outcome improvements.

July – focus on processes put in place during May and June to improve patient flow and work towards achieving 95% for patients being seen, treated, and admitted or discharged within four hours.

Strategic Objective Four

Financial Stability: We will deliver financial sustainability and create value in all that we do

Strategic Blueprint

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.

Lead Directors

Director of Finance

Risk Register Reference

Corporate Risk Register: CRR-2016-015, CRR-2016-007

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
<p>The Trust's Going Concern assessment may be challenged by potential failure to achieve its planned deficit reduction and budget for 2017/18 which would also result in further licence conditions and potential regulatory action;</p> <p>Inability to deliver financial recovery plans and Carter Review efficiencies would threaten long term sustainability;</p> <p>Inability to operate without central funding (loans) restricts the financial operation of the organisation and its autonomy which may impact on its ability to bring about required organisational changes;</p> <p>Work with local partners to develop a financially sustainable organisation/system and develop genuine changes in patient experience and health</p>	<p>Cost Improvement Plans (CIPs) achievement</p> <p>Use of contingency / reserves</p> <p>Carter benchmark data and performance against targets</p> <p>Signed contracts with Commissioners.</p> <p>STP savings plans.</p>	<p>Failure to achieve planned deficit reduction through Cost Improvement Plans and Carter Review efficiencies across the Trust affects the financial sustainability and Going Concern assessment of the Trust.</p> <p>The combination of under investment in a dilapidated estate & the absence of a coherent strategic approach to the management of estates means that the</p>	16 (4X4)	12 (4X3)	6 (2x3)	<p>Reprioritisation of identified capital priorities through reforecasting and engagement with service leads to mitigate in year critical risks, including fire plan especially following Grenfell Tower Incident.</p> <p>The Trust does not have assured funding to deliver the capital plan and is re-prioritising projects within available funds to incorporate the necessary fire risk works.</p>

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Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
<p>outcomes, is essential for the longer term;</p> <p>Inability to receive all the income for activity due to coding and counting omissions and stretched commissioning budgets would adversely affect the financial performance and working capital of the Trust.</p>	Implementation of Service Line Reporting and Patient Level Costing to drive efficiency savings at specialty level	infrastructure does not meet business needs and capital funding and resources may be insufficient to deliver what is required.				<p>Agency usage, particularly for medical staff represents a significant risk to the Trust.</p> <p>Currently no SLR/PLICs data to inform efficiency reviews.</p> <p>Financial Recovery Plan is being developed, with implementation phase due to commence August 2017.</p>

Assurance Providers		
First Line (Business Management)	Second Line (Corporate Oversight)	Third Line (Independent)
<p>Scheme of Delegation and authorisation levels</p> <p>Business planning process</p> <p>Financial Recovery Plan</p> <p>Substantive Director of Finance appointed and substantive Deputy Director of Finance appointed.</p> <p>Improvement Director function included in Director of Human Resources and Organisational Development portfolio.</p> <p>Budgetary Control Framework in place from April 2016 ensuring that budget holders have clear responsibilities and accountability and they are supported by training alongside robust budgets.</p> <p>National agency caps; monitoring by procurement team of contracts for agency workers, majority of agency providers have reduced their charge rates to comply with NHSI cap rules.</p> <p>Control target of £43.8 deficit met for 2016/17.</p> <p>Cost Improvement Plans year end forecast is for CIP delivery to plan, with stretch target in place.</p>	<p>Integrated Audit Committee oversight of financial governance systems</p> <p>Monthly Finance Report to Board includes status report on compliance with Loan Terms from DH.</p> <p>Financial Performance report June 17, agency costs continue to reduce with further improvement offset by increase in substantive and bank and following specific action to convert staff from agency to bank or substantive roles.</p> <p>Finance Committee review of financial performance.</p> <p>High level Financial Recovery work plan presented to the Board shared with NHSI May 2017</p> <p>The Executive Team refine the forecast each month and report this to the Finance Committee and the Board and NHSI colleagues.</p>	<p>External audit of financial accounts and core financial systems</p> <p>Regular submissions to NHSI - NHS Improvement's monitoring of adherence to loan conditions</p> <p>Internal audit reports focused on areas of risk identified by Executive Directors, Non-Executive Directors and Peers.</p>
Actions to address gaps in control / assurance		

Assurance Providers

First Line (Business Management)	Second Line (Corporate Oversight)	Third Line (Independent)
<p>July/August 2017 As part of the Trust's Better, Best Brilliant programme, working in partnership with 2020 Recovery, the dedicated 'workforce' workstreams looks to detail a number of pieces of work primarily aimed at supporting the delivery of the 2017/18 cost improvement programme and delivering Carter/SLR efficiencies.</p> <p>The Trust Fire Plan is presented to the Fire Health & Safety Group quarterly and is on track for all deadlines and externally reviewed by Kent Fire and Rescue, target date for completion is 31.12.2020.</p>		

Report to the Board of Directors

Board Date: 3 August 2017

Agenda item: 12b

Title of Report	Corporate Governance Report
Presented by	Katy White – Acting Director of Corporate Governance
Lead Director	Katy White – Acting Director of Corporate Governance
Committees or Groups who have considered this report	N/A
Executive Summary	The report outlines current activity and issues in corporate governance.
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trustwide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	N/A
Quality Impact Assessment	N/A
Recommendation	The Board are requested to note the report and the assurance and risks stated.
Purpose & Actions required by the Board :	<div>Approval</div> <input type="checkbox"/> <div>Assurance</div> <input checked="" type="checkbox"/> <div>Discussion</div> <input type="checkbox"/> <div>Noting</div> <input type="checkbox"/>

Corporate Governance Report – 3 August 2017

1. EXECUTIVE SUMMARY

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

2. CARE QUALITY COMMISSION (CQC)

- 2.1. The Director of Nursing, the Head of Integrated Governance and the Support Manager to the Chief Executive had a very positive Engagement Meeting with the Trust's Care Quality Commission (CQC) Relationship Manager and Inspection Manager on 28 June 2017.

Key matters discussed included the new Insight Dashboard which the CQC will be producing from July. The dashboard is a tool the CQC has developed to support monitoring across a wide number of quality indicators and will be updated on a monthly basis to show the most up-to-date information the CQC holds about the Trust. An invitation email will be issued to the Chief Executive and the Nominated Individual inviting access to the online CQC Insight Dashboard. A full update on the revised changes to the CQC monitoring and inspection regime was presented to the Quality Assurance Committee on 28 July.

3. RISK AND REGULATION QUALITY ASSURANCE

- 3.1. The Office of Nuclear Regulation conducted an inspection of the Trust's radioactive transport arrangements on 14 July 2017. This was the first time the Trust has been inspected under the transport of dangerous goods regulations. The Nuclear Medicine Department had assessed their compliance with the regulations via an external audit by the Trust's Dangerous Goods Safety Advisor. The Inspector was impressed with the arrangements in place and the Trust will receive a formal report in due course.
- 3.2. The Human Tissue Authority (HTA) has expressed their intention to inspect the Trust's compliance with the terms of its HTA Licence, number 12090, on 26 October 2017. The Head of Risk and Regulation Quality Assurance is the Trust's Human Tissue Authority Designated Individual (HTA DI) and as such responsible and accountable for ensuring compliance and will lead on the inspection and the associated preparations. The last (very successful)

Inspection took place in March 2014, the HTA have an Inspection cycle of 2 to 3 years.

- 3.3. As part of the United Kingdom Accreditation Service (UKAS) transition from Clinical Pathology Accreditation to Accreditation to the International Standard ISO 15189:2012 Medical laboratories -- Requirements for Quality and Competence, there are two scheduled assessment visits within Pathology, Haematology and Blood Transfusion Laboratory on 24 and 25 October 2017 and Biochemistry on 12 and 13 December 2017. The Microbiology laboratory Assessment is yet to be finalised.

4. DOCUMENTATION MANAGEMENT

- 4.1. The table below shows the status of the 17 corporate policies which are identified as requiring Board approval. The Board will note that there are four policies outstanding which require review and approval.

Corporate Policy	Document Owner	Status
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	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	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, Facilities and Security	Director of Finance	Approved; Available on intranet and website
Finance	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
HR	Director of Workforce and OD	Outstanding
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website

Corporate Policy	Document Owner	Status
Medicines Management	Medical Director	Approved; Available on intranet and website
Patient Care and Management	Director of Nursing	Outstanding
Risk Management	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Safeguarding	Director of Nursing	Outstanding
Serious Incidents	Medical Director	Approved; Available on intranet and website
Standards of Business Conduct	Company Secretary	Outstanding
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet and website

5. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

- 5.1. The Trust took part in a Kent Resilience Forum multi-agency Mass Fatalities Exercise in Maidstone on 4 July 2017. The event included representation from the Director of NHS England and Public Health England, along with representatives from Medway and William Harvey Hospitals.

A number of recommendations have been raised as a result of this exercise to strengthen the Kent Resilience Forum Mass Fatalities Plan, the Local Resilience Partnership Mass Fatalities Plan and the two Hospital Mortuary Operational Disaster Victim Identification Plans (Mass Fatalities Plans). The governance process will be via the Local Health Resilience Partnership Delivery Group.

- 5.2. The Clinical Debrief Report from Grenfell Tower Fire is expected to be released by the end of July 2017. In light of this, the Trauma Network have agreed the South East London, Kent and Medway Major Trauma Network Major Incident and Mass Casualty Framework to move from draft to approved with immediate effect; with a view that all Clinical Debrief Reports from Attacks and the Fire, alongside the Emergo Exercise Report, be reviewed together in late September for an uplift to that plan where recommendations apply locally.

- 5.3. The additional item of note in relation to the Network is the link in 2017 which will be established via the South East London, Kent and Medway (SELKaM) Emergency Planning Group to bring together the Critical Care Network and Burns Network in a requirement to strengthen joined up planning.

6. INFORMATION GOVERNANCE

- 6.1. The Information Governance Alliance has issued their briefing guidance to all healthcare Chief Executive Officers in respect of the incoming General Data Protection Regulation - [Changes to Data Protection legislation: why this matters to you, which can be found here](#) highlighting the key changes and requirements under the law. A gap analysis for Trust compliance has been carried out and an action plan mapped against this. Progress will be reported through the Senior Information Risk Owner (SIRO) report to the Board in September 2017.
- 6.2. Last year Dame Fiona Caldicott as the National Data Guardian conducted a review of data security, consent and opt-outs within the NHS. The department of health has now responded to the recommendations of the report whole-heartedly accepting them (especially in the light of the recent cyber-attacks). The report is entitled Your Data: Better Security, Better Choice, Better Care and [The full text can be found here](#) key messages from the report include:
- From September the CQC's 'well led' inspection framework will include the importance of meeting data security standards, and will look to the IG toolkit to evidence this. The toolkit will go through a radical change in the autumn ready for 2018-19, with many historic elements disappearing and a greater level of evidence required for accountability and technical security.
 - This summer, NHS Improvements will issue a new 'statement of requirements' which will require Chief Executive Officers to submit an 'annual statement of resilience' – this will include for each organisation to have a named executive board member responsible for data and cyber security.
 - NHS standard contracts for 2017-18 require organisations to implement the National Data Guardian Review recommendations on data security, which include having recognised security credentials.
 - Organisations must ensure that the national opt-out is implemented effectively by March 2018, engaging the public to understand what their data is used for and by whom, and the choices that they can make around that use.

7. COMPLAINTS

- 7.1. Complaints performance is monitored via the monthly Performance Review meetings with the clinical directorates via the recently developed corporate governance dashboard.

Report to the Board of Directors

Board Date: July 2017

Agenda item:

13a

Title of Report	Workforce Report
Presented by	James Devine, Executive Director HR & OD
Lead Director	James Devine, Executive Director HR & OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	<p>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.</p> <p>The international recruitment plan for nursing continues with a total of 202 nurses being processed for posts at MFT. A further 14 nurses will commence in October from successful EU recruitment. Furthermore, the Trust is taking part in a collaborative regional procurement approach for international recruitment as part of the STP with expected interviews taking place in August.</p> <p>Trust turnover remains static (slight decrease) at just under 10%, sickness remains under 4% (slight decrease), compliance with mandatory training compliance remained at 71%, achievement review compliance decreased to 79%.</p> <p>A rise in the percentage of paybill spent on substantive staff is reported for June (three successive months); with continued and significant reductions in agency spend (to 5% of paybill).</p>
Resource Implications	None
Risk and Assurance	<ul style="list-style-type: none"> • Nurse Recruitment • Temporary Staffing Spend <p>The following activities are in place to mitigate this through:</p> <ol style="list-style-type: none"> 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 2017/18 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.
Recovery 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.
Quality Impact Assessment	n/a
Recommendation	Information
Purpose & Actions required by the Board :	<div> <div>Approval <input type="checkbox"/></div> <div>Assurance <input type="checkbox"/></div> <div>Discussion <input checked="" type="checkbox"/></div> <div>Noting <input checked="" type="checkbox"/></div> </div>

WORKFORCE REPORT – JULY 2017

TRUST BOARD MEETING

1. Introduction

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 international campaigns in both Europe and the Philippines remain on track. 14 European nurses commenced in post on 13 July and a further 14 are due to arrive in October. Harvey Nash, our international partner agency, is processing the 202 of the 241 Filipino nurses (nine individuals have withdrawn, 26 individuals have re-engaged with the process, 30 individuals have failed to follow-up on the offer) that were offered posts in March. It is anticipated that the first cohort of ten Filipino nurses will commence in November 2017.
- 2.2 The Trust is partaking in a collaborative regional procurement approach for International Nurse Recruitment as part of the STP. The Trust undertook an agency evaluation exercise on 22 May and two agency providers were selected to partner with the Trust. The two selected providers (Cpl Healthcare and HCL Clarity) have now signed contracts with the Trust and it is anticipated the Trust will commence interviewing candidates put forward by both partners in August.
- 2.3 The Trust continues to hold regular local and national recruitment campaigns and attend events to promote the Trust as an employer of choice. HR &OD and nursing colleagues attended the Kent County Show (7-9 July) to talk to people about why the Trust is such a great place to work. The event was successful over the three days with visitors of all ages; many who expressed an interest in working at Medway Hospital, follow-up on interested parties is underway.
- 2.4 The Trust has made offers to a high number of qualified nurses and clinical support workers. The table below summarises the position on offers made, starters and leavers for June 2017.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	35	16	10
Clinical Support Workers	14	12	9

- 2.5 Medical Staffing continue to engage with Headhunting agencies to recruit to hard to fill medical posts and as a result, six middle grade ED doctors have been sourced and offered posts (one commenced on 19 July). Three Medical Training Initiative scheme doctors (MTI) commenced in Medicine in July with a further 11 receiving offer letters. The Trust has offered its first Physician Associate a post in Trauma and Orthopaedics and is expected to commence in December.

3. Directorate Metrics

- 3.1 The table below shows performance across five core indicators by directorate. Turnover, at 9.73% (decreased by -0.22%), remains above the tolerance level of 8%. Sickness absence (reduced to 3.84%) remains slightly below the tolerance level of 4%.
- 3.2 Trust achievement review rate stands at 79% (-4%), below the Trust target of 85%, Mandatory training remains below target (at 71%) unchanged – no directorates are currently meeting either target; HR Business Partners are working with directorates to devise robust plans which better support the achievement review approach as opposed to an annual appraisal system which was replaced in late 2016. Reporting mechanisms for achievement review have been simplified to make it easier to report. Smarter, more transparent reports based on MOLLIE data have now been published to help directorates make sense of their data and support departmental planning for training. In addition, directorates have been required to review their approach to mandatory training, and utilise the escalation and consequence process detailed within the policy where necessary.

	Acute & Continuing Care			Co-ordinated Surgical			Families & Clinical Support Services			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	Rate	Trend from previous month	12-month trend
Turnover rate (8%)	11%	▼		9%	▲		9%	▼		13%	▼		6%	▲		10%	▼	
Vacancy rate	15%	►		19%	▼		10%	▼		15%	►		10%	►		15%	►	
Sickness rate (4%)	4%	▼		4%	▼		4%	▼		3%	▲		6%	▼		4%	▼	
Mandatory Training (85%)	69%	►		72%	▼		78%	▲		80%	▲		61%	▲		71%	▼	
Achievement Review (85%)	75%	▼		76%	▼		91%	▲		73%	▼		75%	▼		79%	▼	

4. Temporary Staffing

- 4.1 Agency breaches have now stabilised. In December 2016, the Trust was reporting c.1000 shift breaches per week (on average). Since the end of May 2017, the Trust has reported a figure lower than 300 per week; in June, 175 shifts breached the cap as a weekly average.
- 4.2 The table below shows the three significant, successive monthly decreases in agency spend. Agency spend, as a percentage of paybill has decreased by 16% (absolute) between March 2017 and June 2017. Similarly, the Trust has seen a significant move from agency resourcing to a substantive workforce (up by 9% as percentage of paybill) with a larger contingent bank resource (+7% as a percentage of paybill).

	March 2017		April 2017		May 2017		June 2017	
	Spend in month (£)	% paybill	Spend in month (£)	% paybill	Spend in month (£)	% paybill	Spend in month (£)	% paybill
Agency	3,890K	21%	2,212K	13%	1,944K	11%	860K	5%
Bank	921K	5%	1,057K	6%	1,214K	7%	2,047K	12%
Substantive	13,611K	74%	14,009K	81%	14,303K	82%	14,327K	83%

- 4.3 A total of 16,050 shifts were requested across all staff groups with an overall fill rate of 89%. Temporary staffing nursing demand decreased in June compared to May (13,177 shifts May versus 11,450 in June). The increased nursing demand resulted in a lower than average nursing fill rate (73%, -7% compared to May), work is being undertaken to understand this peak in demand.

5. Other Workforce Updates

5.1 Update on apprenticeships:

The Trust has moved into the implementation phase of the Apprenticeship Workforce Plan with a number of key events. The Big Conversation held on the 6th July saw a number of senior managers come together to hear about the Apprenticeship Workforce Plan.

HR Business Partners are engaging with their Directorates and presentations have now been delivered with action plans drawn up. To date we have over 80 programmes in the pipeline (pending authorisation). The new model is in place and working with all plans being taken to the Strategic Workforce Group and then commissioned via Organisational & Professional Development.

- End

Report to the Board of Directors
Board Date: August 2017
Agenda item: 13b

Title of Report	Workforce Race Equality Standard 2017
Presented by	James Devine, Executive Director HR & OD
Lead Director	James Devine, Executive Director HR & OD
Committees or Groups who have considered this report	Executive Team, Senior HR Team
Executive Summary	<p>The NHS Workforce Race Equality Standard (WRES) is a mandatory annual report, as required by the NHS standard contract. Medway Foundation Trust produced its first WRES report in 2016, which formed the baseline against which this year's assessment can be compared.</p> <p>The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are 9 performance indicators. The Trust's performance on self-declaration is excellent, at 97.6%. The Trust has shown some improvement across all 9 indicators over the past year, but there are still significant improvements that can be made to ensure equality of opportunity for all staff.</p> <p>Actions that the Trust has taken and is putting in place to improve performance are also set out in the WRES summary.</p>
Resource Implications	None identified, as actions for 2017/18 should be achieved within existing resources.
Risk and Assurance	<ul style="list-style-type: none"> • Reputation • Contract Compliance <p>The following activities are in place to mitigate this through:</p> <ol style="list-style-type: none"> 1. Co-ordination of equality and inclusion programmes of work by a dedicated member of staff, including specialist advice and guidance 2. Quarterly monitoring of WRES Performance (judged against the technical guidance) to track progress and spot rising trends.
Legal Implications/Regulatory	The Equality Act 2010 requires all employers to demonstrate equality of opportunity for staff, as measured against nine Protected

Requirements	Characteristics, including Race. The Public Sector Equality Duty, contained within the Equality Act 2010, requires all public sector organisations to publish equality performance data on an annual basis; and the NHS Standard Contract requires all provider organisations to publish information on race equality in the form of the WRES summary.
Recovery Plan Implication	Workforce, 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	n/a
Recommendation	Approval
Purpose & Actions required by the Board :	<div> <div>Approval <input checked="" type="checkbox"/></div> <div>Assurance <input type="checkbox"/></div> <div>Discussion <input checked="" type="checkbox"/></div> <div>Noting <input type="checkbox"/></div> </div>

Workforce Race Equality Standard 2017

3 August 2017

1. INTRODUCTION

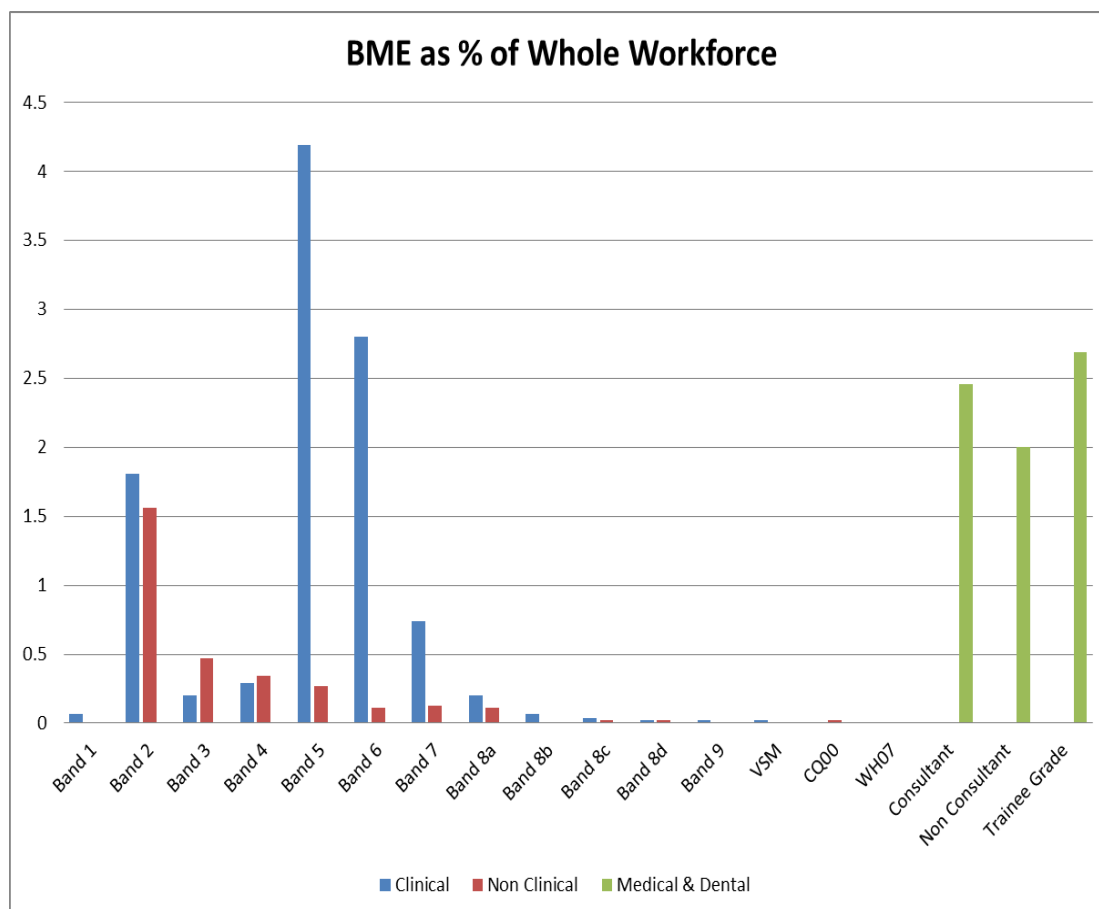
- 1.1 The Five Year Forward View sets out a direction of travel for the NHS which depends on ensuring the NHS is innovative, engages and respects staff, and draws on the immense talent in our workforce. The evidence of the link between the treatment of staff and patient care is particularly well evidenced for BME staff in the NHS, so this is an issue for patient care, not just for staff. The Equality and Diversity Council - representing the major national organisations in the NHS, proposed the Workforce Race Equality Standard, which supports and requires organisations to make these changes.
- 1.2 The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis. Medway Foundation Trust produced its first WRES report in 2016, which formed the baseline against which this year's assessment can be compared.
- 1.3 The main purpose of the WRES is:
 - to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
 - to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
 - to improve BME representation at the Board level of the organisation.
- 1.4 It is now a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WRES.
- 1.5 The WRES Summary assessment is attached with this paper, and the key findings are set out below.

2. KEY FINDINGS

- 2.1 The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are 9 performance indicators. Not included as an indicator, but essential to the quality of reporting, is the percentage of staff who have self-declared their ethnic origin. The Trust's performance on self-declaration is excellent, at 97.6%
- 2.2 **Indicator 1** - Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.

This information was required to be broken down not only by band, but also separating clinical, medical/dental and non-clinical staff. This makes a direct comparison in the

direction of travel difficult, compared to the baseline. However, it can be seen that Black and Minority Ethnic (BME) people are significantly under-represented above band 2 in non-clinical roles, and above band 5 in clinical roles. This indicates that recruitment and progression of BME, needs further work.



2.3 **Indicator 2** - Relative likelihood of staff being appointed from shortlisting across all posts.

In 2015/16, White people shortlisted for interview were 2.58 times more likely than Black and Minority Ethnic (BME) people to be appointed. In 2016/17 this gap narrowed to 1.31 times. This data shows a significant improvement in the likelihood of BME candidates progressing from shortlisting to appointment. However, White candidates still have a greater likelihood of being appointed than BME candidates.

2.4 **Indicator 3** - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

A statistically small number of individuals have entered formal disciplinary procedures in the past year. There has been little change in the likelihood of white staff entering formal procedures in 2016/17, but the proportion of BME staff entering formal procedures has reduced considerably. This may or may not be progress, depending on how and when formal procedures have been triggered; therefore more work is needed to understand why there are still differences in the relative likelihood.

2.5 **Indicator 4** - Relative likelihood of staff accessing non-mandatory training and CPD

Access to non-mandatory training has been analysed on the OLM system (used until December 2016), MOLLIE (used since December 2016), and Continued Professional Development (CPD) provided by Universities and other external providers. These all show that there has been a performance improvement in the take-up of non-mandatory training and CPD since 2015/16. Additionally the data shows that since moving from OLM to MOLLIE in December 2016, there have been further improvements in the take-up of non-mandatory training, especially by BME staff. Access to CPD (via universities and other external providers) has a lower uptake, but with a similar likelihood between White and BME staff in uptake.

2.6 **Indicators 5-8** – National NHS Staff Survey indicators

The Trust is clear that harassment, bullying and abuse is not acceptable as it impacts on wellbeing, productivity, turnover and patient care. Whilst actions have been taken to address this, the indicators 5, 6 and 8 show there has been little shift from the previous year, and the Trust is performing at or below national average.

Even with indicator 7 (Percentage believing that trust provides equal opportunities for career progression or promotion), where the Trust's performance has improved, it is still below national average.

2.7 **Indicator 9** - Percentage difference between the organisations' Board voting membership and its overall workforce.

A marginal shift in this indicator is due only to a change in the size of the workforce. The Board has no voting or executive members from a BME background. Given the low number of people involved, it is not appropriate to identify target dates for change, but the Trust does need to consider what actions may be needed both now and in the future to encourage a wide range of suitable candidates at senior levels.

3. PUBLICATION AND NEXT STEPS

3.1. The WRES summary has been considered by the Executive Group, and has been submitted to Medway CCG, as required by the NHS Standard Contract. The WRES summary is also attached to this report for consideration by the Trust Board. The Trust Board is asked to approve the WRES Summary to inform the Trust's continued improvement. The Trust has already acknowledged that there are significant steps needed to be taken to improve the equality and diversity practice. This return also illustrates many of the measures already put in place in order to shift culture and performance.

3.2. Actions to improve performance for 2018:

Whilst an Inclusion Steering Group has been established, along with a BME Staff Forum, both of these groups now need a clear work programme. Trusts are encouraged to publish detailed action plans with their WRES summaries, however, rather than deal with race equality issues in isolation, it is more effective to develop the work plan alongside the EDS2 assessment currently being completed. The Trust's EDS2 assessment and draft action plan will be prepared in August. However a number of specific actions have already been

identified when analysing the WRES data. These are set out in the final column of Section 5 of the WRES summary.

Appendix

WORKFORCE RACE EQUALITY STANDARD, SUMMARY REPORT, 2017



MFT WRES report
2017 (locked 5 July).r

Workforce Race Equality Standard



REPORTING TEMPLATE (Revised 2016)

Template for completion

Name of organisation

Date of report: month/year

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Name and title of Board lead for the Workforce Race Equality Standard

Name and contact details of lead manager compiling this report

Names of commissioners this report has been sent to (complete as applicable)

Name and contact details of co-ordinating commissioner this report has been sent to (complete as applicable)

Unique URL link on which this Report and associated Action Plan will be found

This report has been signed off by on behalf of the Board on (insert name and date)

1. Background narrative

a. Any issues of completeness of data

b. Any matters relating to reliability of comparisons with previous years

2. Total numbers of staff

a. Employed within this organisation at the date of the report

b. Proportion of BME staff employed within this organisation at the date of the report

3. Self reporting

a. The proportion of total staff who have self-reported their ethnicity

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity

4. Workforce data

a. What period does the organisation's workforce data refer to?

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES Action Plans.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	For each of these four workforce indicators, compare the data for White and BME staff				
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.				
2	Relative likelihood of staff being appointed from shortlisting across all posts.				
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.				
4	Relative likelihood of staff accessing non-mandatory training and CPD.				

Report on the WRES indicators, continued

Page 245 of 303.

	Indicator	Data for reporting year	Data for previous year	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, <u>compare the outcomes of the responses for White and BME staff.</u>				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White BME	White BME		
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White BME	White BME		
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	White BME	White BME		
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White BME	White BME		
	Board representation indicator For this indicator, <u>compare the difference for White and BME staff.</u>				
9	Percentage difference between the organisations' Board voting membership and its overall workforce.				

Note 1. All provider organisations to whom the NHS Standard Contract applies are required to conduct the NHS Staff Survey. Those organisations that do not undertake the NHS Staff Survey are recommended to do so, or to undertake an equivalent.

Note 2. Please refer to the WRES Technical Guidance for clarification on the precise means for implementing each indicator.

6. Are there any other factors or data which should be taken into consideration in assessing progress?

7. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

Click to lock all form fields and prevent future editing



Report to the Trust Board

Date: 3 August 2017
Agenda item:

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Title of Report	Corporate Policy – Conflicts of Interest
Presented by	Sheila Murphy, Trust Secretary
Lead Director	Sheila Murphy, Trust Secretary
Committees or Groups who have considered this report	Executive Group – 19 July 2017
Executive Summary	<p>The purpose of this report is to present a Conflicts of Interest Policy (appendix 1) to the Trust Board for approval. The Policy covers arrangements for declarations of interests including gifts, hospitality and sponsorship arrangements.</p> <p>Key points to note:</p> <ul style="list-style-type: none"> • The Trust does not currently have a conflicts of interest policy (this is an omission); • The arrangements for declaring conflicts of interest, and staff awareness are deficient due to the absence of sufficiently robust awareness raising through training at induction and regular intervals; • NHS England has recently published guidance which came into force from 1 June; this is as appendix 2; parts of the guidance have implications for existing staff and recruitment and these requirements have been shared with HR for integrating into their processes; • The Policy has been drafted using the NHS England template; it is supported by a declaration form (appendix 3) that also follows the NHS England template; • This Policy, once approved, will replace POLCGR004 – Gifts and Hospitality Register Commercial and Charitable Sponsorship Policy; • There will need to be a programme of regular communication and engagement with staff about their responsibilities and obligations (led by the Trust Secretary) to ensure sufficient understanding and recording of interests by staff
Resource Implications	None.
Risk and Assurance	The Policy is a primary step in improving arrangements for declarations of interest in the Trust but it needs to be supplemented by a programme of communication and engagement with staff.
Legal	The NHS England guidance came into force on 1 June

Implications/Regulatory Requirements	<p>2017 and is applicable to the following NHS organisations:</p> <ul style="list-style-type: none"> • CCGs via the statutory guidance to CCGs issued by NHS England • NHS Trusts and NHS Foundation Trusts – which include secondary care trusts, mental health trusts, community trusts, and ambulance trusts • NHS England <p>The guidance supersedes and extinguishes the Standards of Business Conduct for NHS staff (HSG(93)5).</p> <p>The guidance does not apply to bodies not listed above (i.e. independent and private sector organisations, general practices, social enterprises, community pharmacies, community dental practices, optical providers, local authorities).</p> <p>NHS Trusts and NHS Foundation Trusts must have regard to this guidance through its incorporation into the NHS Standard Contract pursuant to General Condition 27.</p>
Recovery Plan Implication	None.
Quality Impact Assessment	None.
Recommendation	The Executive Group have reviewed the Policy and recommend it for approval by the Trust Board.
Purpose & Actions required by the Board :	<div>Approval</div> <div><input checked="" type="checkbox"/></div> <div>Assurance</div> <div><input type="checkbox"/></div> <div>Discussion</div> <div><input type="checkbox"/></div> <div>Noting</div> <div><input type="checkbox"/></div>

Conflicts of Interest Policy

(incorporating arrangements for gifts, hospitality,
sponsorship and other interests)

The Model Policy template published by NHS England in April 2017 has been adhered to in the drafting of this policy.

Author:	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Document Owner:	Trust Secretary
Revision No:	
Document ID Number	POLCGR119
Approved By:	
Implementation Date:	
Date of Next Review:	

Conflicts of Interest Policy

(incorporating arrangements for gifts, hospitality, sponsorship and other interests)

Background and Purpose

From 1 June 2017 guidance on **Managing Conflicts of Interest in the NHS** (the 'guidance') came into force. The guidance:

- introduces common principles and rules for managing conflicts of interest
- provides simple advice to staff and organisations about what to do in common situations
- supports good judgement about how interests should be approached and managed
- Sets out the issues and rationale behind the policy.

This document provides a practical interpretation of the guidance to help organisations with implementation.

Who does the guidance apply to?

- Clinical Commissioning Groups ('CCGs') via the statutory guidance to CCGs issued by NHS England.
- NHS Trusts and NHS Foundation Trusts - which include secondary care trusts, mental health trusts, community trusts, and ambulance trusts
- NHS England

Other resources are available on the NHS England website at:
<https://www.england.nhs.uk/ourwork/coi/>

Conflicts of Interest Policy

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Conflicts of Interest Policy

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1 Policy Summary

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should...	As an organisation we will...
<ul style="list-style-type: none"> Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent Regularly consider what interests you have and declare these as they arise. If in doubt, declare. NOT misuse your position to further your own interests or those close to you NOT be influenced, or give the impression that you have been influenced by outside interests NOT allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money 	<ul style="list-style-type: none"> Ensure that this policy and supporting processes are clear and help staff understand what they need to do. Identify a team or individual with responsibility for: <ul style="list-style-type: none"> Keeping this policy under review to ensure they are in line with the guidance. Providing advice, training and support for staff on how interests should be managed. Maintaining register(s) of interests. Auditing this policy and its associated processes and procedures at least once every three years. NOT avoid managing conflicts of interest. NOT interpret this policy in a way which stifles collaboration and innovation with our partners

Conflicts of Interest Policy

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2 Introduction

Medway NHS Foundation Trust (the 'organisation'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community. As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

3 Purpose

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

This policy should be considered alongside these:

[POLCF001 - Anti-Fraud, Bribery and Corruption Policy](#)

This policy adheres to the National policy described in the NHS Counter Fraud and Corruption manual (Version 3); the policy statement, 'Applying Appropriate Sanctions Consistently;' and having regard to guidance or advice issued by NHS Protect.

[POLCHR041 - Fit and Proper Persons Policy](#)

This policy ensures we meet the fundamental standard regulations – the Health and Social Care Act 2008 (Regulated Activities) Regulations.

[POLCHR014 - Freedom to Speak Up - Raising Concerns at Work -Whistleblowing Policy \(1 attachment\)](#)

[SOP0251 - Freedom to Speak Up Guardians Procedure \(1 attachment\)](#)

[PROCHR002 - Disciplinary Policy \(1 attachment\)](#)

NHS England guidance on managing conflicts of interest www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf

Conflicts of Interest Policy

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4 Key terms

A 'conflict of interest' is:

"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

5 Interests

Interests fall into the following categories:

Type of Interest	Description
Financial interests	<p>Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making. This could include:</p> <ul style="list-style-type: none"> • A director (including a non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; • A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; • Someone in outside employment; • Someone in receipt of secondary income; • Someone in receipt of a grant; • Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence); • Someone in receipt of sponsored research.
Non-financial professional	<p>Where an individual may obtain a non-financial benefit from the consequences of a decision their organisation makes,</p>

* A benefit may arise from the making of gain or avoiding a loss

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interests	<p>such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is:</p> <ul style="list-style-type: none"> • An advocate for a particular group of patients; • A clinician with a special interest; • An active member of a particular specialist body; • An advisor for the Care Quality Commission or National Institute of Health and Care Excellence; • A research role.
Non-financial personal interests	<p>This is where an individual may benefit personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:</p> <ul style="list-style-type: none"> • A member of a voluntary sector board or has a position of authority within a voluntary sector organisation; • A member of a lobbying or pressure group with an interest in health and care.
Indirect interests	<p>This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making. This would include:*</p> <ul style="list-style-type: none"> • Close family members and relatives; • Close friends and associates; • Business partners.

6 Staff

At Medway NHS Foundation Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees
- All prospective employees – who are part-way through recruitment
- Contractors and sub-contractors
- Agency staff; and
- Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation)

* A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

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7 Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this organisation are:

- Executive and Non-Executive Directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money;
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services;
- Those at Agenda for Change Band 8D and above;
- Administrative and clinical staff who have the power to enter into contracts on behalf of the organisation;
- Administrative and clinical staff involved in decision making concerning the purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

8 Identification, declaration and review of interests

8.1 Identification & declaration of interests (including gifts and hospitality)

All staff should identify and declare material interests at the earliest opportunity (and in any event within 28 days). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered. Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

The declaration of interests form is available via this link: [\[add qpulse link\]](#)

Declarations should be made to the Trust Secretary via meadows.adenike@nhs.net

The Trust Secretary's advice must also be sought if you are in any doubt about declarations.

The Trust Secretary is responsible for:

- Providing advice, training and support for staff on how interests should be managed;

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(incorporating arrangements for gifts, hospitality, sponsorship and other interests)

- Maintaining registers of interests;
- Auditing policy, process and procedures relating to this policy at least every three years.

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

8.2 Proactive review of interests

We will prompt decision making staff quarterly to review declarations they have made and, as appropriate, update them or make a nil return. The resulting register will be reviewed by the Integrated Audit Committee on a quarterly basis.

9 Records and publication

9.1 Maintenance

The organisation will maintain one register of all interests that incorporates all interests including gifts, hospitality and sponsorship.

All declared interests that are material will be promptly transferred to the register by the Trust Secretary.

9.2 Publication

We will:

- Publish the interests declared by decision making staff
- Refresh this information on a quarterly basis
- Make this information available on our website

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Trust Secretary to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

9.3 Wider transparency initiatives

Medway NHS Foundation Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings

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- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website:
<http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx>

10 Management of interests – general

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific and Medway NHS Foundation Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

11 Management of interests – common situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

11.1 Gifts

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.

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- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6* in total, and need not be declared.

Gifts from other sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of Medway NHS Foundation Trust (or its associated charity) not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

11.1.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75[†] - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given (by the relevant Director of the corporate function or the Director of Clinical Operations). A clear reason should be recorded on the organisation's register of interest as to why it was permissible to accept.

* The £6 value has been selected with reference to existing industry guidance issued by the ABPI:
<http://www.pmcpa.org.uk/thecode/Pages/default.aspx>

[†] The £75 value has been selected with reference to existing industry guidance issued by the ABPI
<http://www.pmcpa.org.uk/thecode/Pages/default.aspx>

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- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need senior approval (by the relevant Director of the corporate function or the Director of Clinical Operations), should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
 - offers of business class or first class travel and accommodation (including domestic travel)
 - offers of foreign travel and accommodation.

11.2.1 What should be declared

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.3 Outside Employment

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

11.3.1 What should be declared

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.4 Shareholdings and other ownership issues

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- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

11.4.1 What should be declared

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.5.1 What should be declared

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

11.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

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- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

11.6.1 What should be declared

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.7 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

11.7.1 What should be declared

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

11.8 Sponsored events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.

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- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the organisation.

11.8.1 What should be declared

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

11.9 Sponsored research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the organisation.

11.9.1 What should be declared

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
 - their name and their role with the organisation.
 - Nature of their involvement in the sponsored research.
 - relevant dates.
 - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

11.10 Sponsored posts

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.

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- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

11.10.1 What should be declared

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

11.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises^{*} including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[†]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines:
https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

11.11.1 What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

* Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf

[†] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf

Conflicts of Interest Policy

(incorporating arrangements for gifts, hospitality, sponsorship and other interests)

12 Management of interests – advice in specific contexts

12.1 Strategic decision making groups

In common with other NHS bodies Medway NHS Foundation Trust uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

The interests of those who are involved in these groups should be well known so that they can be managed effectively. For this organisation these groups are:

- The Trust Board
- Board Committees (the extent of decision making is restricted to that delegated by the Board and set out in the terms of reference for the Committee)
- The Executive Group (acting within the Chief Executive's delegated limits)

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

12.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

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Those involved in procurement exercises for and on behalf of the organisation should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

13 Dealing with breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

14 Identifying and reporting breaches

Staff who are aware about actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to:

- Their line manager
- The Counter Fraud Service
- The Trust Secretary
- A Freedom to Speak Up Guardian

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised refer to

[POLCHR014 - Freedom to Speak Up - Raising Concerns at Work -Whistleblowing Policy \(1 attachment\)](#)

[SOP0251 - Freedom to Speak Up Guardians Procedure \(1 attachment\)](#)

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

7.4. Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

14.1 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for

Conflicts of Interest Policy

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staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Protect, the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrongdoing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
 - Informal action (such as reprimand, or signposting to training and/or guidance).
 - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

14.2 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Integrated Audit Committee at each meeting.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and made available for inspection by the public upon request.

15 Review

This policy will be reviewed one year from approval and implementation unless an earlier review is required. This will be led by the Trust Secretary.

Conflicts of Interest Policy (incorporating arrangements for gifts, hospitality, sponsorship and other interests)

16 Associated documentation

Freedom of Information Act 2000

ABPI: The Code of Practice for the Pharmaceutical Industry (2014)

ABHI Code of Business Practice

NHS Code of Conduct and Accountability (July 2004)

TEMPLATE INTERESTS DECLARATION FORM

Name	Job Title	Role	What is being declared?	Description of Interest	Dates From	Date To	Comments (confirm who has approved this declaration of interest and their job title)
Mr John Smith	Director of Finance	Executive Director	Hospitality	£95 from [insert name of org] to pay for travel to speak at conference on Managing Conflicts of Interest on 21/12/16	21/12/2016	21/12/2016	Approval to attend event and accept hospitality given by Chief Executive on 01.12.2016

Please see below for information on how to populate the above boxes

The information submitted will be held Medway NHS Foundation Trust for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that Medway NHS Foundation Trust holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to Medway NHS Foundation Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result.

I do / do not [delete as applicable] give my consent for this information to be published on registers that **Medway NHS Foundation Trust** holds.

If consent is NOT given please give reasons:

--

Signed:

--

Date:

Enter email address in signature box above; if the attachment is sent directly from the email account of the person making the declaration a signed hard copy is not required.

Please email this form to meadows.adenike@nhs.net

GUIDANCE NOTES FOR COMPLETION OF SPECIMEN INTERESTS DECLARATION FORM

Name and Role: Insert your name and your position/role in relation to the Organisation you are making the return to

Description of Interest:

Provide a description of the interest that is being declared. This should contain enough information to be meaningful (e.g. detailing the supplier of any gifts, hospitality, sponsorship, etc). That is, the information provided should enable a reasonable person with no prior knowledge should be able to read this and understand the nature of the interest.

Types of interest:

Financial interests - This is where an individual may get direct financial benefits from the consequences of a decision they are involved in making

Non-financial professional interests - This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career

Non-financial personal interests - This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career

Indirect interests - This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making

A benefit may arise from both a gain or avoidance of a loss.

Relevant Dates:

Detail here when the interest arose and, if relevant, when it ceased

Comments:

This field should detail any action taken to manage an actual or potential conflict of interest. It might also detail any approvals or permissions to adopt certain course of action

TEMPLATE INTERESTS DECLARATION FORM



Executive and Non-Executive Directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers’ money;

- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services;
- Those at Agenda for Change Band 8D and above;
- Administrative and clinical staff who have the power to enter into contracts on behalf of the organisation.
- Administrative and clinical staff involved in decision making concerning the purchasing of goods, medicines, medical devices or equipment, and formulary decisions.
- Other – i.e. none of the above. Anyone selecting Other is deemed to be a non-decision maker in the spending of taxpayers’ money

Managing Conflicts of Interest in the NHS

Guidance for staff and organisations



NHS England INFORMATION READER BOX
Directorate

Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:

0

Document Purpose	Guidance
Document Name	Managing Conflicts of Interest in the NHS
Author	NHS England
Publication Date	07 February 2017
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, CSU Managing Directors, Foundation Trust CEs, Medical Directors, Directors of Nursing, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, Directors of HR, Directors of Finance, NHS Trust CEs
Additional Circulation List	Care Trust CEs, GPs
Description	This guidance provides guidance for the management of conflicts of interest in the NHS. It is applicable to Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts and NHS England. Other bodies involved in the provision of NHS services are invited to consider implementing this guidance.
Cross Reference	Managing Conflicts of Interest: Revised Statutory Guidance for CCGs
Superseded Docs (if applicable)	
Action Required	Review and update existing relevant organisational policies.
Timing / Deadlines (if applicable)	This guidance comes into force 1 June 2017
Contact Details for further information	england.psu@nhs.net

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Scope of this guidance



This guidance is intended to protect patients, taxpayers and staff covering health services in which there is a direct state interest. It comes into force on 1 June 2017.

It is applicable to the following NHS bodies:

- Clinical Commissioning Groups ('CCGs')
- NHS Trusts (all or most of whose hospitals establishments and facilities are situated in England) and NHS Foundation Trusts - which include secondary care trusts, mental health trusts, community trusts, and ambulance trusts
- NHS England

For the purposes of this guidance these bodies are referred to as '[organisations](#)'.

The principles of this guidance will be included in a revised version of the statutory guidance for CCGs issued by NHS England pursuant to its powers under s.14O and s.14Z8 of the National Health Service Act 2006. Until this guidance comes into force existing guidance issued under these powers continues to apply, and is accessible at: <https://www.england.nhs.uk/commissioning/pc-co-comms/coi/>

NHS Trusts and NHS Foundation Trusts must have regard to this guidance through its incorporation into the NHS Standard Contract pursuant to General Condition 27.

Its applicability to NHS England will be delivered through amendments to our Standards of Business Conduct.

This guidance does not apply to bodies not listed above (i.e. independent and private sector organisations, general practices*, social enterprises, community pharmacies, community dental practices, optical providers, local authorities – who are subject to different legislative and governance requirements). However, the boards/governing bodies of these organisations are invited to consider implementing the guidance as a means to effectively manage conflicts of interest and provide safeguards for their staff. The requirements of GC27.2 of the generic NHS Standard Contract (2017/18 and 2018/19 edition) should be interpreted in that light.

* However, GP practice staff should note that the requirements in the statutory guidance for CCGs on the management of conflicts of interest (referred to above) continue to apply to GP partners (or where the practice is a company, each director) and individuals in a practice directly involved with the business or decision making of their CCG.

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1. Purpose



1.1. Every year the taxpayer entrusts NHS organisations with over £110 billion to care for millions of people. This money must be spent well, free from undue influence.

1.2. To deliver high quality and innovative care organisations need to work collaboratively with each other, local authorities, industry and other public, private and voluntary bodies. Partnership working brings many benefits, but also creates the risk of conflicts of interest.

1.3. Organisations and the people who work with, for, and on behalf of them (referred to as **‘staff’** in this guidance) want to manage these risks in the right way. Staff and organisations may already be taking steps to do this. However, how this should be done has not always been made clear and there is variation in current practice – implementation of this guidance will make things easier and enable greater consistency across the NHS.

1.4. By implementing this guidance staff and organisations will understand what to do to take the best action and protect themselves from allegations that they have acted inappropriately.

This guidance:

- Introduces consistent principles and rules for managing conflicts of interest.
- Provides simple advice to staff and organisations about what to do in common situations.
- Supports good judgement about how interests should be approached and managed.

2. Action: What should staff and organisations do?

Action for staff	Action for organisations
DO <ul style="list-style-type: none"> Familiarise yourself with this guidance and your organisational policies and follow them. Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent. Regularly consider what interests you have and declare these as they arise. If in doubt, declare. 	DO <ul style="list-style-type: none"> Ensure that you have clear and well communicated processes in place to help staff understand what they need to do. Identify a team or individual with responsibility for: <ul style="list-style-type: none"> Reviewing current policies and bringing them in line with this guidance. Providing advice, training and support for staff on how interests should be managed. Maintaining register(s) of interests. Auditing policy, process and procedures relating to this guidance at least every three years.
DON'T <ul style="list-style-type: none"> Misuse your position to further your own interests or those close to you. Be influenced, or give the impression that you have been influenced by, outside interests. Allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money. 	DON'T <ul style="list-style-type: none"> Avoid managing conflicts of interest. Interpret and deploy this guidance in a way which stifles the collaboration and innovation that the NHS needs.

Organisations should ensure their policies as a minimum meet the standards in this guidance. They can also introduce local requirements that are more stringent, on the basis of their own circumstances, should they think this is necessary. Organisations may wish to adopt or adapt the Model Policy at [Annex A](#) to assist with implementation.

3. Definitions: Conflict of interest

3.1. For the purposes of this guidance a ‘[conflict of interest](#)’ is defined as:

“A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.”

3.2. A conflict of interest may be:

Actual

There is a material conflict between one or more interests

Potential

There is the possibility of a material conflict between one or more interests in the future

3.3. Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently. It will be important to exercise judgement and to declare such interests where there is otherwise a risk of imputation of improper conduct.

3. Definitions: Interests

3.4. ‘Interests’ can arise in a number of different contexts. A material interest is one which a reasonable person would take into account when making a decision regarding the use of taxpayers’ money because the interest has relevance to that decision.

3.5. Interests fall into the following categories:

Financial interests	Non-financial professional interests	Non-financial personal interests	Indirect interests
Where an individual may get direct financial benefit* from the consequences of a decision they are involved in making	Where an individual may obtain a non-financial professional benefit* from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career	Where an individual may benefit* personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career	Where an individual has a close association** with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making

* A benefit may arise from the making of gain or avoiding a loss

** These associations may arise through relationships with close family members and relatives, close friends and associates, and business partners. A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

Further guidance on how to interpret these categories is at [Annex B](#).

4. Declarations: Processes to follow

4.1. Organisations should support staff to understand that having interests is not in itself negative, but not declaring and managing them is.

4.2. All staff must be aware of how and to whom declarations should be made, declaring material interests at the earliest opportunity (and in any event within 28 days) via a positive declaration to their organisation. Therefore, declarations should be made:

- On appointment with an organisation
- When a person moves to a new role or their responsibilities change significantly
- At the beginning of a new project/piece of work
- As soon as circumstances change and new interests arise

4.3. Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as **'decision making staff'**.

4.4. Because of their influence in the spending of taxpayers' money, organisations should ensure that, at least annually, decision making staff are prompted to update their declarations of interest, or make a nil return.

4.5. Organisations should define decision making staff according to their own context, but this should be justifiable and capture those groups of staff that have a material influence on how taxpayers' money is spent.

4.6. The following non-exhaustive list describes who these individuals are likely to be:

- Executive and non executive directors* who have decision making roles which involve the spending of taxpayers' money
- Members of advisory groups which contribute to direct or delegated decision making on the commissioning or provision of taxpayer funded services
- Those at Agenda for Change band 8d** and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of good, medicines, medical devices or equipment, and formulary decisions.

4.7. There may be occasions where staff declare an interest but, upon closer consideration, it is clear that this is not material and so does not give rise to the risk of a conflict of interest. The team or individual responsible for managing organisational policy should decide whether it is necessary to transfer such declarations to an organisation's register(s) of interests.

* equivalent roles in different organisations carry different titles – this should be considered on a case by case basis

** reflecting guidance issued by the Information Commissioner's Office with regard to Freedom of Information legislation:

<https://ico.org.uk/media/1220/definition-document-health-bodies-in-england.pdf>

5. Management: Principles and situations

5.1. Organisations should manage interests sensibly and proportionately. If an interest presents an actual or potential conflict of interest then management action is required.

5.2. Some common sense management principles should be adopted by organisations which, for the purposes of this guidance, are referred to as '[general management actions](#)':

- Requiring staff to comply with this guidance
- Requiring staff to proactively declare interests at the point they become involved in decision making
- Considering a range of actions, which may include:
 - deciding that no action is warranted
 - restricting an individual's involvement in discussions and excluding them from decision making
 - removing an individual from the whole decision making process
 - removing an individual's responsibility for an entire area of work
 - removing an individual from their role altogether if the conflict is so significant that they are unable to operate effectively in the role
- Keeping an audit trail of the actions taken

5.3. Each case will be different. The general management actions, along with relevant industry/professional guidance, should complement the exercise of good judgement. It will always be appropriate to clarify circumstances with individuals involved to assess issues and risks.

5.4. However, there are a number of common situations which can give rise to risk of conflicts of interest, being:

- Gifts
- Hospitality
- Outside employment
- Shareholdings and other ownership interests
- Patents
- Loyalty interests
- Donations
- Sponsored events
- Sponsored research
- Sponsored posts
- Clinical private practice

The following pages discuss the risks and issues posed in these situations, and the principles and rules that staff and organisations should adopt to manage them.

What are the issues?

Staff in the NHS offer support during significant events in people's lives. For this work they may sometimes receive gifts as a legitimate expression of gratitude. We should be proud that our services are so valued. But situations where the acceptance of gifts could give rise to conflicts of interest should be avoided. Staff and organisations should be mindful that even gifts of a small value may give rise to perceptions of impropriety and might influence behaviour if not handled in an appropriate way.

A gift means any item of cash or goods, or any service, which is provided for personal benefit, free of charge, or at less than its commercial value.

Principles and rules

Overarching principle applying in all circumstances:

- Staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with an organisation should be declined, whatever their value.
- Subject to this, low cost branded promotional aids may be accepted where they are under the value of a common industry standard of £6* in total, and need not be declared.

*The £6 value has been selected with reference to existing industry guidance issued by the ABPI:

<http://www.pmcpsa.org.uk/thecode/Pages/default.aspx>

Gifts (continued)

Principles and rules

Gifts from others sources (e.g. patients, families, service users):

- Gifts of cash and vouchers to individuals should always be declined.
- Staff should not ask for any gifts.
- Gifts valued at over £50 should be treated with caution and only be accepted on behalf of an organisation (i.e. to an organisation's charitable funds), not in a personal capacity. These should be declared by staff.
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

What are the issues?

Delivery of services across the NHS relies on working with a wide range of partners (including industry and academia) in different places and, sometimes, outside of 'traditional' working hours. As a result, staff will sometimes appropriately receive hospitality. Staff receiving hospitality should always be prepared to justify why it has been accepted, and be mindful that even hospitality of a small value may give rise to perceptions of impropriety and might influence behaviour.

Hospitality means offers of meals, refreshments, travel, accommodation, and other expenses in relation to attendance at meetings, conferences, education and training events, etc.

Principles and rules

Overarching principles applying in all circumstances:

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors – these can be accepted if modest and reasonable but individuals should always obtain senior approval and declare these.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75* - may be accepted and must be declared.
- Over a value of £75* - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).

*The £75 value has been selected with reference to existing industry guidance issued by the ABPI

<http://www.pmcpa.org.uk/thecode/Pages/default.aspx>

Hospitality (continued)

Principles and rules

Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on an organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type.
- A non exhaustive list of examples includes:
 - offers of business class or first class travel and accommodation (including domestic travel).
 - offers of foreign travel and accommodation.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature and value of the hospitality including the circumstances.
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Outside employment

What are the issues?

The NHS relies on staff with good skills, broad knowledge and diverse experience. Many staff bring expertise from sectors outside the NHS, such as industry, business, education, government and beyond. The involvement of staff in these outside roles alongside their NHS role can therefore be of benefit, but the existence of these should be well known so that conflicts can be either managed or avoided.

Outside employment means employment and other engagements, outside of formal employment arrangements. This can include directorships, non-executive roles, self-employment, consultancy work, charitable trustee roles, political roles and roles within not-for-profit organisations, paid advisory positions and paid honorariums which relate to bodies likely to do business with an organisation. (Clinical private practice is considered in a separate section).

Principles and rules

- Staff should declare any existing outside employment on appointment, and any new outside employment when it arises.
- Where a risk of conflict of interest is identified, the general management actions outlined in this guidance should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from an organisation to engage in outside employment.
- Organisations may also have legitimate reasons within employment law for knowing about outside employment of staff, even this does not give rise to risk of a conflict. Nothing in this guidance prevents such enquiries being made.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Shareholding and other ownership interests

What are the issues?

Holding shares or other ownership interests can be a common way for staff to invest their personal time and money to seek a return on investment. However, conflicts of interest can arise when staff personally benefit from this investment because of their role with an organisation. For instance, if they are involved in their organisation's procurement of products or services which are offered by a company they have shares in then this could give rise to a conflict of interest. In these cases, the existence of such interests should be well known so that they can be effectively managed.

Principles and rules

- Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with their organisation.
- There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.
- Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the shareholding/other ownership interest.
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

What are the issues?

The development and holding of patents and other intellectual property rights allows staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas. Staff are encouraged to be innovative in their practice and therefore this activity is welcomed.

However, conflicts of interest can arise when staff who hold patents and other intellectual property rights are involved in decision making and procurement. In addition, where product development involves use of time, equipment or resources from their organisation, then this too could create risks of conflicts of interest, and it is important that the organisation is aware of this and it can be managed appropriately.

Principles and rules

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by their organisation.
- Staff should seek prior permission from their organisation before entering into any agreement with bodies regarding product development, research, work on pathways, etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the organisation.
- A description of the patent or other intellectual property right and its ownership.
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

Loyalty interests

What are the issues?

As part of their jobs staff need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall in the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means - it can be as simple as having informal access to people in senior positions. However, loyalty interests can influence decision making.

Conflicts of interest can arise when decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process. The scope of loyalty interests is potentially huge, so judgement is required for making declarations.

Principles and rules

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how their organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation with whom close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

Where holding loyalty interests gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the loyalty interest.
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

What are the issues?

A donation is a charitable financial payment, which can be in the form of direct cash payment or through the application of a will or similar directive. Charitable giving and other donations are often used to support the provision of health and care services. As a major public sector employer the NHS holds formal and informal partnerships with national and local charities. Staff will, in their private lives, undertake voluntary work or fundraising activities for charity. A supportive environment across the NHS and charitable sector should be promoted. However, conflicts of interest can arise.

Principles and rules

- Acceptance of donations made by suppliers or bodies seeking to do business with an organisation should be treated with caution and not routinely accepted. In exceptional circumstances a donation from a supplier may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.
- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for an organisation, or is being pursued on behalf of that organisation's registered charity (if it has one) or other charitable body and is not for their own personal gain.
- Staff must obtain permission from their organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of a professional fee they receive may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared

- Organisations should maintain records in line with their wider obligations under charity law, in line with the above principles and rules.

Sponsored events

What are the issues?

Sponsorship of NHS events by external parties is valued. Offers to meet some or part of the costs of running an event secures their ability to take place, benefiting NHS staff and patients. Without this funding there may be fewer opportunities for learning, development and partnership working. However, there is potential for conflicts of interest between the organiser and the sponsor, particularly regarding the ability to market commercial products or services. As a result there should be proper safeguards in place to prevent conflicts occurring.

Principles and rules

- Sponsorship of events by appropriate external bodies should only be approved if a reasonable person would conclude that the event will result in clear benefit for the organisation and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from which they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At an organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified in the interest of transparency.
- Organisations should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff should declare involvement with arranging sponsored events to their organisation.

What should be declared

- Organisations should maintain records regarding sponsored events in line with the above principles and rules.

Sponsored research

What are the issues?

Research is vital in helping the NHS to transform services and improve outcomes. Without sponsorship of research some beneficial projects might not happen. More broadly, partnerships between the NHS and external bodies on research are important for driving innovation and sharing best practice. However, there is potential for conflicts of interest to occur, particularly when research funding by external bodies does or could lead to a real or perceived commercial advantage. There needs to be transparency and any conflicts of interest should be well managed.

Principles and rules

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to their organisation.

What should be declared

- Organisations should retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
 - their name and their role with the organisation
 - a description of the nature of the nature of their involvement in the sponsored research
 - relevant dates
 - any other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance)

Sponsored posts

What are the issues?

Sponsored posts are positions with an organisation that are funded, in whole or in part, by organisations external to the NHS. Sponsored posts can offer benefits to the delivery of care, providing expertise, extra capacity and capability that might not otherwise exist if funding was required to be used from the NHS budget. However, safeguards are required to ensure that the deployment of sponsored posts does not cause a conflict of interest between the aims of the sponsor and the aims of the organisation, particularly in relation to procurement and competition.

Principles and rules

- Staff who are establishing the external sponsorship of a post should seek formal prior approval from their organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and confirm the appropriateness of arrangements continuing.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. For the duration of the sponsorship, auditing arrangements should be established to ensure this is the case. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's specific products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What should be declared

- Organisations should retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this guidance.

Clinical private practice

What are the issues?

Service delivery in the NHS is done by a mix of public, private and not-for-profit organisations. The expertise of clinicians in the NHS is in high demand across all sectors and the NHS relies on the flexibility that the public, private and not-for-profit sectors can provide. It is therefore not uncommon for clinical staff to provide NHS funded care and undertake private practice work either for an external company, or through a corporate vehicle established by themselves.

Existing provisions in contractual arrangements make allowances for this to happen and professional conduct rules apply. However, these arrangements do create the possibility for conflicts of interest arising. Therefore, these provisions are designed to ensure the existence of private practice is known so that potential conflicts of interest can be managed. These provisions around declarations of activities are equivalent to what is asked of all staff in the section on Outside Employment.

Principles and rules

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises* including:

- where they practise (name of private facility)
- what they practise (specialty, major procedures).
- when they practise (identified sessions/time commitment)

*Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf

Clinical private practice (continued)

Principles and rules

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.**
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines:
https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on his or her behalf.**

** These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical_advice_at_work/contracts/consultanttermsandconditions.pdf

Where clinical private practice gives rise to a conflict of interest then the general management actions outlined in this guidance should be considered and applied to mitigate risks.

What should be declared

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when you practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this guidance).

5. Management: Strategic decision making groups

5.5. Many organisations use boards (or committees and sub-committees of boards), advisory groups, and procurement panels to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts
- Awarding grants
- Making procurement decisions
- Selection of medicines, equipment, and devices

These are referred to in this guidance as ‘**strategic decision making groups**’.

5.6. It is important that the interests of those who are involved in these groups are well known to those involved. Organisations must therefore identify relevant strategic decision making groups and ensure they operate in a manner consistent with the following principles, which reflect wider standards of good governance:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant interests
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise
- Any new interests identified should be added to the organisation’s register

- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement

5.7. If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting
- Ensuring that the member does not receive meeting papers relating to the nature of their interest
- Requiring the member to not attend all or part of the discussion and decision on the related matter
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate
- Removing the member from the group or process altogether

5.8. The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. An example is the need for clinical involvement, when clinicians may hold and represent a diversity of interests. Good judgement is required to ensure proportionate management of risk. The composition of groups should be kept under review to ensure effective participation.

5. Management: Procurement decisions

5.9. Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients.

5.10. Organisations should keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process. NHS Improvement and NHS England have published detailed and specific guidance on procurement processes which staff and organisations should consult.

5.11. For the avoidance of doubt, nothing in this section or this guidance waives or modifies any existing legal requirements relating to conflicts of interest and procurement decisions.



NHS Improvement Guidance on Procurement, Patient Choice and Competition:

<https://www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance>



NHS England Guidance on Conflicts of Interest for CCGs:

<https://www.england.nhs.uk/commissioning/pc-co-comms/coi/>

6. Transparency: Maintenance and publication of register(s)

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Maintenance of Register(s)

6.1. Organisations must ensure that a nominated team or individual collates and maintains up to date organisational register(s) of interests. An interest should remain on the register(s) for a minimum of 6 months after the interest has expired. Organisations should retain a private record of historic interests for a minimum of 6 years after the date on which it expired.

6.2. Template declaration of interests and register of interests forms for organisations to use are provided at [Annex C and D](#). They should always contain:

- The returnee's name and their role with the organisation
- A description of the interest declared (reflecting the content of section 5 of this guidance for common situations)
- Relevant dates relating to the interest
- Space for comments (e.g. action taken to mitigate conflict)

6.3. Using the common format in the templates will help minimise burdens on staff who might need to submit returns to multiple organisations.

Publication

6.4. All staff should declare interests and, as a minimum, organisations should publish the interests of decision making staff at least annually in a prominent place on their website. Organisations without websites should maintain registers locally, available for inspection on request.

6.5. The format of published registers should be accessible and contain meaningful information. Adopting the templates and advice on content in this guidance will assist organisations in this task.

6.6. Organisations should put in place processes for staff to make representations that information on their interests should not be published. This will allow for, in exceptional circumstances, an individual's name and/or other information to be redacted from any publicly available registers where the public disclosure of information could give rise to a real risk of harm or is prohibited by law.

6.7. As well as taking these steps, organisations should seek to ensure that staff who are subject to wider transparency initiatives such as the ABPI Disclosure UK scheme are aware of and comply with them:

<http://www.abpi.org.uk/our-work/disclosure/Pages/disclosure.aspx>



[Declaration of interests template](#)



[Register of interests template](#)

7. Breaches: How should these be dealt with?

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7.1. There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or organisations. For the purposes of this guidance these situations are referred to as 'breaches'.

7.2. Organisations should identify a team or individual to be notified of breaches, and be clear as to how staff or other parties can raise concerns about these. Staff should be encouraged to speak up about actual or suspected breaches, in compliance with their organisation's whistleblowing policy.

7.3 Organisations should also identify a team or individual empowered to investigate breaches, involving organisational leads for human resources, fraud, audit etc. as appropriate. Each breach needs to be investigated and judged on its own merits and this should start with those involved having the opportunity to explain and clarify any relevant circumstances.

7.4. Following investigations organisations should:

- Decide if there has been or is potential for an actual breach and the severity
- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum
- Consider who else inside and outside the organisation

should be made aware of the breach

- Take appropriate action, such as clarifying existing policy, taking action against the staff member(s) responsible for the breach, or escalating to external parties such as auditors, NHS Protect, the Police, statutory health bodies and/or regulatory bodies

7.5. When dealing with instances of breach organisations may want to take legal or other appropriate advice prior to imposing sanctions which could have serious consequences for those involved. A range of responses should be considered in terms of proportionate sanctions for breaches, including:

- Employment law action
- Reporting incidents to external bodies
- Contractual or legal consequences

Further information on the consequences of breaches and the range of potential sanctions is at [Annex E](#).

7.6. Organisations should consider whether reports on breaches, the impact of these, and action taken (i.e. if strong management action or sanctions are taken) should be considered by their governing body, audit committee, executive team or similar on a regular basis.

7.7. To aid transparency organisations should consider whether anonymised information on breaches and action taken in response should be prepared and published on websites on a regular basis.

8. Resource Annexes

ANNEX A – Model Conflict of Interest Policy

[due for publication in March 2017]

ANNEX B – Types of interests

ANNEX C – [Template interests declaration form](#)

ANNEX D – [Template interests register](#)

ANNEX E – Potential sanctions for breach of conflicts of interest policies

Annex B – Types of interests

Type of interest	Description
Financial interests	<p>Where an individual may get direct financial benefits* from the consequences of a decision their organisation makes. This could include:</p> <ul style="list-style-type: none"> • A director (including a non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • A shareholder, partner or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding • Someone in outside employment • Someone in receipt of secondary income. • Someone in receipt of a grant. • Someone in receipt of other payments (e.g. honoraria, day allowances, travel or subsistence). • Someone in receipt of sponsored research.
Non-financial professional interests	<p>Where an individual may obtain a non-financial professional benefit* from the consequences of a decision their organisation makes, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is:</p> <ul style="list-style-type: none"> • An advocate for a particular group of patients. • A clinician with a special interest. • An active member of a particular specialist body. • An advisor for the Care Quality Commission or National Institute of Health and Care Excellence. • A research role.

* A benefit may arise from the making of gain or avoiding a loss

Annex B – Types of interests (continued)

Type of interest	Description
Non-financial personal interests	<p>This is where an individual may benefit* personally from a decision their organisation makes in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:</p> <ul style="list-style-type: none"> • A member of a voluntary sector board or has a position of authority within a voluntary sector organisation. • A member of a lobbying or pressure group with an interest in health and care.
Indirect interests	<p>This is where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit* from a decision they are involved in making. This would include**:</p> <ul style="list-style-type: none"> • Close family members and relatives. • Close friends and associates. • Business partners.

* A benefit may arise from the making of gain or avoiding a loss

** A common sense approach should be applied to these terms. It would be unrealistic to expect staff to know of all the interests that people in these classes might hold. However, if staff do know of material interests (or could be reasonably expected to know about these) then these should be declared.

Annex E – Potential sanctions

Disciplinary sanctions

Staff who fail to disclose any relevant interests or who otherwise breach an organisation's rules and policies relating to the management of conflicts of interest are subject to investigation and, where appropriate, to disciplinary action. This may include:

- Employment law action which might include:
 - Informal action – such as reprimand or signposting to training and/or guidance.
 - Formal action – such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion or dismissal.
- Referring incidents to regulators.
- Contractual action against organisations or staff.

Professional regulatory sanctions

Statutorily regulated healthcare professionals who work for, or are engaged by, organisations are under professional duties imposed by their relevant regulator to act appropriately with regard to conflicts of interest. Organisations should consider reporting statutorily regulated healthcare professionals to their regulator if they believe that they have acted improperly, so that these concerns can be investigated. These healthcare professionals should be made aware that the consequences for inappropriate action could include fitness to practise proceedings being brought against them, and that they could, if appropriate be struck off by their professional regulator as a result.

Information and contact details for the healthcare professional regulators are accessible from the Professional Standard Authority website:

<http://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/find-a-regulator>

Annex E – Potential sanctions (continued)

Civil sanctions

If conflicts of interest are not effectively managed, organisations could face civil challenges to decisions they make – for instance if interests were not disclosed that were relevant to the bidding for, or performance of contracts. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Criminal sanctions

Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for the organisation concerned and linked organisations, and the individuals who are engaged by them.

The Fraud Act 2006 created a criminal offence of fraud and defines three ways of committing it:

- Fraud by false representation
- Fraud by failing to disclose information and
- Fraud by abuse of position.

In these cases an offender's conduct must be dishonest and their intention must be to make a gain, or a cause a loss (or the risk of a loss) to another. Fraud carries a maximum sentence of 10 years imprisonment and/or a fine and can be committed by a body corporate.

The Bribery Act 2010 makes it easier to tackle this offence in public and private sectors. Bribery is generally defined as giving or offering someone a financial or other advantage to encourage a person to perform certain activities and can be committed by a body corporate. Commercial organisations (including NHS bodies) will be exposed to criminal liability, punishable by an unlimited fine, for failing to prevent bribery.

The offences of bribing another person or being bribed carries a maximum sentence of 10 years imprisonment and/or a fine. In relation to a body corporate the penalty for these offences is a fine.